

VOL. 3

JAN.—APRIL 1987

NO. 1

THE INDIAN JOURNAL OF COMMUNITY HEALTH

(Official Publication of U. P. Chapter of Indian Association of
Preventive & Social Medicine)

Head Office of the Journal

Department of Social and Preventive Medicine

L. L. R. M. Medical College, MEERUT, (U. P.)

$\alpha = 0.05$ and $\beta = 0.80$ (Table 1). The power of the test is 0.80, which is the probability of rejecting the null hypothesis when the alternative hypothesis is true. The power of the test is 0.80, which is the probability of rejecting the null hypothesis when the alternative hypothesis is true.

THE NEW YORK PUBLIC LIBRARY
ASTOR LENOX TILDEN FOUNDATION
155 E. 42ND STREET
NEW YORK 17, N.Y.

۱۲۰۰

1. The first step is to identify the problem or question that needs to be answered. This involves understanding the context and the specific requirements of the task.

1

THE INDIAN JOURNAL OF COMMUNITY HEALTH

JAN.-APRIL, 1987, VOL. 3, NO. 1

Chief Editor

Dr J. S. Mathur

Editor

Dr. R. K. Gupta

Asstt. Editor

Dr. A. K. Govila

Technical Adviser

Dr. V. N. Mishra

MEMBERS OF EDITORIAL BOARD

1. Dr. Rameshwar Sharma
2. Dr. G. S. Bidhaiya
3. Dr. P. V. Gulati
4. Dr. R. N. Srivastava
5. Dr. B. Raj
6. Dr. A. Rauf
7. Dr. M. P. Dwivedi
8. Dr. I. C. Tewari
9. Dr. S. N. Sinha
10. Dr. S. K. Mehrotra
11. Dr. G. S. Anjaneyulu
12. Dr. N. K. Vaidya
13. Dr. Gopa Kothari
14. Dr. V. C. Jain
15. Dr. Gyanendra Singh
16. Dr. Deeki Nandan
17. Dr. B. S. Garg

CONTENTS

- 1 Editorial—V. B. Bhatnagar —1
- 2 Knowledge of Parents of a Backward community Regarding Malnutrition in children. —3
C. P. Mishra, D. C. S. Reddy, I. C. Tewari & K. P. Shukla.
- 3 Filariasis in the villages Around Lucknow. —9
V. K. Srivastava, P. Tiwari, A. K. Rastogi & K. C. Saxena.
- 4 A study on Morbidity Profile of Tibetan Refugees of Chandragiri in the Ganjam District of Orissa —15
T. Sahu, S. B. Kar and B. K. Patnaik
- 5 Morbidity Differentials Amongst the families of the employees of Medical College Meerut. —21
N. Kamboj, J. S. Mathur, M. Bhatnagar, V. N. Mishra, R. B. Singh & B. S. Garg.
- 6 Assessment of change of knowledge through on the Job Training of Health workers (Female) in Varanasi —28
V. K. Gupta, Raj Kumar & I. C. Tewari
- 7 Proceedings of V General Body of UP Chapter of IAPSM. —32

Managing Editors

Dr. Gopal Krishna (Kanpur)

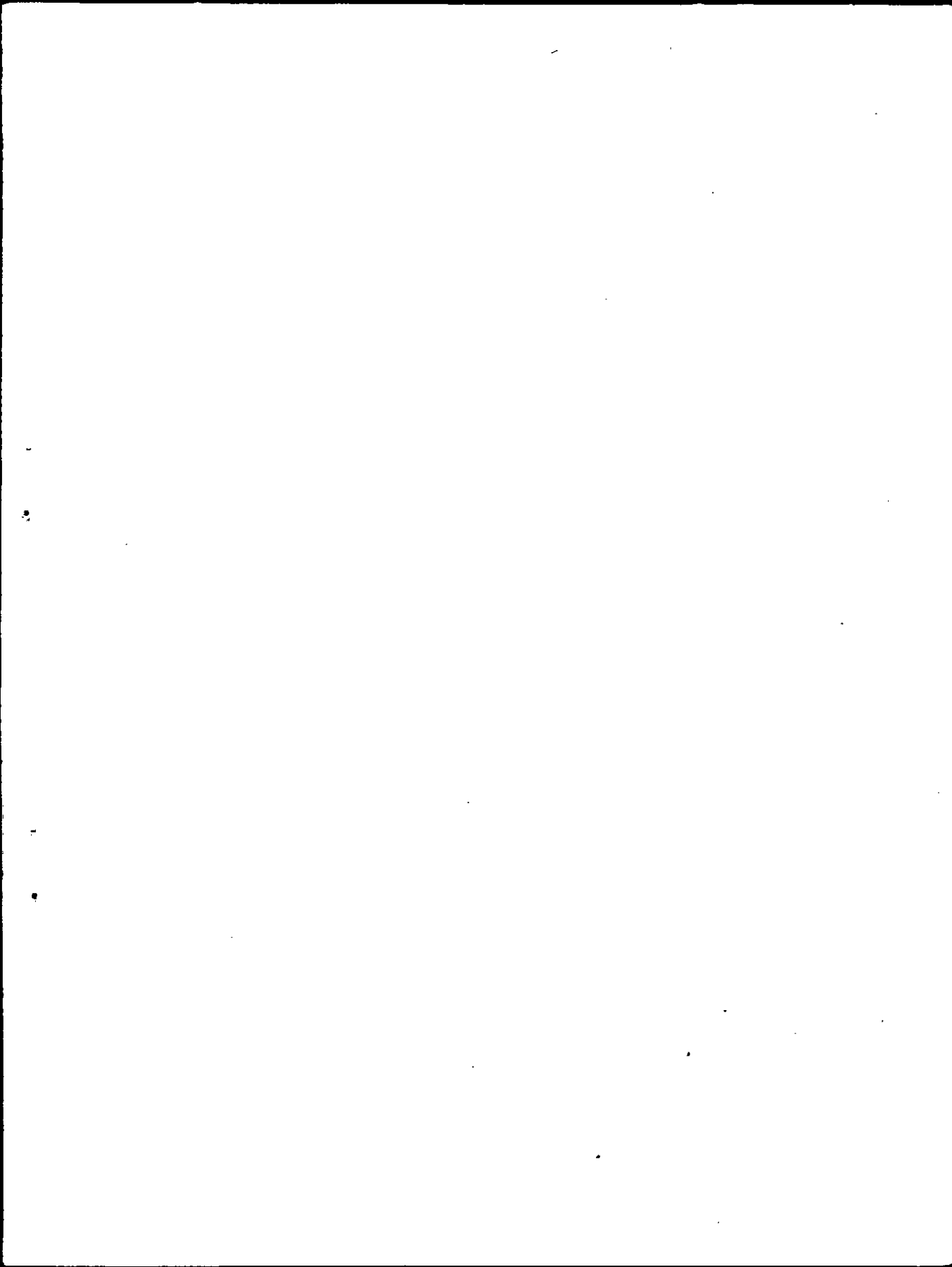
Dr. J. V. Singh (Meerut)

Administrative Officer

Dr. (Mrs.) M. Bhatnagar

Statistical Adviser

Dr. Ranbir Singh



Editorial

"EARLY DETECTION OF CANCER"

Early detection of cancer is based upon three fundamental assumptions, firstly that the treatment of benign and precancerous lesions reduces the incidence of cancer, secondly, that the treatment of in situ cancers is conducive to total cure and thirdly that early diagnosis and management of invasive cancer ensures better survival. When patient seeks medical advice for vague symptoms, which could however be due to a possible malignant tumour at a particular site, the alert clinician should investigate the patient immediately to exclude cancer. At this stage cancer is usually not significantly advanced.

Currently the U. I. C. C. (International Union for Cancer Control) is studying the epidemiology of cancers in various countries. The importance of this is two folds: Firstly by focussing attention on a section of population vulnerable to a particular cancer an early detection is facilitated. Secondly by changing the causative factors responsible to a particular cancer, the incidence of that cancer can be reduced e. g. reduction in lung cancer following campaigns against cigarette smoking and reduction in breast cancer after campaigns for advocating breast feeding of infants, lowering fat consumption and encouraging self palpation of breast regularly.

Indeed early diagnosis of cancer implies diagnosis of cancer in almost a symptomatic stage. It involves motivation of the population towards acquisition of knowledge, attitude and practice.. Epidemiologists and clinicians should be able to recognise high risk cases exposed to particular neoplasia and knowledge of alarming symptoms should be propagated for wide publicity through common available media and means. Probable cases should have regular clinical examination periodically and relevant investigations including radiological, imaging techniques and Bio-Chemical examination should be undertaken as and when desired. Suspicious lesions should be investigated by specific tests including smear cytology, aspiration cytology, tru-Cut needle biopsy and incisional or excisional biopsy to exclude or confirm the diagnosis. A vigilant clinician thus may diagnose cancer at early stage.

Oral cancer patients who are at high risk due to a predisposing condition like betel Chewing-habit and chronic irritation due to sharp teeth should be frequently examined and any suspicious ulcer or change in oral mucosa should certainly be subjected to biopsy.

In cancer of cervix, poor hygiene, early marriage and multiple pregnancies are possible predisposing factors. In western countries the use of yearly papanicolaou smear, the Schiller's iodine test and where indicated cone biopsy of the cervix, over the age of 30 years has considerably increased the diagnosis of stage 'O' and stage I cancer cervix at which stage total cure is possible. The Indian Academy of cytology is making efforts to have the 'Pap' test included in the gynaecological examination for women who report to primary health centres for advice on family planning

In breast cancer, mammography, thermography coupled with clinical examination, aspiration cytology and immediate biopsy of suspicious lump are being employed for early detection. Self examination is in-expensive and women should be educated to adopt this simple screening measure. Use of mammography for masses is deemed restricted due to possible radiation hazards, expenses involved and scarcely available facility. Low dose, units for mammography have now come for use to cut short the radiation hazards of conventional mammography. Xero-radiography is being increasingly used in different countries. The use of ultrasonics, trans illumination and radio active isotopes are still in the experimental stage.

Lung cancer is thirty times commoner in heavy smokers. So all chronic smokers above the age of forty years, who complain of productive chronic cough for more than two weeks should be considered at risk and subjected to repeated sputum cytology and chest-x-ray examination, bronchoscopy and biopsy and scalene node biopsy. An X-ray of the chest every six months is a must in all heavy smokers over 45 years.

In cancers of anorectal region, 75% are with-in the reach of examination finger and proctoscopy, facilitating an early detection. Any patient aged 40 years and above, complaining of passage of blood in the stools or altered bowel habits should under go rectal examination, Procto-sigmoidoscopy Barium enema studies & colonoscopy. Similarly, patients with familial or other types of polyposis or ulcerative colitis should be identified as being at high risk and need repeated examination for early detection. Fibreoptic flexible endoscopy is assuming great importance in this area. Fibre-optic oesophago-gastroscope and the use of gastric camera and gastric cytology now a days are excellent aids for early detection of oesophageal and gastric cancer. Energetic efforts by Japanese in the early detection of gastric carcinoma have led to 90% 5 years survivals. This must be considered the most outstanding achievement in the field of cancer control during the past decade due to early detection of cancer.

V. B. BHATNAGAR
Professor of Surgery,
L. L. R.M. Medical College,
Meerut.

Knowledge of Parents of a Back-ward Community Regarding Malnutrition in Children

C. P. Mishra¹, D. C. S. Reddy², I. C. Tiwari & K. P. Shukla⁴.

Introduction

Protein energy malnutrition (PEM) in children has been considered as the most important problem in the field of preventive medicine particularly so in the developing countries (WHO, 1974). Various crash activities and nutrition programmes in our country could not bring an appreciable change in the over-all magnitude of the problem (ICSSR and ICMR, 1981). In order to have sustained improvement, parents education holds great promise. Information education and communication (IEC) is emerging as an important tool in the delivery of Primary Health Care (PHC) as well as nutrition related services. For proper application of this tool it is imperative to have basal knowledge of parents regarding identification, causes and preventability of important nutritional disorders. The specific objectives of the present study were to explore—

(a) The ability of parents to recognise marasmus, kwashiorkor, vitamin A and vitamin B deficiencies with photograph of these disorders and also on description.

(b) Knowledge of parents regarding causes of marasmus, kwashiorkor, vitamin A and B complex deficiencies.

(c) Knowledge of parents regarding prevention of malnutrition disorders.

The important facets and concepts of a backward community of Banda District, Uttar Pradesh as revealed by the present study may be of immense help in planning a 'Nutrition Education programme'.

Material and Methods

All the parents having underfive children in the six clusters of Manikpur Block in Banda District, Uttar Pradesh have formed the population of this study. The clusters of population were selected purposively keeping operational feasibility in mind viz travel, accessibility of the study population. Two clusters were within 5 kms, two between 5-10 kms and remaining two beyond 10 kms from Manikpur Headquarter. In the selected clusters, 171 mothers and 171 fathers belonging to

1. M. O. H. 2. Reader 3. Professor 4. Reader

Department of Preventive and Social Medicine Institute of Medical Sciences, Banaras Hindu University, Varanasi-221005.

Harijan and tribal group and having under-five child/children were enlisted by total enumeration. Nearly all the subjects belonged to families who earn their bread through daily wages. Majority of the parents of the study area were illiterate and they had considerable variation in their income potential. Only 16.3% of the adults were literate while 1.6% of them were educated upto college level.

Mothers and fathers were interviewed separately with the help of photographs of children suffering from marasmus, kwashiorkor, vitamin A and B deficiencies. Considering the fact that photographic recall will be less than that of photographic recall plus description, if parents were unable to recognise the respective photographs, features of the disease depicted on a particular photograph were described to them. However, such description were standardised beforehand (Jelliffe, 1966) Another reason of providing descriptions was the idea that picture alone may not help the undertaken community to recognise various nutritional disorders. It may so happen that the community have not seen cases recently but only heard of such diseases, so on description they could recall and identify the pictures shown.

Out of the 171 enlisted mothers and fathers, 156 each could be contacted for the present study, thus giving a coverage of 91.2% of the study subjects.

Observations and Discussion

Knowledge of Mothers : Marasmus was identified by 40 mothers (25.6%) while

seventeen mothers (10.9%) could recognise vitamin A deficiency. Recognition of Kwashiorkor and vitamin B deficiency was poor i.e. 1.3% with photographs. On describing the photographs of marasmus and vitamin A deficiency recognition of these disorders was possible in 56 (35.9%) and 73 (46.8%) cases respectively. Corresponding figures in cases of Kwashiorkor and vitamin B deficiency were 43 (27.6%) and 40 (25.6%). The differences observed in the recognition of these disorders with photograph and photograph plus description were statistically significant (Table-1).

Knowledge of Fathers : Out of the 156 fathers who could be studied with photograph 52 (33.3%) and 50 (32.0%) were able to recognise marasmus and vitamin A deficiency respectively. On description their recognition increased to 80 (51.3%) and 98 (68.8%) respectively. Kwashiorkor and vitamin A deficiency was identified in 6 (3.8%) and 21 (13.5%) cases respectively. Corresponding figures after describing the photographs of these disorders were 45 (28.8%) and 50 (32.0%) cases respectively. The observed differences in the identification of these disorders with photographs and by describing them were statistically significant (Table-2).

These observations clearly demonstrate that in a primitive society description of photograph contributes significantly in the recognition of important nutritional disorders. Unfortunately, relatively little research has been done into the way photographs can contribute in communicating

Knowledge of Parents regarding Malnutrition

with parents particularly the illiterate group (Moynihan et al 1981). In the present study higher recognition of marasmus and vitamin A deficiency with photographs as well as description is a reflection

of occurrence of these conditions in a considerable proportion. Also these conditions tend to run a chronic course and are likely to have greater impression in the mind of the parents than other conditions

Table 1 : Knowledge of mothers regarding malnutrition in children (n=156).

	With Photograph		On describing Photograph		Statistical Significance	
	No.	%	No.	%	Z	P
Marasmus	40	25.6	56	35.9	1.976	$\angle 0.05$
Kwashiorkor	2	1.3	43	27.6	7.143	$\angle 0.01$
Vitamin A deficiency	17	10.9	73	46.8	7.625	$\angle 0.01$
Vitamin B deficiency	2	1.3	40	25.6	6.724	$\angle 0.01$

Table 2 : Knowledge of fathers regarding malnutrition in children (n=156).

	With Photograph		On describing Photograph		Statistical Significance	
	No.	%	No.	%	Z	P
Marasmus	52	33.3	80	51.3	3.269	$\angle 0.01$
Kwashiorkor	6	3.8	45	28.8	6.343	$\angle 0.01$
Vitamin A deficiency	50	32.0	98	68.8	5.721	$\angle 0.01$
Vitamin B deficiency	21	13.5	50	32.0	4.017	$\angle 0.01$

Verma et. al (1986) while evaluating the increase in knowledge of women in Haryana State following a special broadcast series on mother and child care, reported a very poor initial knowledge of nutritional diseases. Only 2.6% women were knowledgeable about vitamin A deficiency which after exposure increased to 72.4%. Losses occurred between exposure and retention stage over the stipulated period of one week. In another study by Vyas (1986) gain in the knowledge about

vitamin A deficiency was 69.85% and retention score was 67.24%.

(b) Knowledge of parents regarding causes of nutritional disorders :

Marasmus : As much as 131 (83.97%) mothers and 124 (79.49%) fathers were ignorant about the causes of marasmus. Fever was considered as a cause of marasmus by 12 (7.69%) mothers. Insufficient diet as cause of marasmus was considered by 6 (3.85%) mothers and 10 (6.4%) fathers.

Table 3 : Knowledge of parents regarding causes of Marasmus in underfives (n=156).

Cause	Mother		Father	
	No.	%	No.	%
Fever	12	7.69	6	3.85
Insufficient diet	6	3.85	10	6.41
God's wishes	4	2.56	2	1.28
Diarrhoea ± Fever	2	1.28	7	4.49
Food related	1	0.64	4	2.56
Not known	131	83.97	124	79.49
Contagious	0	0.0	2	1.28
Eating left over food	0	0.0	1	0.64

Kwashiorkor : 145 (92.95%) mothers and 135 (86.5 %) father were unable to state any cause for kwashiorkor. Three mothers and fathers (1.92% each) considered disease proneness as causative factor. One (0.64%) mother and 5 (3.21%) fathers considered it to be food related. Only one individual of each group considered it to be due to diarrhoea with or without fever.

Vitamin A and B deficiencies : Nearly 75% mothers and 70% fathers did not learn about the cause of vitamin A deficiency. Majority of the mothers and fathers who could assign any cause of vitamin A deficiency, considered it to be effect of sun. Only 8 (5.13%) mothers and 5(3.21%) fathers considered it to be food

Knowledge of Parents regarding Malnutrition

related. Out of the 156 from each group 1.6 (80.76%) mothers as well as fathers could not assign any cause of vitamin B deficiency in underfives. 24 (15.38%) mothers were of opinion that eating of leftover food is responsible for glossitis with or without angular stomatitis, only 1 (0.64%) mother and 3 (1.92%) fathers considered it to be food related.

Analysis of the causes of various disorders clearly reflects that majority of parents were ignorant about the causes of marasmus, kwashiorkor, vitamin A and B deficiencies. Even those subjects who could assign some cause, their response were considerably different from that has been

quoted in literature. Like dietary intake and infectious (Scrimshaw et al, 1968 and Mata et al, 1972).

(c) Knowledge of parents regarding prevention of malnutrition disorders :

Out of 156 mothers, 62 (39.74%) were of the opinion that malnutrition can be prevented. Combination of good food alongwith treatment of illness was considered as the method of its prevention by 12 (19.35%) mothers. A combination of good food, treatment of illness and magico-religious practices was considered to be the method of prevention by the 28 (45.16%) mothers. (Table 4). 80 (51.28%)

Table 4 : Knowledge of parents regarding prevention of malnutrition disorders (n=156 each).

Method of Prevention	Mother		Father	
	No.	%	No.	%
(a) Good food	5	8.06	9	11.25
(b) Treatment of illness	7	11.29	8	10.00
(c) a+b	12	19.35	25	31.25
(d) a+b+traditional Practices	2	3.22	2	2.50
(e) Magico-religious practices	5	8.06	3	3.75
(f) a+b+c	28	45.16	29	36.25
(g) God only can prevent	2	3.22	2	2.50
(h) No opinion	1	1.61	2	2.50
Total	62	39.74	80	51.28

fathers considered malnutrition as a preventable condition .25 (31.25%) fathers were of opinion that these conditions could be prevented by combination of food plus treatment of illness .29 (35.25%) fathers thought that if the above approach is combined with magico-religious practices, these disorders can be prevented (Table-4).

There is not only a need to educate the parents that malnutrition disorders are preventable but the 'Nutrition Education Programme' should also emphasise the ways of prevention of these disorders. Food intake and morbidities are the chief factors in determining a child's health. Parents should be educated to realise this aspect of child care. Studies by Vyas (1986) and Manoff (1984) have clearly reported that there was no significant difference in the gain in the nutritional knowledge in the illiterate, women with less formal education and educated women. While designing the Nutrition Education Programme local culture especially the health culture should not be ignored. (Moynihan et. al. 1981). In the field of nutrition, supply oriented programmes can not make a success unless parents attitude regarding nutritional disorders is changed. This clearly reflects the importance of demand strategy i.e. nutrition education in combating the problem of malnutrition in children

References :

1. I. C. S. S. R. and I. C. M. R. (1981) : Health for All-an alternative strategy. Report of study group set up jointly by the Indian Council of Social Science Research and the Indian Council of Medical Research .6.
2. Jelliffe, D. B. (1966). The assessment of the nutritional status of the community. WHO Monograph series No. 53.
3. Manoff, R. K. (1984). Social marketing and nutrition education. Going to scale for child survival and development. UNICEF 65/68, 95-113.
4. Mata I. J., Albertazzi, C., Pellegrini, O and Arellano, E (1972). Influence of recurrent infections on nutrition and growth of children in Guatemala. Amer. J. Clin. Nutr. 25, 1267-1275.
5. Moynihan, M. and Mukherjee, U (1981). Visual communication with non literates : a review of current knowledge including research in northern India. Int. Jour. Hlth. Ed-24, 95-102.
6. Scrimshaw, N. S., Taylor, C. E. and Gordon J. E. (1968). Interactions of nutrition and infections. WHO Monograph. Geneva. WHO.
7. Verma, T and Grover, I (1986). Evaluation of Radio information, utilisation, retention and constraints faced by rural women in Haryana. Interaction, 4 (3), 61-69.
8. Vyas, D. S. (1986). Impact of radio on extension of child survival and development in India. Sampadana Ist Ed. National Council of Development Communication, Varanasi 176-207.
9. W.H.O. (1974) Malnutrition and mental development, W. H. O. Chron. 28, 95-102.

Filariasis in The Villages Around Lucknow

By

V. K. Srivastava*, Pradip Tiwari*, A. K. Rastogi* and K. C. Saxena***

Introduction :

The lymphatic filariasis in man is caused by *Wuchereria bancrofti*, *Brugia malayi* and *Brugia timori* (Duke, 1981). It manifests into a spectrum of acute and chronic clinical features (Nelson, 1979; Ottesson, 1980 & Dasgupta, 1981) as a result of continuous exposure and a long association with the parasite. Of the exposed population, a small proportion of subjects shows clinical features of lymphatic obstruction, but a large proportion of subjects remains clinically silent with circulating larva (microfilaria) in their blood. A considerable number of subjects remain positive for clinical symptoms, as well as, for microfilariae (mf) in blood. This leads to three main groups in the community, i.e. subjects with symptomatic filariasis, asymptomatic microfilaraemia, and symptomatic microfilariaemia. For a subject to be infective for others, depends upon the frequency of microfilaria per unit blood. The present study was aimed at finding out the prevalence of filarial infection in random population, clinical presentation of disease and the frequency of mf per unit volume of blood in a rural population.

Material and Methods :

The present study was carried out in the villages around Experimental Teaching Health Sub-Centres Mati and Banthra

under the Upgraded Department of Social and Preventive Medicine, K. G. Medical College, Lucknow. This area is endemic for nocturnally periodic *W. bancrofti*. All the age groups and both sexes were included in the study. Subjects were screened for mf in nocturnal blood by the standard 20mm³ thick smear technique between 20.00 and 22.00 hours. The smears were dehaemoglobinized, fixed in menthol, stained with 5% giemsa and examined for microfilariae.

A thorough clinical examination of all the subjects was carried out in order to detect any features of disease viz. filarial leg, scrotal filariasis, epididymo-orchitis, lymphadenitis, filarial hand and breast. Microfilaria (mf) frequency per unit blood (20mm³) was also found out.

Observations :

Out of total 945 individuals surveyed, 13.7% were asymptomatic mf carriers (1 or more mf per 20 mm³ of blood) and 9.8% were having filarial diseases without mf in peripheral blood. Only 1.8% of individuals surveyed presented with disease, as well as, mf in their peripheral blood. An increasing trend in infection and disease rate was observed with rise in age. This however, declined in those 55 years and above. This difference in the prevalence of infection and disease, in different age groups was statistically significant.

*Upgraded Deptt. of S. P. M.

**Department of Surgery

***Central Drug Research Institute, Lucknow.

} K. G. Medical College,
J Lucknow.

Table I : Prevalence of filariasis by age

Age	No. examined	Infection		Disease		Infection +disease		Total endemicity (infection &/or +disease)	
		No.	%	No.	%	No.	%	No.	%
< 5	27	1	3.7	Nil	0.0	Nil	0.0	1	3.7
5-14	243	27	11.1	5	1.8	1	0.4	33	13.6
15-24	232	34	14.6	26	11.2	2	0.9	62	26.7
25-44	279	45	16.1	35	12.5	7	2.5	87	31.2
45-54	84	16	19.0	17	20.2	4	4.8	37	44.0
55+	80	7	8.7	10	12.5	3	3.7	20	25.0
Total	945	130	13.7	93	9.8	17	1.8	240	25.4

Test of significance :

(For the purpose of calculating X^2 value, the categories <5 & 5-14 have been pooled together).

Infection by age : $X^2=18.09$, d.f. =4, $p < .005$

Disease by age : $X^2=47.96$, d.f. =4, $p < .001$

Total endemicity by age : $X^2= 43.9$, d.f. =4, $p < .001$

The prevalence of disease was significantly higher in males (11.2%) than females (7.2%). The prevalence of infection was higher in females (14.8%) than

in males (13.2%) but it was insignificant. The subjects with infection and disease both, were 2.2% among males against 0.9% in females (Table II).

Flariasis in the villages around Lucknow

Table II : Prevalence of filariasis by sex

Sex	No. examined	Infection		Disease		Infection + disease		Total endemicity (infection &/or disease)	
		No.	%	No.	%	No.	%	No	%
Male	627	83	13.2	70	11.2	14	2.2	167	26.6
Female	318	47	14.8	23	7.2	3	0.9	73	22.9
Total	945	130	13.7	93	9.8	17	1.8	240	25.4

Test of significance :

Infection by sex : $\chi^2 = .03$, d.f. = 1, $p > .50$

Disease by sex : $\chi^2 = 5.29$, d.f. = 1, $p < .05$

Total endemicity by sex : $\chi^2 = 1.50$, d.f. = 1, $p > .10$

Filarial leg (60.9%) was the commonest presentation of the disease, followed by serotal filariasis (22.8%), epididymoorchitis (9.1%), inguinal lymphadenitis (3.6%), filarial hand (2.7%) and filarial breast (0.9) (Table III).

Table III : Disease pattern in filariasis

Main presenting feature	No. of case	Percentage
Filarial leg	67	60.9
Scrotal filariasis	25	22.8
Epididymo-orchitis	10	9.1
Inguinal lymphadenitis	4	3.6
Filarial hand	3	2.7
Filarial breast	1	0.9
Total	100	100.0

In more than half of the mf carriers (56.5%), frequency of mf was only upto 10 in 20 mm³ of blood. Microfilarial frequency

of more than 50 per 20 mm³ of blood was seen only in 6.2% of carriers (Table IV).

Table IV : Microfilarial frequency in mf carriers

Mf count/20 mm ³ blood	No. of carriers	Percentage
Upto 10	83	56.5
11-50	55	37.3
51-100	7	4.8
100+	2	1.4
Total	147	100.0

Discussion :

The public health importance of filariasis in India is only second to malaria amongst the mosquito borne disease. Uttar Pradesh is one of the heavily infected states of India. Lucknow and its surrounding areas have been reported endemic for filaria by many workers (Srivastava and Prasad, 1969 ; Chandra et al, 1973). In the present study the overall filarial endemicity rate was found to be 25.4% : the infection alone accounted for 13.7%, disease in 9.8% and infection + disease in 1.8%. Srivastava and Prasad (1969) in the villages around Lucknow reported the prevalence of infection and disease to be 11.9% & 3.9% respectively, and endemicity rate to be 15.4%. Chandra et al (1973) observed filarial endemicity to be 17.9% in the same area. This shows that there is no let up in

the disease transmission and repeated infections in last two decades. In the present study the higher endemicity rate in the villages around Lucknow reflects unchanged climatic conditions, unplanned urbanization, industrialization and formation of irrigation channels etc. in last two decades, adding upto already existing bad drainage system. Raghavan (1976) has also observed that in areas where no organised control measures are undertaken, infection and disease rates have gone up in last 20 years.

In the population studied, a higher infection, disease and endemicity rate was observed in the higher age groups (>14 years). This suggests a continuous transmission of disease in the area resulting into repeated infection, i.e. hyper-filariation and

Filariasis in the villages around Lucknow

is thus cumulative with the years of residence in an endemic area (Raghavan, 1976).

A higher disease and endemicity rate in the males observed in the present study is in conformity with the findings of Srivastava & Prasad (1969) and Sharma et al (1986). This higher prevalence in males is attributable to their scanty dressing, making them more prone to mosquito bites.

The commonest presentation of the filarial disease in the present study was filarial leg (60.9%). Srivastava & Prasad (1969) observed hydrocoel being the commonest presentation. Rao et al (1977) found filarial hydrocoel in 54.0% cases of filariasis. The rarest presentation of disease in form of filarial breast as observed in the present study has also been reported by Rao et al (1977).

An optimal microfilarial density in the peripheral blood which can infect a mosquito is not yet known. A varying mf density has been reported by various workers. In the present study more than 50% carriers had 1 to 10 mf/20 mm³ of blood while in 94.0% subject the mf density was below 50/20mm³ of blood. Chandra et al (1973) found mf density in the range of 1 to 30 in over 60% of their carriers. Misra and Dwivedi (1979) reported mf density of 1 to 10/20 mm³ of blood in 58.7% and 1 to 50 in 98.8% carriers.

As the Government of India is committed to the goal of Health for All by 2000 A.D., extension of filarial control

activities to the rural areas is, therefore, imperative. The strategies adopted so far, as antilarval measures with chemicals and vector control have not been successful for the population at large, and are operationally laborious and expensive. The latest strategy drawn up by the Government of India in VII plan period is to extend the filariasis control activities to the total rural population at risk, through primary health care. The aim is to reduce the load of filarial disease by involvement of village health guides (VHG) and multipurpose workers (MPW). They would be given DEC for treating acute and chronic clinical cases of filariasis at very peripheral out set. The field trials have shown the feasibility of this approach.

References

1. Chandra, S., Chandra, R., Katiyar, J. C., Govil, P., George, P. A. and Sen, A. G. (1973). Observation on filariasis in some villages around Lucknow, Uttar Pradesh. *Indian J. Med. Res.* 61,8,1127-1133.
2. Dasgupta, A. (1984). Cursory survey of lymphatic filariasis. An overview. *Ind. J. Path. Micro.* 27 : 273.
3. Duke, B.O.L. (1981). Lymphatic and other filariasis. *Br Med. J.* 283 : 1036.
4. Misra, S. S. and Dwivedi, M. P. (1979). An epidemiological study of filariasis in Rewa Town (MP), Ind. *Jour. Pub. Health.* 13.1,7-16.

5. Nelson, G. S. (1979). Current concept in parasitology. filariasis. New Eng. J. Med. 300 : 1136.
6. Ottesson, E A. (1980). Immunology of lymphatic filariasis in man. Springer Seminars in Immunopathol. 2 : 373.
7. Raghavan N.G.S. (1976). Clinical features and some epidemiological aspects of filariasis in India. J. Com. Dis., 18,3) : 189-192.
8. Rao, C.K, Sen, T. Narsinham, M. V. V. L., Rao, K. C. and Sharma, S P. (1977). Variation in clinical pattern of bancroftian filariasis in Kerala and Uttar Pradesh. J. Comm. Dis., 9 (2) : 203-205.
9. Sharma, R. S., Raina, V. K., and Rao, C.K. (1986). A filarial survey among the migratory labourers at Alwar, Rajasthan. J. Com. Dis, 18 (8) 287-290.
10. Srivastava, R. N. and Prasad. B. G. (1969). An epidemiological study of filariasis in the villages of the Rural Health Training Centre, Sarojini Nagar, Lucknow. Ind. Jour. Med. Res, 57, 3.

GREETINGS

From

MICRONIC DEVICES

403, GAGAN DEEP, 12, RAJENDRA PALACE, NEW DELHI-110008

Tel. No. 589771

Telex No. 031- 62235

Branches At :—

BOMBAY, BANGALORE AND CALCUTTA

Distributors in India For :

M/s. CARDIAC PACEMAKERS INC., U. S. A.

M/s. MARQUETTE ELECTRONICS INC., U. S. A.

M/s. DATASCOPE B. V. HOLLAND

M/s. COROMETRICS MEDICAL SYSTEMS INC., U. S. A.

"A STUDY ON MORBIDITY PROFILE OF TIBETAN REFUGEES OF CHANDRAGIRI IN THE GANJAM DISTRICT OF ORISSA"

T. Sahu S. B. Kar and B K. Patnaik

INTRODUCTION :

With the help of Government of India and State Governments the Tibetan refugees were settled up at different places in India; and Chandragiri situated at a distance of 78 KMs from Berhampur.

The community which has adopted some of the socio-cultural practices of local population and have retained most of their original practices offer an excellent material for the study of effects of different social - cultural - demographic - economic - religious factors on morbidity pattern. Tibetan race, culture, customs, tradition and religion are alien to that of Indian and more so to that of Orissa. This refugee population was available within the reach of resources. The comparative ease of collection of data encouraged to carry out the study so as to obtain valuable informations on morbidity pattern of the community which can be utilised in varied situations in taking up community health work.

The present study was undertaken to obtain an integrated picture of different leading diseases prevalent in the community and recommend measures for their control and eradication,

MATERIAL AND METHODS :

A simple random sample of 30% house-holds with proportional allocation

of Tibetan refugees settled at Chandragiri have been selected for study. All the members of the house-hold were included in the study population. Informations on history of sickness for past one year physical examination of individuals and laboratory investigation of diagnostic material where-ever necessary were obtained through the administration of pre-planned, pre-tested questionnaires with the help of community leaders.

Of the 1053 persons in study sample 1012 persons could be covered giving a non-response of 3.8%. The study was carried out During Jan.-Feb., 1983.

OBSERVATIONS AND DISCUSSION :

Out of total 1012 persons; 186 persons gave the history of having suffered from one or more diseases during the previous one year, where as 216 persons were found to be suffering from one or more diseases at the time of survey.

The distribution of morbid persons by age was high in early and late age groups and minimum in the age group of 15-24 years indicating that the disease conditions were much less in young adults (Table I and II).

Table-I. Age and Sex Distribution of Morbid During Past One Year.

Age Group	Persons					
	M A L E			F E M A L E		
	Total	No. Sick	Prevalence/ Thousand	Total	No. Sick	Prevalence/ Thousand
<50—	77	19	246	58	14	241
5—	109	17	156	95	15	158
15—	65	8	123	62	8	129
25—	68	9	132	63	12	190
35—	74	11	148	47	11	234
45—	81	14	173	61	15	246
55—64	91	16	176	61	17	278
TOTAL	565	94	166	447	92	205

Table-II. Age and Sex Distribution of Morbid Persons at the Time of Survey.

Age Group	M A L E			F E M A L E		
	Total	No Sick	Prevalence/ Thousand	Total	No. Sick	Prevalence/ Thousand
	Total	No Sick	Prevalence/ Thousand	Total	No. Sick	Prevalence/ Thousand
<50—	77	27	351	58	18	311
5—	109	23	211	95	18	189
15—	65	10	154	62	8	129
25—	68	13	191	63	9	143
35—	74	15	203	47	7	149
45—	81	17	210	61	12	197
55—64	91	24	264	61	15	246
TOTAL	565	129	228	447	87	195

A Study on Morbidity Profile of Tibetan Refugees

Table III : Diseases Suffered by the Study Population During Past One year and at the time of Survey.

Disease groups	Past one year	At the time of survey
Group—1 :		
Infective & Parasitic diseases :		
(a) Infective diseases—	135)	46)
(b) Parasitic diseases—	27)	110)
Group—2 :		
Malignant, benign, lymphatic haemopoietic and unspecified neoplasms	—	—
Group—3 :		
Endocrinal Nutritional & metabolic diseases	—	20
Group—4, 5, 6		
Diseases of blood forming organs Mental disorders		
Diseases of nervous system eye, ear and mastoid processes	—	—
Group—7 :		
Rh. fever, hypertensive and heart diseases	2	5
Group—8 :		
Diseases of respiratory system	33	65
Group—9 :		
Diseases of the digestive system	9	6
Group—10 :		
Diseases of urinary system, male genital disorders and diseases of the breast and female genital system	3	1
Group—11 :		
Diseases of musculo-skeletal system and connective tissues	8	12
Group—12 & 13 :		
Congenital abnormalities & Certain causes of perinatal morbidity	—	—
Group—14 :		
Other Symptoms and ill defined conditions	18	15
Group—15 :		
Other injuries and reactions and fractures, dislocations and sprains	— 5	—

The average duration of sickness per episode and per sick person was calculated for leading diseases (Table-V) reported during past one year except for tuberculosis, leprosy and arthritis. The average duration of sickness per episode and per sick person was highest for worm infestation, followed by diseases of ear, skin diseases and dental diseases. Further it was seen that the people suffering from these diseases ordinarily did not seek medical advice till such time when it became unbearable.

The differences in the prevalence of diseases as revealed by recorded history (past one year) and physical examination (at the time of survey) are shown in Table-VI. Although history revealed fever as a leading disease yet it did not come

into picture at all in the leading causes of morbidity at the time of survey, but skin disease was the leading cause.

This analysis of ranking orders also showed that the population was ignorant of signs and symptoms of nutritional deficiency diseases and as such were unable to report them though they might have suffered.

The main health problems as identified were diseases due to poor personal hygiene, insanitary housing conditions, unprotected water supply and absence of latrines leading to indiscriminate soil pollution. Health educational measures with active community participation are required to bring about a reduction in the prevalence of diseases.

Table VI : Ranking Chart on Morbidity Pattern of Tibetan Refugees.

In Past One Year	Diseases in Rank Order		At the time of Survey
Fever	1	1	Diseases of skin
Diseases of G. I. tract	2	2	Respiratory diseases (Excluding T. B.)
Respiratory diseases (Excluding T.B.)	3	3	Worm infestations
Dental diseases	4	4	Dental diseases
Diseases of skin	5	5	Pediculosis
Tuberculosis	6	6	Nutritional disorders
Worm infestations	7	7	Diseases of G. I. tract

Morbidity Differentials Amongst The Families of The Employees of Medical College. MEERUT.

N. Kamboj, J. S. Mathur, M. Bhatnagar, V. N. Mishra, R. B. Singh &
B. S. Garg.

Introduction

Morbidity surveys are intended to provide over all picture of health and sickness of a community. Due to fast development of medical sciences and the medical facilities, the pattern of diseases is changing fast. Mortality is being replaced by morbidity as an index of health and disease. Up to-date information is needed so that the Government in particular and the society in general can devise new and feasible plans to apply for the maximum benefit of masses. In India due to industrialization and urbanisation, the urban population is growing fast which may lead to changes in the morbidity and mortality pattern of different diseases in the urban areas. The present work has been carried out to find out the general and specific morbidities amongst the employees and their family members residing in the campus of L.L.R M. Medical College, Meerut.

Material & Methods :

The material for the present study consisted of all Government employees & their family members who were residing

in the Medical College, campus except the nurses and the students. In total 436 such families were residing in the campus. For the purpose of this study only 356 (81.4%) families with 1623 population could be covered, 18.6% families could not be included because of non-availability at the time of visit. The study was carried out from July 1983 to March 1984 through house to house visit with the help of a pre-designed schedule. Data regarding socio-demographic characteristics, environmental sanitation and physical and clinical examinations of each and every individual belonging to the families was collected. The lab. investigations were done only in those persons where these were needed. The morbid condition was defined as "any departure subjective or objective from a state of physiological wellbeing resulting from disease injury or impairment" (Swaroop 1960). The diseases were classified according to International classification of diseases, (WHO, 1975).

Observations :

The majority (88.5%) of the families were nuclear type while the remaining 11.5% were joint type of families. The average family size was 4.6 persons per family. Hindus constituted 95.5% of the total population followed by Muslims 2.2%, Christians 1.9% and Sikhs 0.1%.

The population of children below 15 years of age was 44.6% and above 60 years of age was 1.5%. The sex-ratio in the study population has been found to be 930 females per thousand males. The married population was 44.4% never married were 54.7% and 0.9% were widows/widowers.

Only 22.9% of males and 4.1% of females were at work. The literacy rate was as high as 73.5%. Those with either college education or professional qualifications were 14.0% in the total population. Out of the total employees, 53.4% belonged to occupational status of class-IV. Only 2.5% of the families belonged to socio-economic class-I. The per capita income was estimated at Rs. 3378/- per annum.

Morbidity in different age groups has been calculated (Table-1). Morbidity was found to be slightly higher (43.2%) in males than females where it was 42.3%. In males the morbidity was maximum (59.8%) in 0-4 years age-group followed by (53.6%) in 45-59 years age group and the morbidity-

Table 1 : Morbidity in relation to Age and Sex.

Age group years	Male			Female			Total		
	Number	Morbid	Morbi- dity%	Number	Morbid	Morbi- dity%	No.	Morbid	Mor- bidity%
0-4	122	79	59.8	120	65	54.2	242	144	59.5
5-14	251	115	45.8	231	93	40.3	482	208	43.2
15-44	402	134	33.3	389	153	39.3	791	287	36.3
45-59	56	30	53.6	28	11	39.2	84	41	48.8
60+	10	5	50.0	14	9	64.3	24	14	58.3
Total	841	363	43.2	782	331	42.3	1623	694	42.8

Age $\chi^2=49.39$, d. f.=4, $P<0.001$, Sex : $\chi^2=0.4$, d. f.=1, $p>0.50$.

Morbidity Differentials Amongst the Families of Employees

was minimum (33.3%) in the age-group 15-44 years. In females the morbidity was maximum (64.3%) in older women (60 years & above) and followed by 0-4 years age-group where the morbidity was 54.2% and least morbidity was found in the age-group of 45-59 years. The differences in relation to the sex ($P = > .50$).

Morbidity was slightly higher (47.2%) in persons living in joint type of

families as compared to those living in nuclear families (42.1%).

Morbidity in relation to marital status has been found to be significantly different (Table-II). Morbidity was maximum (66.6%) in widows/widowers followed by unmarried persons (43.0%) and least in married persons where the morbidity was (41.9%).

Table II : Morbidity in relation to marital status.

Marital Status	Total Population	No. of sick persons	Percentage
Never married	888	382	43.2
Married	720	302	41.9
Widow/Widower	15	10	66.6
Total	1623	694	42.8

$$X^2 = 191.89, \quad d. f. = 2, \quad p < 0.001.$$

Morbidity was maximum in Christians (63.3%) followed by Muslims (55.6%) and Hindus (42.3%) and was least in Sikhs (16.7%) where the

sample was very small (Table-III). Differences in morbidity between Hindus, Muslims and Christians were not found statistically significant ($p > 0.20$).

Table III : Morbidity in relation to religion.

Religion	Total Population	No. of sick persons	Percentage
Hindu	1551	654	42.3
Muslim	36	20	55.6
Christian	30	19	63.3
Sikh	6	1	16.7
Total	1623	694	42.8

$$X^2 = 3.24, \quad df = 2, \quad p > 0.20.$$

The morbidity was found to be negatively associated with the level of education of the individuals (Table IV).

The differences in levels of morbidity were found statistically significant in relation to educational status ($P < .001$).

Table IV : Morbidity in relation to educational status.

Educational Status	No. of individuals	No. of sick persons	Percentage
Pre-School	217	124	57.1
Illiterate	372	180	48.4
Upto Primary	395	176	44.7
Upto High School	324	122	37.7
Intermediate	88	29	33.0
College education	147	42	28.6
Professional education	80	21	26.3
Total	1623	694	42.8

$$X^2=52.14, \quad df=6, \quad p<0.001$$

Morbidity was significantly different service classes (Table-V). It may be seen that morbidity increased with the lowering

of service class status. In class-I the morbidity was 25.4% which increased to the level of 46.1% in class-IV employees.

Table V : Morbidity pattern according to Occupational Status.

Occupational status	No. of individual	No. of sick persons	Percentage
Class I	71	18	25.4
Class II	16	6	37.5
Class III	117	45	38.5
Class IV	233	108	46.4
Total	437	177	40.5

$$x^2=10.73, \quad df=3, \quad p<0.001$$

Morbidity Differentials Amongst the Families of Employees

The morbidity has been found to be negatively correlated with the socio-economic status. The morbidity was lowest (33.0%) in the social class-I which in-

creased to 52.2% in class-V (Table-VI). The differences in the levels of morbidity in different socio-economic classes have been found to be statistically significant ($P < 0.001$)

Table-VI. Morbidity according to socio-economic classes.

Social Class	No. of families	No. of individuals	No. of persons	Percentage
I	45	162	37	33.0
II	67	215	75	34.8
III	85	361	137	38.0
IV	150	812	407	50.1
V	9	73	38	52.2
Total	356	1623	694	42.8

$$\chi^2 = 55.39,$$

$$df = 4,$$

$$p < 0.001$$

The ten leading causes of morbidity per thousand population were ill-defined intestinal lesions (53.0), malaria (35.7), diarrhoea (27.1), dysentery (20.9), acute bronchitis (19.8), measles (18.5), disorders of menstruation and other bleeding from female genital tract (17.9), amoebiasis (17.2), disorders of refractions and accommodation (15.4) and conjunctivitis (4.2).

Discussion: Age and sex distribution of the study population was typical that of the developing countries as characterised with a broad base and gradually declining proportion of people in higher age-groups. The total number of children

below the age of 15 years were 44.6% which is slightly higher than that of Marwah et al (1970), 41.6%, Bhātnagar et al (1979) and Census of India (1981) of 39.3%. The proportion of elderly people above the age of 60 years in this study was only 1.5% which is much lower than that of Census of India (1981) of 8.3%, the reason being that most of the employees were residing away from their homes and from their elderly parents.

The overall morbidity at the time of survey was 42.8% which is less than that of Tamboli et al (1976) of 48.8% but it was higher in comparison to Marwah et al

(1970) Joshi and Sharma (1971) and Bhatnagar et al (1979) who reported the morbidity rates of 29.6%, 25.2% and 25.9% respectively. The higher morbidity in the present study may be primarily due to the higher health consciousness in the study population.

In this study morbidity in males was 43.2% and in females 42.3% which is almost similar in both the sexes whereas Marwah et al (1970, reported that morbidity was higher in females (38.4%) in comparison to males (26.2%). Morbidity in this study was 58.3% and 59.5% in the age-group of 60 years and above and 0-4 years respectively. Similar were the findings of Tamboli et al (1979) from Jaipur City and Bhatnagar et al (1976) from Meerut City while Marwah et al (1970) reported that morbidity was highest (55.2%) in the 0-4 years age group while it was lowest (13.6%) in 60 years and above age-group.

The morbidity was slightly higher (47.2%) in joint families as compared to 42.1% in clear families. This difference might be due to the fact that in joint families old parents were also living.

In the present study the morbidity was inversely related to the occupational status. It was minimum in class-I (25.4%) and increased to 46.4% in class-IV employees while Marwah et al (1970) reported maximum (44.2%) morbidity in teaching staff and minimum (26.9%) in ministerial staff.

Morbidity was found to be negatively correlated with the level of education of the individual which is a usual phenomena and has also been reported by Garg et al (1981). By grouping the leading causes of morbidity in the present study it can be concluded that it was maximum (229.8 per 1000 population) due to infective and parasitic diseases while Marwah et al (1970) reported that five most leading causes of morbidity were acute respiratory tract infections (20.6%), diarrhoeas and dysenteries (10.4%) and typhoid-paratyphoid fevers (3.3%).

In the present study the total number of morbidities were 756 which amounted to 0.5 sickness per person. The average sickness per sick person was 1.1 while Marwah et al (1970) reported 0.4 sickness per person and average sickness per sick person being 1.27.

References :

1. Bhatnagar M, Gupta SC, Mishra VN, Singh RB & Garg SK (1985) Health assessment of Urban population through Health indicators. Ind. Med. Gazette Vol. CXIX, No. 1, Page 22-28.
2. Census of India (1981) Provisional population total series, 18, Director of census operations, Uttar Pradesh, 10.
3. Garg BS, Bhatnagar M & Gupta SC, (1984) Health statistics at Urban Health Centre Suraj Kund, Meerut.

Morbidity Differential Amongst the Families

- Determination of priorities for health programme Ind. Med. Gazette, Vol. CXVIII, No. 8 & 242-246.
4. Joshi CK, & Sharma R (1971) Health of the industrial worker and their families Bharat Med Jour. 3 : 132.
 5. Marwah SM, Tiwari IC, Rao NSN and Gaur SD (1970) Morbidity survey of BHU residential staff and their families. Ind. Jour. Prev. & S.c. Med. 11, 167.
 6. Tamoli BL, Joshi CK & Sharma R (1976) General health survey in Sindhi colony Jaipur. Ind. Jour. Pre. & Soc. Med. 17 : 30.

Assessment of Change of Knowledge Through on the Job Training of Health Workers (Female) in Varanasi

V. K. Gupta, Raj Kumar and I. C. Tewari

Introduction :

Health care infrastructure of our country lacks in effective, bulitin system of on the job training or continuing education for different level of workers. This adversely affects the work performance particularly of those working at peripheral level. It is, therefore, aptly mentioned in "curricula for training of staff of PHC" (1980) that 'job assigned to the workers can be carried out effectively and efficiently only when they are given adequate training for the purpose, whether as part of their basic professional training or as inservice

orientation training followed by refresher courses and on the job continuing education.' Against this background, an action study was planned and conducted in 3 PHCs of Varanasi, with the objective, to assess the change in the Level of knowledge of health worker (females) about MCH care, through short term inservice orientation Training programme.

Material and Methods :

The study was conducted in the PHCs namely ; Chirgaon, Cholaipur and Kashividyapith and their sub-centres of Varanasi district during the years 1980—

Lecturer P.S.M. University, College of Medical Sciences Ring Road, New Delhi-110029

82. These PHCs are attached to the Institute of Medical Sciences, Banaras Hindu University under the 'Reorientation of Medical Education' Scheme. In all, 12 Health workers (Female), four from each PHC & its subcentres were selected for the purpose of study

In order to assess the level of knowledge about MCH Care, a pretested questionnaire schedule consisting of 64 multiple choice questions with one or more correct responses was prepared keeping the job responsibilities of the worker in view. These responses were independently scored by 4 different persons having experience in MCH field. Scores for each correct response were, thus, allotted taking the mean.

These 12 Health Workers (Female) were given a short term on the job training in 4 sessions of $1\frac{1}{2}$ hrs. duration each at each of the three PHCs. The specific areas of MCH care covered were :

- registration and identification of high risk antenatal cases ;

- diagnosis and management of anaemia and immunization in antenatal cases ;

- nutrition education for antenatal cases and lactating mothers ;

- screening for malnutrition in underfive children including the management of diarrhoea ;

- diagnosis and management of anaemia and immunization in underfive children ; and

- nutrition education for underfive children.

Method of imparting training was lecture-cum-demonstration. Health Assistant (Female) of respective PHCs were actively involved in training programme.

Teaching aids used were : Charts ; Flash Cards for imparting nutrition education to mothers and children ; Cases for demonstration purposes ; Reagents ; and manual (in Hindi) in which an attempt was made to incorporate the elements of actual practice situation as well as innovations of tested value. In it, emphasis was laid on the areas of MCH care being covered in the training. The manual prepared for the study was brief, practical and covered the important aspects of MCH care. In contrast to Government of India Manuals (1978) and (1981) which were found too exhaustive and in English language. Subsequently, to improve their skills, workers were provided with the workaids as well as MCH Kit designed by keeping the field conditions of work in view.

Within one month after training, workers were administered same questionnaire to have an idea about the deficiencies in knowledge. To overcome it, reinforcement was done at an individual level. Then, after one more followup, post training assessment was undertaken after a period of six months.

Observations and Discussion Maternal Care

The mean score for identification of high risk mothers after training was 151.7 points

Assessment of Change of Knowledge Through on the Job Training

With an increase of 46.7 points over pre-training score. The difference was statistically significant indicating that the training in small groups and reinforcement had the positive impact in increasing the level of knowledge of Health Workers (Female). Similar findings were observed

for other aspects also. The differences were also found to be statistically significant. In post training assessment for anaemia—diagnosis and management in antenatal cases, all the Health Workers (Female) scored 100 percent points allotted. (Table I)

Table-I. Pretraining & posttraining level of knowledge of Health Workers (Female) regarding Maternal Care

Aspects of Maternal care	Max Allotted Score	A Pretraining Score		B Post training Score		Change in level of knowledge		A & B
		Mean	S. D.	Mean	S. D.	Mean	S. D.	
Identification of High Risk Cases	160	105.0	16.7	151.7	7.2	46.7	17.8	t=9.05 P<0.001
Anaemia-diag. & management	64	36.0	8.5	64.0	—	28.0	8.5	t=11.44 P<0.001
Immunization	47	34.4	3.9	43.2	2.5	8.8	2.8	t=10.95 P<0.001
Nutrition Education	82	55.7	15.5	77.8	1.9	22.1	15.8	t=4.83 P<0.001

Child Care

The Health Workers (Female) knowledge regarding child care, as a whole, excepting immunisation was found to be inadequate. During post training assessment, an increase in level of knowledge was found for all aspects which was statistically significant (Table II).

The cost per manual prepared for Health Workers (Female) was Rs. 6 per copy (1981 prices). This will go down

considerably if production is on a large scale at district level. Other teaching aids involved like flash cards, charts, reagents costed a nominal expenditure of Rs. 40 per set (1981 prices). This cost will be further less if training is officially conducted at PHC level since some of the education material and reagents are already available.

Response and coordination of the workers was found to be excellent, thus, reflecting their eagerness and interest to undergo such training programme.

Table II : Pretraining & post training level of knowledge of Health Workers (Female) regarding Child Care.

Aspects of Child Care	Max. allotted score	A		B		Change in level of knowledge		A & B	
		Pretraining Score		Post training Score					
		Mean	S.D.	Mean	S. D.	Mean	S. D.		
Screening of mal-nourished cases	161	96.3	15.2	150.3	6.7	54.0	18.9	t=9.87	P<0.001
Anaemia-diag. & management	20	8.9	3.2	18.3	3.0	9.4	5.2	t=6.28	P<0.001
Immunisation	74	56.5	4.8	73.0	1.8	16.5	5.4	t=10.63	P<0.001
Nutrition Education	63	36.5	8.9	56.4	3.2	19.9	10.4	t=6.62	P<0.001

The study thus revealed that lack of adequate knowledge is one of the factors responsible for poor MCH Care being delivered through health workers (Female). It was also effectively demonstrated that the knowledge of female health workers regarding MCH Care should be considerably improved by a short term in Service Training. This type of periodic trainings are essential and must form an integral part of our health care infrastructure.

References

1. Govt. of India (1978) : Manual for Health Worker (Female), Vol. 1 and
2. Govt. of India (1980) : Curricula for Training of Staff of the Primary Health Centre, Rural Health Division, Ministry of Health and Family Welfare, New Delhi.
3. Govt. of India (1981) : Primary Health Centre Training Guide : Part IV-Training of Health Assistants (Male and Female) and Health Workers (Male and Female); Ministry of Health and Family Welfare, New Delhi.

**PROCEEDING OF THE Vth GENERAL BODY MEETING OF
U. P. CHAPTER OF INDIAN ASSOCIATION OF PREVENTIVE
AND SOCIAL MEDICINE HELD AT L. L. R. M. MEDICAL
COLLEGE, MEERUT ON 11-4-1987, AT 2.00 P. M.**

The Vth General Body meeting of UP Chapter of IAPSM was held on 11.4.1987 under the Chairmanship of Dr. S.K. Mehrotra. The following decisions were taken:—

1. It was resolved that in order to print the constitution of UP chapter of Indian Association of Preventive and Social Medicine, the Secretary General should be sent Rs. 500/- by Organising Secretary of Vth UP Chapter Conference of IAPSM and Rs. 500/- by Prof. S.K. Mehrotra, to enable the constitution to be available with all its members.
2. It was resolved to enlarge the scope of U P. Chapter of IAPSM to make it a regional chapter by involving the neighbouring States. Himachal Pradesh and Haryana have already been co-opted to be members for the region. It was further resolved that a letter should be written to other neighbouring states also to join the regional Chapter.
3. The report of Secretary General for 1987 was accepted and approved. The General Body observed with regret that the Secretary General IAPSM (All India) has not sent the State Contribution to the Sec. General UP Chapter IAPSM which has caused hinderence for smooth functioning of UP Chapter.
4. Prof. J S. Mathur was elected to deliver Dr. B. G. Prasad oration 1987 unanimously.
5. The organising committee of Vth UP Chapter Annual Conference announced the award for the best paper sent by UG/Interns for this year. It was further resolved that the best paper award shall be given each year for the best paper published in the Indian Journal of Community Health.
6. The following office bearers were elected by the General Body for 1987.

President	Dr V. N. Mishra
Vice President	Dr J. V. Singh
Secretary General	Dr. B. Raj (Second year of 3 year term).
Joint Secretary	Dr. P. L. Joshi
Treasurer	Dr. (Mrs.) M. Bhattacharya

Executive Members

Dr. S. N. Sinha
Dr. Arun Kumar
Dr. Gopal Krishna
Dr. V. K. Srivastava
Dr. Bhakt Prakash
Dr. Sanjai Chaturvedi
Dr. P. K. Sen

7. Prof. J. S. Mathur briefed the General body of IAPSM with the details of the talks held in Delhi regarding the Publication of the Journal of IAPSM from UP with Dr. L. M. Nath, Dr. M. C. Mittal, Dr. M. P. Dwivedi, Dr. Harcharan Singh, Dr. A. K. Govila and Dr. I. C. Tewari. It was informed that the assurance was given to hand over the Journal to UP in the next All India Conference of IAPSM. It was further resolved that the implementation of resolution No. 5 and 6 of IV UP Chapter IAPSM regarding dissociation from All India body should be postponed in the light of assurance given in the meeting

8. It was resolved that the Indian Journal of Community Health shall continue to be published as an Official Publication of UP Chapter of IAPSM.

9. The proposal of holding next Conference at Allahabad was accepted with great enthusiasm.

10. It was emphasised that M. C. I. has categorised S. P. M. as a Clinical subject & as such, S. P. M. is a clinical subject. A letter should be sent to the D.M.E. Lucknow to clarify this point.

11. It was also decided to write to D. M. E. regarding abolition of dual nomenclature of lecturer/MOH cum lecturer and Reader/Reader in Community Medicine. They should be designated as Lecturer and Reader in S. P. M. only.

12. The house was adjourned by passing vote of thanks to the Organising Committee of the Conference.

1. The first part of the report is a summary of the work done during the year.

2. The second part is a detailed account of the work done during the year.

3. The third part is a summary of the work done during the year.

4. The fourth part is a summary of the work done during the year.

5. The fifth part is a summary of the work done during the year.

6. The sixth part is a summary of the work done during the year.

7. The seventh part is a summary of the work done during the year.

8. The eighth part is a summary of the work done during the year.

9. The ninth part is a summary of the work done during the year.

10. The tenth part is a summary of the work done during the year.

11. The eleventh part is a summary of the work done during the year.

12. The twelfth part is a summary of the work done during the year.

13. The thirteenth part is a summary of the work done during the year.

14. The fourteenth part is a summary of the work done during the year.

15. The fifteenth part is a summary of the work done during the year.

16. The sixteenth part is a summary of the work done during the year.

17. The seventeenth part is a summary of the work done during the year.

18. The eighteenth part is a summary of the work done during the year.

19. The nineteenth part is a summary of the work done during the year.

20. The twentieth part is a summary of the work done during the year.

21. The twenty-first part is a summary of the work done during the year.

22. The twenty-second part is a summary of the work done during the year.

23. The twenty-third part is a summary of the work done during the year.

24. The twenty-fourth part is a summary of the work done during the year.

25. The twenty-fifth part is a summary of the work done during the year.

INFORMATION TO CONTRIBUTORS

1. The Indian Journal of Community Health is devoted to research in Medical Science and welcomes original contribution in the Journal.
2. Articles should be short, clear, precise and highlight the observations.
3. The script should be sent in triplicate and typed in double space on one side of the white paper. A 1.5" margin on left side and sufficient margin on other sides should be left.
4. Every article must have introduction to explain the background of the topic. The article should be described under Material and Methods, Observations duly analysed statistically, Discussion and References. Captions must not be typed in Capital letters.
5. In reference cited in text first mention the name of the author/authors and then year of publications. The bibliography should be submitted in alphabetical order to include the name of the authors, year of publication in bracket, title of paper, name of the Journal volume, number and page number.
6. The restraint should be exercised in sending illustrative matter. Two sets of unmounted figures and graphs prepared in Indian ink on white paper suitable for re-production should be supplied with short and crisp legend clearly including their position in the text of the paper.
7. Photographs should be submitted on the glossy paper. The top of the microphotographs and photographs should be marked.
8. All enquiries should be accompanied with a self addressed Inland cover for reply.
9. Member authors shall be supplied copy of the Journal. Reprints may be provided on payment and requirement must be indicated at the time of sending article.
10. Non-member authors and co-authors shall be supplied the Journal only on payment of Rs. 25 per single copy.
11. Every article must be accompanied with a self address Inland for acknowledgement and an envelope (4" x 7" size) with Postage Stamps worth Rupees Five & paisa twenty five for processing.
12. The Editorial Board shall have right of publication. The article or part of the article published in this Journal shall not be published anywhere else without the prior permission of the Editorial Board
13. As far as possible figures requiring block making should be restricted.
14. All Remittance should be made by Bank Draft in the name of "The Indian Journal of Community Health".
15. The Annual subscription for Journal is Rs. 20.00 and to be paid on 1st January of every year.
16. The life membership for the Journal is Rs 150/- only.