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लोका समस्ता सुखिनो भवन्तु

Editor :

Dr Dilip Gupta

For Circulaion to Members only

ASSOCIATION OF RURAL SURGEONS OF INDIA

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Rural Surgery - Vol 9 No 1 April - June 2013

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EDITORIAL

Dear Friends

This issue contains a review on the Book written by Professor UN Jaoo, " TOWARDS HOLISTIC HEALTH: A SARVODAYA WAY", reviewed by Dr Anupama Gupta, Professor of Pathology, MGIMS, Sevagram, Wardha. I had gone through this book and felt that it should be read by one and all who are serving in Rural areas. As practicing Rural Surgeons I hope you will find this book useful.

Excerpts

"The book proposes Sevagram's adventure with rural health care and medical education to be a well researched way to achieve the much vociferated goal of 'health for all' in real world. Also the book disdains the current political policy of subsidies, donations and pitying for rural upliftment. A whole chapter is dedicated to what mayhem money without cultural values can produce and how the author and his team managed it. During this utterly unbelievable journey the author succeeded in touching the chord of faith in catered villagers and this is the real achieve-ment of the movement."

"The gist is the book has simply redefined the primary health care from Indian perspective and is full of innovations we haven't even thought of. In fact the book is not for leaders and planners who dream change on paper and then materialize them on paper. The book is for common citizens who dare to dream to bring change in their sur-roundings without having any other personal agenda than love for fellow country folk."

I am indebted to the reviewer of this book and the Chief Editor of Journal of MGIMS for granting me permission to publish this review without any change in our Bulletin.

This issue also contains a guest article from Dr S Chhabra, citing her experiences in establishing a tribal health centre in Melghat region of Maharashtra.

Dr Dilip Gupta
Editor

GUEST ARTICLE

A New Dawn for Women and Children of Tribal Hilly Forestry Region, Melghat of Amravati, Maharashtra, India

S. Chhabra

Social accountability in health care and medical education has been the hallmark of Mahatma Gandhi Institute of Medical Sciences, Sevagram in Wardha district of Maharashtra. The base of the institution itself is social accountability by none other than Mahatma Gandhi himself, 'the conceptualisation of 2 bedded dispensary way back in 1938 for women and children in Gandhiji's Sewagram Ashram, as women found it very difficult to avail health services from the nearby town.' Opening of the medical college in the Gandhi Centenary year was another step of social accountability. The institute was started because then Honourable prime minister late Lal Bahadur Shastri had felt that rural people remained deprived of health services and only a rural medical college could take care of their health. Further it was believed that students from rural areas after education would work in their villages and would do a better job for their own people so, the birth of Mahatma Gandhi Institute of Medical Sciences, Sewagram, way back on 12th September 1969, country's first rural medical institute at the service of rural masses.

Expanding health services to Melghat region of Amravati, Maharashtra now is another step of MGIMS of Kasturba Health Society, Sewagram towards social accountability in health and medical education. Melghat region in Amravati district of Maharastra, 260 kms away from Sewagram, is a tribal hilly area with dense forests and tigers. The region has been known for high Maternal, Neonatal, Infant-Child Mortality and Malnutrition.

Services of a Physician and Ophthalmologist of MGIMS, Sevagram were available in Melghat region since 13 years under the Mahatma Gandhi Adiwasi Dawakhana and Dr. Sushila Nayar Netralaya being run by Kasturba Health Society, Sewagram. Of course there are two sub district hospitals in the region, one in Dharni block and other Chikhaldara, many Primary health centres and Sub centres providing basic care, but neither comprehensive obstetric neonatal care nor other specialized services were available. With the blessings of Bapu and Behanji (Dr. Sushila Nayar), the team of MGIMS joined hands and took a step, to walk a long distance for care of women and children, which lead to the birth of the new hospital at Utawali, Dharni, Amravati for women and children. Government of India and Government of Maharashtra were approached with the proposal but delays of the system were worrisome. As is said, if there is a will, there is always a way and that if you wish to do a good deed, reward usually comes in a better way and the same was true for us. The charitable trust "Shri Brihad Bhartiya Samaj, Mumbai" came forward with the generous help to serve the needy. So a beginning was made on 1st January 2012. Before this beginning, alterations/additions were done in the existing building to have make shift delivery area, minor operation theatre converted into a theatre where caesarean section, hysterectomy were possible and other needed changes were made in the building and equipment, instruments procured. While working on health seekers needs, providers were not forgotten. So in the existing guest house, alterations and additions were made and a hut converted into Kitchenette and dining area. Also sports were arranged and a mini-library too, even an online Maharashtra University of Health Sciences library was connected for every one to remain healthy and updated. Entertainment and communication were not forgotten, mobile phones, television and other possible recreational facilities were

Director, Professor, Obstetrics Gynaecology, OSD, Melghat Project, MGIMS, CEO, Akanksha Shishu Kalyan Kendra, Kasturba Health Society, Sewagram, Wardha, Maharashtra, India-442102, And The Team

taken care of to make the life of everyone easy and reduce the general reluctance to live in the region.

With the guidance, support and help of KHS/MGIMS family which is always united in the hours of need, the team of Obstetrician - Gynaecologist, Paediatrician, Anaesthetist, Medical Officers, Interns, Administrative Officer, nurses with other paramedical staff are working at Utawali hospital for managing obstetric - gynaecological emergencies, neonatal and child care in outpatient, inpatient and operation theatre, 24/7 days. Efforts continue to be made to make life easy for the health seekers as well as providers with every day improvements in our attempts to provide the best of services and facilities in the given circumstances with limited resources. Caesarean sections, minor and major gynecological surgeries are being performed, of course normal and instrumental births. All this has been made possible as most of the necessary equipments and instruments including ventilators have been made available. Thanks to the generous donation of Shri. Brihad Bhartiya Samaj. As and when possible, support from the Sub District Hospital Dharni is available, though we still await government's grants and recognition of this health facility for humanitarian services under various schemes of Government of India and Maharashtra, Government.

Though it is a make shift arrangement in the available space, everybody is trying to give his/her best with whatever is available. There were no facilities for Caesarean section. The very first caesarean section in the Melghat region was performed in our Mother and Child hospital on 21st January, 2012, mother and baby discharged healthy in a week. The first hysterectomy with removal of a uncommon 'malignant ovarian tumor struma ovarii' was performed on 15 February, 2012 and the woman doing well now since more than a year. A 45yrs. old woman had multiple uterine fibroids with a large central cervical sessile fibroid arising from posterior cervical wall. She needed major surgery, but her haemoglobin (Hb) was merely 3 gm/dl (we have been seeing more of such women now and one wonders how they are surviving). This woman with fibroids needed multiple blood transfusions, but blood storage facility was not available with us (now approval has been procured and shortly, blood will be available). There is a blood storage system in sub district hospital, Dharni but they were not in a position to issue blood for the patients admitted in our hospital. So with mutual understanding and the best of the co-operation, we found the way. The patient was discharged from our side and admitted in sub district hospital, Dharni where she received 3 units of blood and was discharged. She was admitted with us again with Hb7 gm/dl. We could take out her cervical fibroid vaginally and curettage was done. As she was being prepared for abdominal hysterectomy, needed for multiple large uterine fibroids, she went home and again bled, Hb back to 5 gms/dl. It was a task but, with the help of Blood bank of Medical College, Amravati we could give her transfusions at our own hospital and were able to perform the required surgery and patient discharged healthy.

Within weeks of making a beginning, caesarean section had to be performed within minutes of admission on a woman who was brought drowsy with eclampsia, haematuria and the growth retarded baby with severe foetal bradycardia, both mother and baby could be saved and discharged healthy. While trying to do whatever we can and there are many such experiences, we have also realised that there are many practical difficulties. We know under nutrition, anaemia, poor health are not merely medical conditions, their causes are deep rooted in the community, in the social and cultural practices, in the non availability of food, in the ignorance even when the food is available, gender bias, unemployment, and addictions. Hindrances also include lack of awareness and lack of resources to keep the needy in the hospital. Sometimes making the patient stay in the hospital for her own good or her child's health is a tough job, testing our patience, counselling skills and the best of dedication. We have realized that a lot more, including community based services are needed. So a step has been taken in this direction also, with nurse midwives providing community based antenatal services,

intranatal, postnatal, neonatal advocacy and we hope that things will change.

We know there are going to be many more difficulties, but where there is a will, there is a way. It needs some time before awareness will come with in this population and their many unlisted social and economical issues will also be addressed. Here we stand, united, with unmoved determination, knowing this is just the beginning and we through our services will, surely make a difference! Land has been procured for a multispecialty hospital and a building with flats for residence. We have taken the step, "The journey of miles begins with the first step", we will reach our goal of having every mother and child of this region healthy and happy. May almighty help us for the cause.

ACKNOWLEDGEMENTS :

We are grateful to the almighty for always being with us. We thank Shri Brihad Bhartiya Samaj, Mumbai, Shri Dhirubhai Mehta President and Shri Halbeji Trustee KHS, Sewagram who have always been the pillars of strength by guiding, helping and supporting in whatever is needed. We also thank everyone of KHS and MGIMS family, from all sections and everyone of Melghat region, Health and Administration. A very special "Thanks" for Mr. Jayant Banthia present Hon Principle Secretary, earlier Additional Secretary Public Health, Government of Maharashtra for all the help, guidance, constant support and encouragement.

ORIGINAL ARTICLE

Prevention of infertility: Role of Rural Surgeon

- Dr.S.K.Basu

"Death. Death of lot of things. It is the end of my family and family name.
It dies with us because of me….Death before life… before we even knew our child,
because he never existed. The hardest part of this kind of death is that it is a death of a dream.
There are no solid memories, no picture, nothing to remember.
You can't remember your child's blond hairs, or brown eyes, or his favorite toys,
or the way he laughed, or the way it felt to be pregnant with him.
He never existed." *- Expression of an infertile woman*

Key words : Infertility, STI (Sexually transmitted infection), RTI (reproductive tract infection), HIV (Human immunodeficiency virus)

Society has elaborate rituals to comfort the bereaved in death. Infertility is different. There is no funeral, no wake, and no grave to lay flowers upon. Agony and suffering may not be even ever known to the outside world. In silence infertility reduces quality of life, especially through negative psychosocial consequences. It is often perceived as a life crisis by the couple, characterized by feeling of surprise, denial, anger, isolation, guilt, grief, abuse, loss of gender identity, marital instability and many more. Yet we are so possessed with population explosion and other health issues that infertility receives very little attention! It continues to struggle even today.

Globally an estimated 9% of women of reproductive age suffer from infertility. This equals 80 Million women. Paradoxically, high infertility rates are often observed in countries which also have high total fertility rates. This irony can be explained by sexual behaviour which is orientated towards repeated child birth, early age at marriage and low use of contraception in settings where there are also many risk factors for infertility (e.g. high prevalence of sexually transmitted diseases, formal and informal polygamy, poor pregnancy care with high rates of pregnancy-related sepsis). Thus many developing countries have a problem of both over-population and infertility. India is one amongst them.

Evidence on the prevalence of infertility in India is sparse and dated. The WHO's estimates of primary and secondary infertility in India are 3% and 8%, respectively. Data extrapolated from WHO by the Indian Council of Medical Research (ICMR) suggest that approximately 13-19 million couples are likely to be infertile in India at any given time.

The dominant cause of infertility among women in Asia was found to be either an STI or unsafe management of abortion and delivery. Among men with a demonstrable cause, about one in three may have become infertile as a result of an STI experience. In India, the prevalence of STIs was also found to be high among women reporting infertility and pelvic inflammatory disease. For several reasons including unequal gender relationships, access and quality of care issues, RTI/STIs and unsafe abortions have not been adequately addressed in India.

One of the major barriers to infertility care in India is cost. This is likely the most important barrier limiting access to safe and effective fertility treatment. Ignorance of the general population about infertility, associated with lack of financial and societal support keeps infertile people in emotional isolation.

It can't be denied that even today, where available, the basic diagnostic work up and

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infrastructure is usually inadequate and incomplete in India, particularly in public sector and rural areas. It is felt by majority of the providers that limited information is provided on conception, infections, infertility treatment, unsafe abortion-related infertility, effects of repeated abortions, hygiene and over-use of oral contraceptives. There is no provision for counseling, semen testing, hormonal profiles, fallopian tube testing (HSG) and IUIs. Investigations are usually unavailable for STIs/RTIs. The main development in the last 15 years or so has been a proliferation of infertility services in the private sector. This includes ARTs which are mostly unaffordable, of varying quality and costs with low success rates and are usually accessed only by middle and upper class couples who can afford them. Therefore it is obvious that there is hardly any focus on prevention even though most providers (public and private) feel that infertility is largely preventable.

With these socio-cultural, behavioural and bio-medical determinants (which also include malnutrition, anaemia and tuberculosis) of infertility, there are still ways and means to prevent infertility which is essential to bring down the prevalence of infertility in our country.

Role of Rural surgeons in preventing infertility

In a situation where issues of infertility is being largely ignored and little emphasis has been placed on assisting couples who are unable to produce, rural surgeons can play a significant role at least bringing down the prevalence of infertility by preventing infertility. As primary health care provider treatment choices may be limited for rural surgeons. Besides providing advice for the best option for treatment and counseling, there may even be an opportunity to apply simple treatment when indicated based on the clinical experience of a rural surgeon. However they can play a major role in preventing infertility by providing public education and other programs that can help society understand infertility better. General education and health care prevention strategies can substantially reduce the prevalence and burden of infertility. The objective of this paper is to highlight those preventive strategies which a rural surgeon can easily execute.

Education at all levels is the first step of prevention. There should be access for all to education about fertility, infertility and reproductive health as a whole. Educating people about the importance of reproductive health to the quality of life is imperative. Facts about female reproduction should be emphasized. Many people do not have idea about reduction in female fertility due to decreased ovarian function with increasing age, neither they are aware about the risk involved in postponing conception until later part of reproductive life particularly after the age of 37. With increasing age, chances of miscarriage and risk of having a baby with abnormalities increases. Likewise, risk of adolescent pregnancy (<19 years) and its impact on subsequent fertility should be talked about. Besides obstetrical complications like placenta previa, toxemia, low baby birth weight, intra uterine growth retardation, premature delivery etc. adolescent mothers face adverse individual and social consequences.

Rural surgeons may utilize every opportunity to educate people about sex, birth control and healthy sexual life style. Factors pertinent to fertility like timely intercourse both to enhance and reduce the probability of pregnancy, use of birth control means when not attempting pregnancy, information about major contraceptive method should be the core objectives of education. It is also important to inform younger people about the benefit of delaying sexual activity as per the cultural norms, importance of single partner relationship to avoid the risk of STI/ HIV and other disease transmission and value of avoiding unwanted pregnancy.

Many life style factors adversely affect fertility. Smoking, tobacco chewing, obesity, diabetes, under-nutrition, chronic stress reduces fertility. Therefore every educational approach should emphasize on healthy life style, healthy and unhealthy diets, weight control, avoiding tobacco products, benefit of eating well, all of

which are important for present and future reproductive and general health.

Incidence of STI/RTI and pelvic inflammatory diseases are very high among patients suffering from infertility in India. Many such infections like Chlamydia trachomatis, gonorrhea, streptococcus and others can cause damage of fallopian tubes, pelvic adhesions leading to infertility. They are preventable. Abdominal and genital tuberculosis quite often causes extensive damage to the pelvic organs. They can be easily identified and treated. HIV infection results in reproductive dysfunction, risk of infertility, risk of pregnancy and health of the child and finally compromise with the health of both parents to raise the child. There are many organizations who are involved with education and prevention programs of such infections, promote diagnosis, treatment and even support patients suffering from such problems. Besides treating and educating such patients and community, rural surgeons can associate with those organizations and coordinate many activities that may go a long way to prevent transmission of HIV/STI and thus infertility.

Childlessness due to failure to conceive, miscarriage, stillbirth, neonatal death is commonly perceived as infertility. Therefore it is important not simply to get pregnant but to continue pregnancy till term to have a healthy child and family. Efforts are needed to achieve this goal. This will reduce the demand for further child and therefore infertility. For this, community needs to be educated about significance of safe abortion, safe pregnancy and healthy baby and mother care. All of them in a way prevent future infertility. Infections related to unsafe abortion and puerperal sepsis are one of the major causes of subsequent infertility. Every wanted healthy baby born to healthy mother consolidates a family and reduces the unmet fertility desires. Therefore it is utmost important that rural surgeon as primary health care provider should educate and promote safe abortion, safe pregnancy and healthy baby and mother care. If a rural surgeon is unable to provide these services, he must collaborate with other professionals, providers for timely referral. These resources should be publicized and every opportunity should be utilized to educate infertile patients and women during their follow up care even if they have delivered at home.

Practicing family planning prevents unplanned pregnancies; avoid risks associated with pregnancy and unsafe abortion, helps in spacing pregnancies. All of them help to protect future fertility. Delaying another pregnancy contribute to a healthier subsequent pregnancy, baby and mother. Barrier method of contraception protect against HIV/STI infection. Rural surgeon can play an important role in educating younger generation and all sexually active men and women about the benefits of practicing family planning. Also a liaison with voluntary agencies and Govt. sponsored PHC who provide contraceptive programs will be of great help for rural community to ensure constant access and better contraception.

Finally, few words about our own education and ethics. Reproductive medicine is a sensitive issue and quite often challenging because of various customs, values, and forces that prevail in every society. To provide appropriate care and to make it acceptable and effective, rural surgeons have to learn and recognize the societal frameworks in which they are providing care. At the same time principle of patient's independence, social fairness, "do no harm" and "do good" should be the aphorism of a rural surgeon in making decision.

Infertility may be an outcome of diverse etiologies exacerbated by severe social isolation, restrictions and stigma. Childless women suffer a great deal in a family context and even though only a small fraction of women and couples are affected by infertility in the population, it is an important reproductive health and rights issue. Its effective prevention and management is a crucial element of a more holistic approach to women's reproductive health and their physical and mental well-being. Timely education, awareness about available resources for fertility/ infertility program and access to various support services can bring down the prevalence of infertility for rural community of India.

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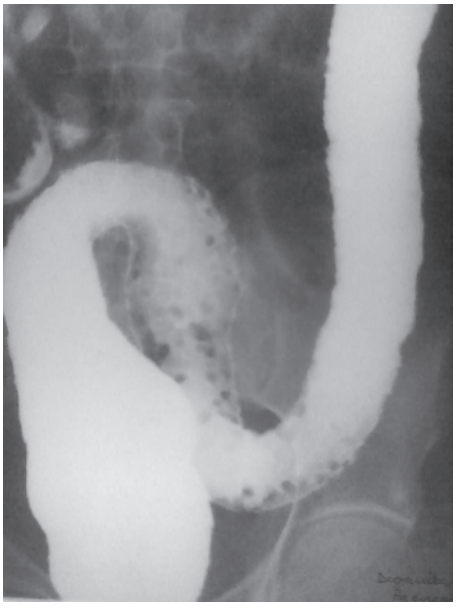
IMAGE OF THE MONTH

"ULCERATIVE COLITIS WITH PSEUDOPOLYPOSIS"



(Note : If you have any interesting Images please do send with short note about the case to the Editor)

CASE REPORT

TOPICAL VACUUM THERAPY FOR FOURNIER'S GANGRENE : A CHALLENGE

Dr. J Gnanaraj

INTRODUCTION

Fournier's gangrene is a type of necrotizing infection or gangrene usually affecting the perineum.

It was first described by Baurienne in 1764 and is named after a French venereologist, Jean-Alfred Fournier following five cases he presented in clinical lectures in 1883. In most of the patients it is caused by a mixed infection of aerobic and anaerobic bacteria. It is an emergency which has a mortality of almost 78% if sepsis is present at the time of admission [1].

Diabetes is a common predisposing factor. It is a rapidly spreading necrotizing fasciitis. The patients often present in Septic shock. The recommended treatment includes broad spectrum antibiotics after resuscitation of the patient and radical wound debridement and if available hyperbaric oxygen therapy. We describe how we used topical vacuum therapy in the successful treatment and the challenges involved in providing it.

THE PATIENT

Seventy five year old Mr. P was brought to our hospital in severe sepsis and with retention of Urine after having treatment elsewhere. His renal function improved after resuscitation and catheterization. He had progressive radical debridement of three occasions after treatment with Crystalline Penicillin and Piperacillin.

Since hyperbaric oxygen therapy was not available it was decided to offer topical vacuum therapy? It was a challenge to have vacuum at the perineum.

THE METHOD

The apparatus shown in Figure 1 was then finally used. The timer controlled the on and off mechanism of the suction apparatus. The cover over the perineum was a metal sheet and the entire lower limb was inside the large thick polythene bag and the bag was made air tight at the chest using Velcro strapping material. The Figure 2 shows the improvement within a week of treatment.

DISCUSSION

Fournier's gangrene is an uncommon disease with high mortality. It needs radical surgical treatment and hyperbaric oxygen therapy is useful[2] because of the anaerobic infection. However the treatment is expensive. It is also not available in rural areas. The commercial Vacuum therapy units have shown promise in treatment[3] but are again expensive and it is difficult to have an airtight closure in the perineum.

The above method of treatment is effective, less expensive and could be made from locally available materials. The patient who was sent home to die recovered within two weeks of treatment and part of the credit goes to the vacuum therapy unit.

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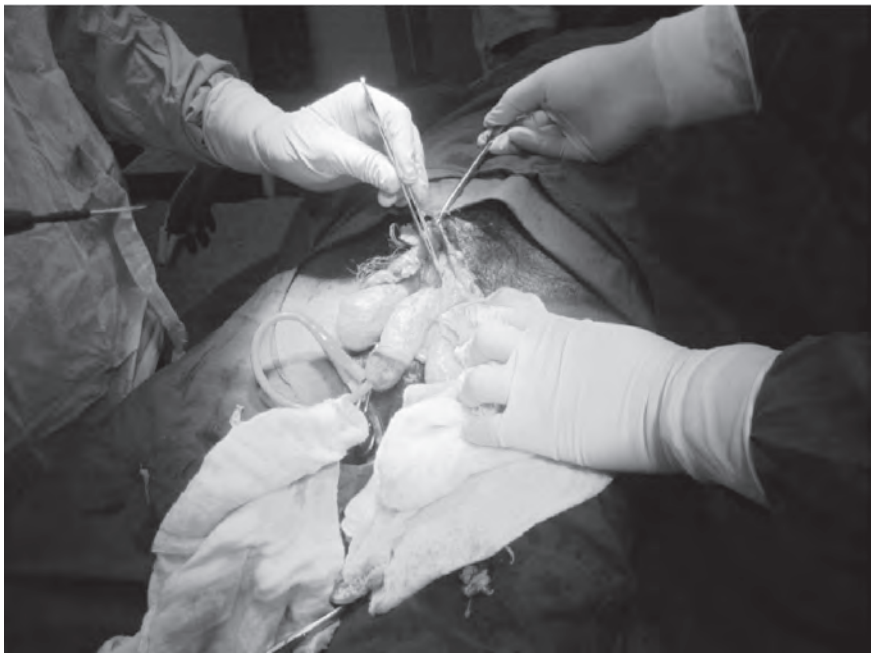
FIGURE 1: THE VACUUM THERAPY SET UP

FIGURE 2: RESULT AFTER 10 DAYS



BRIEF COMMUNICATION

AN AUDIBLE THUD - A SIGN OF MOBILE FOREIGN BODY IN THE TRACHEA

Jehangir S*, Jacob TJ, Zedek E A#, Ninan PJ, Ravikishore BSS, Thomas RJ, Sen S
Departments of Paediatric Surgery and #Anaesthesiology

Abstract

We report a 10 month old child who presented with an unusual inspiratory knock after a witnessed accidental aspiration of a custard apple seed. The seed was removed using a rigid bronchoscope under general anaesthesia. The knocking sound disappeared immediately after the removal of the foreign body.

Key words :

Foreign body, Bronchoscopy, Aspiration

1. Introduction

Airway foreign bodies are common in children. The commonest presenting complaints are cough, wheezing and recurrent respiratory infection. The usual findings are unilateral decreased breath sounds with collapsed or hyperinflated lung on the affected side. We present a 10 month old baby with an inspiratory knock following custard apple seed aspiration.

2. Case report

A 10 month old baby presented to the Paediatric Casualty with an audible knocking sound noticed by the mother. This sound occurred after the child was seen mouthing a custard apple seed. The child was tachypneic but maintaining saturation without oxygen. On auscultation there was a clear inspiratory knock heard bilaterally.

The parents consented for bronchoscopy. A chest radiograph was deferred due to the strong history and findings.

The bronchoscopy was performed with a Wolff rigid ventilating bronchoscope size 5 (OD-7.5 mm). The seed was retrieved from the trachea. The knock disappeared immediately after the seed was removed. The patient remained stable postoperatively and was discharged the next day.

3. Discussion

The most important factor in the accurate diagnosis of a bronchial foreign body is a positive history of choking or aspiration[1]. There is a slight male preponderance. The usual findings on examination are decreased breath sound, wheeze or in long standing cases signs of bronchiectasis or recurrent pneumonia.

Infants are at particular risk of aspiration due to the absence of posterior dentition, immature swallowing and airway protection and the tendency of mouthing objects. The curious crawling infant is at the highest risk of aspiration especially if left unattended. The proper education and awareness of the general population have been reported to decrease the incidence of foreign body aspiration [2].

Conflict of interest

The authors declare no conflict of interest.

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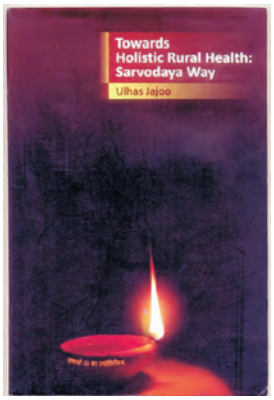
BOOK REVIEW



THE BOOK THAT ISN'T!
"TOWARDS HOLISTIC RURAL HEALTH : SARVODAYA WAY"

Author - **DR ULHAS JAJOO**
Publisher-Mahatma Gandhi Institute of Medical Sciences, Sevagram
ISBN: 978-81-923212-0-2

Reviewed by -- **DR ANUPAMA G.***

Reading is almost second nature to me but this time it wasn't 'reading' when I was traversing through the pages of book I am referring to. And I wondered till first 20 pages or so, 'what is it actually!'

No, it is not a book at all; it is a fascinating odyssey of a prototype Indian rural child, and I was witnessing a nearly complete recording-fanfare at birth, teething troubles, not achieving weight & height milestones at times and then moments of eureka for the parents full of absolute, unconditional love for their apple of eye.

Written by a Gandhian, teacher, administrator, physician and also a visionary rural scientist Dr Ulhas Jajoo, the book is spread over five chapters starting from an all but personal quest for answers and reaching up to alumni of the institute joining the itinerary. The narrative is purely an awesome experience - not a literary one, which all good books suppose to possess in the ordinary way of their making; but a higher one - creating an assertive niche in rural psyche, often perceived as an impenetrable domain by educated Indian urban intellect. Not only it is the saga of a unique health assurance mission (Jawar scheme) of a rurally biased hospital in nearly 28 neighboring villages, the very first of its kind in India but it also answers in a scientific way, why our health missions, one after the other, fail to change the rural health scenario despite years of planning and investing real big money. It appraises the concepts of trained Dai, ANM and VHW in Indian primary health care, criticizes the negligible role of Gram Sabha in distribution of health care resources and raises the issue of complete hijack of health services by the 'haves' on the cost of 'have nots'.

The book is about how prestructured beliefs of newly baptized doctor are shattered (only if one allows them to be), how rationality replaces knowledge and how a modern clinician finds its true place in the community.

It is about what place health care does have in the life of rural folk, when age old Indian sense of sanitation and self dignity is put away to just live somehow, where economic-cultural realities or later the spirituality cross your path towards the change you wish to bring, what it is to talk with people and not at them and even what a pucca road means when you want to save lives in a village just 6 km from the referral hospital.

"The cause of our illness?"
You would know better by looking our rags.
It is the same disease that consumes our bodies and our rags!" (Excerpt from the book)

It means that health cannot be taken as an isolated entity in a community. And so, though

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not deduced in the book but, the only logical inference is that India must develop an ingenious medical education and health care system cut smartly to fit its own precise needs. The miserable progress of health sector by choosing the western path without taking our ground realities into account can be reverted only when we stop production of mere treating clinicians in our medical colleges and initiate making doctors who can go beyond the very narrow objective of medical health; who are health activists, deeply concerned about 'non-health' issues as well and an integral part of rural sociosphere.

The book proposes Sevagram's adventure with rural health care and medical education to be a well researched way to achieve the much vociferated goal of 'health for all' in real world.

Also the book disdains the current political policy of subsidies, donations and pitying for rural upliftment. A whole chapter is dedicated to what mayhem money without cultural values can produce and how the author and his team managed it. During this utterly unbelievable journey the author succeeded in touching the chord of faith in catered villagers and this is the real achieve-ment of the movement.

The book propagates three vital traits for success of every rural health program -

1. Selfless voluntary healthcare managers who are able to understand socioeconomic influences affecting health and to provide innovations to tackle them.
2. The philosophy of 'Swavalamban' (self reliance) and social financing for development percolating up to lowest rung of the community. Participation of community, not only in taking responsibility of their health but of every obstacle in its orbit is the essential.
3. Pooling people together for material gain is not development and so the means are as much important as the aim.

However the book will be more complete if day to day experiences of some junior team members are included which will help to get firsthand insights as it is they who metamorphosed receivers/beneficiaries into stakeholders in their own health & development and who made thriving cooperatives out of simple villagers.

As I said, it is not an ordinary book so rules of book writing do not apply here but nonetheless the book had its editors and therefore some abrogable repetition could have been taken care of.

The gist is the book has simply redefined the primary health care from Indian perspective and is full of innovations we haven't even thought of. In fact the book is not for leaders and planners who dream change on paper and then materialize them on paper. The book is for common citizens who dare to dream to bring change in their sur-roundings without having any other personal agenda than love for fellow country folk.

A bookworm I may be but I too have dreams for my country and so the book was read to the very end and the joy was many more times than reading just a great literary work.

Note :
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- Editor

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All submissions will be subject to an immediate screening process by the Editor. Papers not within the scope, or that obviously do not meet the scientific standards of the journal, may be declined by the Editor without further review. Those that meet the criteria for consideration will usually be sent to two reviewers. All articles are edited to ensure conciseness and clarity. The Editorial board reserves the right to make literary corrections. The Editor will make every effort to reach decisions within 8-10 weeks of submission. Accepted articles will be prepared for publication in any of the forthcoming issues.

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Articles in the following categories are published :

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1. Rose ME, Huerbin MB, Melick J, Marion DW, Palmer AM, Schiding JK, et al. Regulation of interstitial excitatory amino acid concentrations after cortical contusion injury. Brain Res. 2002; 935(1-2):40-6.

Journal article, organization as author:

2. Diabetes Prevention Program Research Group. Hypertension, insulin, and proinsulin in participants with impaired glucose tolerance. Hypertension. 2002;40(5):679-86.

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4. Royal Adelaide Hospital; University of Adelaide, Department of Clinical Nursing. Compendium of nursing research and practice development, 1999 - 2000. Adelaide (Australia): Adelaide University; 2001.

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Part of an Internet website :

15. American Medical Association [homepage on the Internet]. Chicago:The Association;c1995-2002. AMA Office of Group Practice Liaison; [about 2 screens]. Available from: http://www.ama-assn. Org/ama/pub/category/1736.html. [updated 2001 Aug 23; cited 2002 Aug 12]

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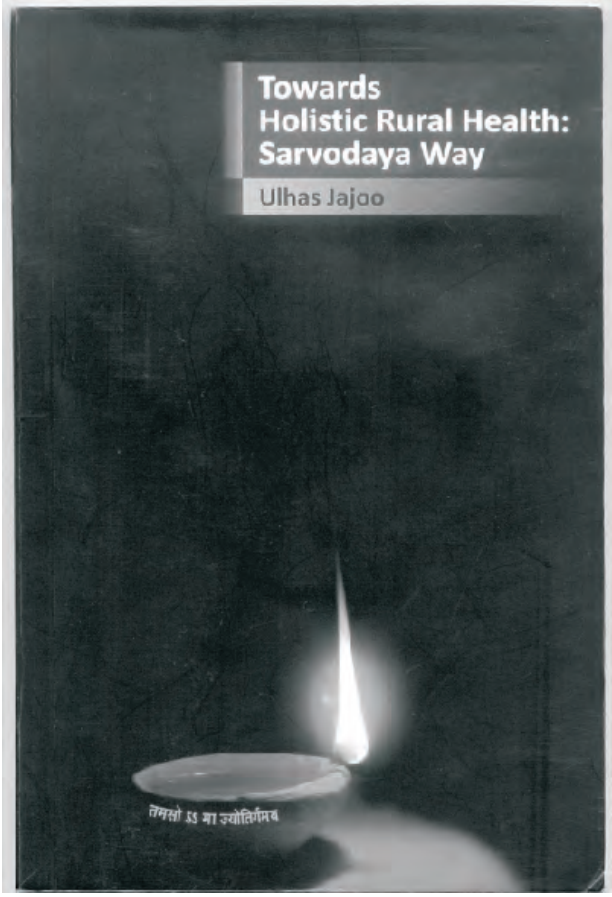

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