

I - INTRODUCTION

CHAPTER I

INTRODUCTION

INTRODUCTION

In this chapter an attempt has been made to explain the different systems of medicine, effects of medical system and utilization of medicine, self medication, sickness, and Tamil Nadu Government Health Care system in Madurai District.

Concept of medicine

One of the most dramatic events that have occurred in this century in the medical world is its emergence as a science. The various discoveries in biochemistry, genetics, pharmacy dynamics, imaging science and anesthesiology, to mention only some of the disciplines, coupled with the use of statistics, electronics and molecular biology had revolutionized the very outlook of this ancient and hoary branch of learning. There was an era in the dim, distant past when the art of medicine was a way of life and when medicine had its origins in mysticism and astrology, and when medicine, literature and poetry were irretrievably intermingled. Dhanvanthari, the symbolic fountainhead of ancient Hindu medicine was a God, whereas Hippocrates was a divine philosopher and others apostles of saintly wisdom. The modern physician starts looking at the patient from a narrow angle as a machine composed of many systems and hopes that it can be repaired by correcting the local and manifest faults, he causes a big slide in the value systems of medicine and irretrievable damage is done. It is well to remember that there is never an illness which affects only one portion of the body or one system and that disease affects the whole person including his psyche. Health is not only absence of disease, but according to WHO a state of positive enjoyment and happiness. Thus it is easy to find that the people can prosper only if the people imbibe the concept of holistic medicine. If the people examine the history of medicine, the people will find that medicine developed

through folk-healing techniques and the folk healers were always the first to realize that man is a composite whole and that as important or even more important than the other systems, was the psyche of the individual. His self-esteem, his physical and mental environment, his beliefs and faith of all had tremendous potential to cause and cure illness.

Herbs have been used by man since the beginning of human culture as a source of medicine. Herbal drugs refer to the plant derived materials or preparations with therapeutic or other human health benefits which contain either raw or processed ingredients from one or more plants. Before 18th century the whole humanity was depending on herbal drugs for meeting health care needs. Introduction of abstract medicine in the form of basic chemicals and pharmaceuticals during the 18th and 19th century has demonstrated methods for bringing quick relief from sufferings and this won instant admiration and popularity. This system known as 'Allopathic' made rapid advances during the 19th and 20th century, as a result of the spectacular advances made in biological, chemical and pharmaceutical sciences. Now the pendulum is swinging back and the herbal drugs are finding increasing demand worldwide. During the past decade there has been an ever increasing demand for herbal drugs and herbal cosmetics especially from the developed countries. This revival of interest in herbal drugs and other natural products is mainly due to the increased awareness and mounting scientific evidence of harmful side effects of most of the modern chemical drugs, antibiotics, cortisones etc. According to a survey conducted by WHO, the use of medicinal plant remedies are on the increase even in the developed countries especially among the younger people. In the industrialized countries, the consumers are seeking safe alternative to modern medicine. The primitive and preventive medicines widely prevalent in oriental medicine especially the Indian (Ayurveda, Siddha, Unani, Amchi) and the Chinese systems of medicine are finding increasing popularity and acceptance the world over. In India the only form of indigenous medicine in the distant past was Ayurveda. In the early days prior foreign influences, this was the most commonly practiced form of medicine. With the Muslim invasions, Unani medicine was introduced into India by the Arabs, In the 18th Century. Allopathy and Homeopathy gained entry into India, These are the common medicine Systems found In India, more particularly in an urban setting it.

Owing to some reason or the other, we observe that the people give priority to the use of one system compared to the others. This may be owing to the concept about the system among the people, their idea about its advancement or any other cause.

Alternative Therapy

Alternative medicine is a commonly used general term to describe all the indigenous methods of healing other than those practiced by conventional doctors working in general practice or in hospitals. Most people are less informed about alternative therapies. This may partly due to the fact that a bewildering variety of alternative therapies exists. However, a more significant factor is almost certainly that until very recently, methods of alternative medicine were regarded with complete skepticism by much of the medical and scientific establishments. Attitudes have gradually become more on lightened and there has been a growing realization that alternative therapies have much to offer in the common aim of helping and healing patients.

Ayurveda

The word Ayurveda is composed of terms, "AYUUSH" meaning life and "VEDA" meaning science. Thus, Ayurveda means the science of life. This medical system has its root in antiquity and has been practiced in our country for centuries. Its origin is traced for back to vedic times, about 5000BC In the sutras of charaka samhitha the author has devoted a full explain the social life of an individual. "AYURVEDA is the science which treats of what is advantageous and what is harmful for the body and also the happy and unhappy states of life. It explains what is good and what is bad for human life, its measurement and other related matters. It is in this connection than one has to think Ayurveda which is more than system of medicine. Ayurveda provides rational help for the treatment of many internal diseases which are considered to be obstinate and incurable in other system's of medicine. Simultaneously it lays a great deal of emphasis upon the maintenance of positive and cure of disease. Ayurveda also studies basic human nature, and natural urges like hunger, thirst, sleep, sex, etc..and inculcate a sense of disciplined, diseases free life in the minds of human beings. Another important aspect of

Ayurvedic treatment is with herbs. Ayurveda practitioner's knowledge of minerals, metals and plants was stupendous. This was successfully used by them from time immemorial. Also Ayurveda maintained that if the mind and body are sound, there was no diseases. If these two deviated the diseases will arise.

The Ayurveda practitioners will endeavor to investigate correctly each diseases by the use of three means namely authoritative instruction, direct examination, inference, of all the above instructions proper diet is much imperative to preserve our health one should take the food in proper quantity. The quantity of food to be take again depending on the power of one's digestion. One must not over-eat anything and should drink water in good quantity. Apart from that Ayurveda recommends vegetarian foods which give more nourishment to the body than the non-vegetarian foods .After taking food rest at least of 10 minutes must be taken No food should be taken in a hurry. In short, Ayurveda has sound enough to give community for the development of positive health and cure of diseases. The laws of manu were a code personal hygiene. According to some authorities the medical knowledge in the atharvaveda gradually developed into the science of Ayurveda. Ayurveda witnessed tremendous growth and development during Buddhist times King Ashoka and other Buddhist Kings patronized Ayurveda as state medicine and established schools of medicine, the" CharakaSamhita".The golden age of indian medicine was between 800B.C and 600 A.D .During Moughul period and subsequent years Ayurveda declined due to lack of state support.

Siddha Medical Science And Tamil Nadu

Siddha system of medicine was a contribution of Dravidian culture. It is presumed that earlier to sangam age, a form of faith cure was being practiced in Tamilnadu. People believed that evil spirits and supernatural forces were mainly responsible for all diseases. Even today cholera and small pox are attributed to that kind of belief. Thus the magic and superstition were inevitable and also associated with herbs and other home remedies during primitive permitve period of Tamilnadu. Medicine has been practiced inn Tamil nadu from time immemorial. In the beginning it was taught by Guru-shishya method. This system has been later developed by the "SIDDHARS".A sect of people with tremendous power in them selves were called "SIDDHARS" inTamilnadu. They studied

the human anatomy, philosophy, illness, etc. medicine especially of siddhars science the religious and other cultural aspects are closely related and interwoven with the medicine. This aspect of culture and civilization can be traced to Indus valley civilization which is supposed to have spread from Tamil country. In the mediaval period there are many records and archeological evidences to bear out the existence, of hospitals and medical school in the period of pallava, chola and other rulers. A medical was run at thiruvaduthurai and tax free lands were assigned to the physicians. In the seventh century A.D during pandian rule there had been two physicians by name "MARAN KARIAND" maraneyinar working as ministers. In 11th century during the period of veera rajendran, hospitals were maintained by the temple. King Sarfogi of Tanjore (1798-1832) compiled the best of siddha systems of medicine. Agasthiar an ancient siddhar has written 342 literary works on medicine. Bogar was considered to be a Chinese Philosopher who came to south india and learnt medicine. Agasthiar described the medicinal properties, sources, description and action of 473 plants and organic and inorganic materials pharmacology in siddha system. Theraiyer one of the eighteenth siddhar who lived in the 15th century A.D has written several books in medicine.

Homeopathy

The principle of homeopathy is to cure an illness or disorder by treating the whole person rather than merely concentrating on a set of symptoms. Hence in this therapy the approach is holistic and the overall state of health of the patient especially his or her emotional and psychological well being is regarded as being very significant. A homeopathic remedy must be suitable both for the symptoms and the patients with the same illness may be offered different remedies according to their individual natures. Homeopathic remedies are based on the concept that like cures like an ancient philosophy that can be traced backed to the 5th century BC when it was formulated by HIPPOCRATES. In the early 1800, modern Homeopathy is based on his work and the medicines derived from plant mineral and animal sources are used inn extremely dilute amounts. It is believed that the curative properties are enhanced by each dilution be cause impurities that might cause unwanted side affects are lost substances used in Homeopathy are first soaked in alcohol to extract their essential .

Unani System Of Medicine

Unani system of medicine or tip is a branch of knowledge which deals with the state of health and disease in the human body for the purpose of adopting suitable measures for preserving or restoring health. This system is based in humoral theory this they supposes the presence in the body of four humours blood, phlegm, yellow bile black bile. The four humours correspond with four basic temperaments. For instance blood is hot and moist phlegm is cold and moist yellow bile is not and dry and black bile is cold and dry. Any change in the unique humoral constitution will bring about a change in the state of health In unani extensive use is made of drugs derived from plant mineral and animal sources. The foundation of this system of medicine was laid by great greek physician Hippocrates 460B.C. later on this system was further developed by the other eminent greek physicians. After the advent of Islam it was later developed into an elaborate medical system by Arabs who gave it a scientific base. Hippocrates established that the disease was a natural process and that its symptoms were the reactions of the body to the disease. Unani tip believes that our body has been gifted with a power of self preservat. This innate power called 'Tabiyat' helps in preventing diseases also this medicine recognizes the influence of surroundings and ecological conditions on the state of health of a person air, food and drink mental movement and repose evacuation and retention, bodily movement and repose sleep and wakefulness. The unani system of medicine is deemed to cure the disease completely though slowly but steadily its drugs are safe with out side effects and they don't cause damage to the vital organs of our body as the ingredients used in the preparations are utilized from the plant sources in their natural form with out involving the synthesized chemical.

Contribution Of Sociology To Medicine

Medicine although a noble profession, developed into a bad trade sold by the physician and purchased by the patient. As medicine became complex , the cost of medical care also increased. Charitable institutions in the past played a notable role in providing free medical care of the poor. But charity can not be depended upon for adequate health protection. An attitude also developed that charity is unworthy of man

and that the benefits of medical science should be available to all people. A solution was to be found. It was socialization of medicine.

Germany , the first country instituted compulsory sickness insurance in 1883. It brought immense benefits to the workers, employers and society at large. Other countries followed suit. England in 1911 and France in 1928. United kingdom passed a National Health Services Act in 1946.

Evolution Of Social Medicine In India And Abroad

The art of healing began with the innovations of the primitive man trying to provide relief to those of his kindred in sickness and suffering, motivated by feelings of sympathy and kindness. There is also evidence that pre-historic man improvised stone and flint instruments with which he performed circumcisions, amputations and of skulls. But it is obvious that medicine in the pre-historic era was intermingled with superstition, religion, magic and witch craft.

The elements of primitive medicine are still current in many countries. Man still takes to charm mantras and other kinds of magical remedies for the cure of illness. Primitive medical systems still exists among the people who live in India and other countries based on various combination of religion, magic and empiricism. Primitive man may be extinct, but the 'Super natural theory of disease' in which he believed has not yet extinct in our modern society.

Indian medicine

The medical systems that are truly Indian in origin and development are the Ayurveda and the Siddha- systems. 'Ayurveda is practiced throughout India but the siddha system is practiced in Tamil speaking areas if South-india only. These systems differ very little in theory and practice. In ancient India. The celebrated authorities in Ayurvedic medicine were Atreya, 'charaka ,Susruta and Vaghbatta. Atreya is acknowledged as the first great Indian physician and teacher. Ayurveda witnessed tremendous growth and development during the Buddhist times.

Hygiene was given an important place in ancient Indian medicine. The laws of Manu were a code of personal hygiene. Archaeological excavation at Mohenjo-Dara and Harappa in the Indus valley, uncovered cities over two thousand years old which revealed rather advanced knowledge of sanitation, water supply and engineering.

The golden age of Indian medicine was between 800 BC and 600AD. During the Moghul period and subsequent years, Ayurveda declined due to lack of State support.

Chinese Medicine

Chinese medicine claims to be the world's first organized body of medical knowledge going back to 2700B.C. It is based on two principles the yang is believed to be an active masculine principle and the yin, a negative female principle. The balance of these two opposing forces meant good health.

The Chinese were early pioneers of immunization. They practiced variolation to prevent smallpox. To a Chinese "the great doctor is one who treats not someone who is already ill but someone not yet ill" the Chinese have great faith in their traditional medicine which is fully integrated with modern medicine.

Egyptian Medicine

Egyptian medicine dates from about 2000B.C. the best known medical manuscript is the Papyrus (1500BC) which was found with a mummy on the banks of the Nile. The Egyptian concept of medicine is far from primitive. They believed that disease was due to absorption from the intestine of harmful substances which gave rise to putrefaction of blood and formation of pus. Diseases were treated with cathartics, enema, blood-letting and a wide range of drugs. Specialization prevailed in Egyptian times. There were eye doctors, head doctors and tooth doctors. All these doctors were officials paid by the state.

Homer, speaking on the doctors of the ancient world, considered the Egyptians to be "the best of all". "They built planned cities, public baths and underground drainage systems. Egyptians had also some knowledge of inoculation against small pox, the value of mosquito nets and the association of plague with rats. Egyptian medicine occupied

dominant place in the ancient world for about 2500 years when it was replaced by Greek medicine.

Greek Medicine

The Greeks earned the reputation the civilisers of the ancient world. They taught men to think in terms of “why and how” An early loader in Greek medicine was Aesculapulus (1200 BC) whose daughter Hygeia was worshiped as the goddess of health. The greatest Greek physician was Hyppocrates (469370 BC) who is often described as the Father of medicine. He studied and classified the diseases based on observation and reasoning. The greatness of Hyppocrates lay in the application of clinical methods in medicine. Hyppocrates left a rich store of his observation in his collection of papers the “corpus Hyppocrati cum”. His book, “Air, water and places” is considered a treaties on social medicine. Since he recognized epidemics as mass phenomena; he was in fact the first true epidemiologist.

In short the Greeks gave a new direction to medical thought. They looked upon disease as a natural process not a visitation from a god of immolation. They attributed disease to disturbances of bodily “humours” caused by climatic and atmospheric changes. The Greek civilization fell into decay and was succeeded by the Roman civilization.

Roman Medicine

The Romans borrowed their medicine largely from the Greeks whom they had conquered. They were more practical minded people than the Greeks. They had a keen sense of sanitation. They made fine roads throughout their empire, brought pure water to all their cities through adequate drained marshes to combat malaria, built sewerage systems and established hospitals for the sick.

The medical men of note in Roman times were celsus (25-50) who gave us the cardinal signs of inflammation , and Galen (130-205 AD) who was a pioneer of experimental medicine . Galen was an author of some 500 treatises on medical subject. His writings were accepted as standard textbooks in medicine for centuries after his death.

Medicine And History

India has one of the most ancient civilizations in recorded history. Thousands of years before the Christian era, there existed a civilization in the Indus valley, known as the Indus valley civilization. Excavations in the Indus valley Mohenjo-Dara and Harappa showed relics of planned cities with drainage houses and public baths built by baked bricks suggesting the practices of environmental sanitation, by an ancient people as far back as 3000 BC. India was invaded by the Aryans around 1,400BC. It was probably during this period, the "Ayurveda" and the "Siddha" system of medicine came into existence. Ayurveda or the science of life developed a comprehensive concept of health. The manu "samhita" prescribed rules and regulation for personal health, dietetic and hygiene, ritual at the time of birth and death and also emphasized the unity of the physical mental and spiritual aspects of life "Sarve Jana Sukhaivo Bhavatu" .This concept of happiness has its roots in the ancient Indian philosophy of life which conceived the oneness and unity of all people wherever they lived.

The post-vedic period (600BC-600AD) was dominated by the religious teaching of Buddhism and Jainism. Medical education was introduced in the ancient Universities of Taxilla and Nalanda, leading to the titles of pranacharya and pranavishara. A hospital system was developed during the reign of Rahula Sankirtiyarta (son of the Buddha) for men, women, and animals and the system was continued and expanded by King Asoka.

The next phase in Indian history (650-1850AD) witnessed the rise and fall of the Moghul Empire. The Muslim rulers introduced, in to India around, 1000AD, the Arabic system of medicine, popularly known as the Unani system origin of which is traced to Greek medicine. The unani system since then became part of Indian medicine. With the changes in the political conditions in India, the torch which was lighted thousands of years ago by the ancient sages grew dim, medical education and medical services became static and the ancient universities and hospitals disappeared. By the middle of the 18th century, the British had established their rule in India which lasted till 1947. Many significant events in the history of public health took place during the 200 years old British rule in India.

Medicine And Anthropology

From the beginning medicine and man are interlinked. From time immemorial, man has been interested in trying to control disease. Anthropology is derived from two Greek words “anthropoids” meaning “man” and “logos” meaning study. This, according to its etymological meaning. Anthropology is the study of man as such.

The medicine man, the priests, the herbalist and the magician, all undertook in various ways to cure man’s diseases and to bring relief to the sick. In an almost complete absence of scientific medical knowledge, it would not be fair to say that the early practitioners of medicine contributed nothing to the alleviation of man’s suffering from disease.

Medical knowledge in fact has been derived, to a very great degree, from the intuitive and observational propositions and cumulative experiences gleaned from others. A history of medicine thus contributes a review of accomplishments and errors, false theories and misin formations and mistaken interpretations. It is also a study of the evolution of man and of human knowledge down the ages; of the biographies of eminent individuals who developed medicine; of the discoveries and inventions in different historical periods, and of the ever changing concepts, goals and objective of medicine.

While physical anthropology dealt with bodily characteristics of man, medicine deals with the illness of man. In spite of the interdependence of these two sciences the field of the study of each is quite distinct. Anthropology is the study of the whole society. It studies its political and legal problem, family organization, religion, art, industries and occupations etc. But medicine tries to attain the goal of health care for all by the year 2000AD, The goal of modern medicine is no longer merely treatment of sickness. The other and more important goals which have emerged are prevention of disease. Promotion of health and improvement of the quality of life of individuals and groups or communities.

Medicine Culture And Religion

Ancient history reveals in records of medicine in prehistoric times. What we know about the care of the sick in primitive times has been discovered through myths, songs and feelings of archaeologist. Ancient man's interest was in the mysteries of life, birth, disease and death. He lived close to nature and soon associated spiritual values to a natural object believing that a thing in nature like a tree or river had a spirit or soul. Such a religion is known as Animism. Things in nature became friends or foes according to man's ability to control them. Water and trees were friends while storms and poisonous plants were enemies. Diseases appeared to be associated with sorcery, magic breaking a taboo and bodily invasion by a spirit. It was necessary to find solution to free the body from the influence of evil spirits. To get rid of these evil spirits dwelling in the body, the rituals and ceremonies and sudden fright were also tried. If the evil spirit was thought to live in a special part of the body, holes were made to allow it to escape. In the excavated graves of ancient men, skulls with holes have been found. Medical treatment was primitive. They believed that diseases were caused by sin and anger from God. Principal method of treatment consisted of giving bitter concoctions in order to drive away the evil from the sick.

The "medicine man" was one who paid close attention to signs and symptoms and thus knew what to do in some conditions has attracted attention by wearing strange costumes using magic words and queer procedures.

After the pre-historic period, writing was invented. Community living changed from tribal groups to urban settlements. What role did medicine play in the disappearance of these systems of treating diseases? We find Medicine changing from witch craft to craft.

The team approach was used to treat the sick person by Babylonians (now Iraq) . The physician directed the treatment, the nurse carried out the care. The pharmacist prepared the medicine and the spiritual care was administered along with these.

In Persia (now Iran) these types of practitioners came out of their medical centres; those who healed with the knife, those who healed with herbs and those who healed with holy words.

The Hebrews (now Isreal) had many rules and regulations in regard to social and religion, customs, health, and sanitary practices, were compiled into what is called the “Mosain Code”. The high priest was priest-physician and health inspector. They practiced excellent hospitality, visiting and caring for the sick was a religious duty.

Indian medicine are to be found in the sacred books or “vedas”. The “Ayur-Veda” is divided into a number of parts which deal with prevention and cure of diseases in medicine, surgery, children’s diseases etc. Hospitals for both men and animals were founded during the reign of king Asoka (272 B.C) Operations were preceded by religious ceremonies and prayer. The nurses were usually men or old women.

Medicine and Economics

The fact that society is influenced by economic factors , while economic processes are largely determined by the social environments which are very intimated . Economics is defined as a study of mankind in ordinary business of life or to be more exact, it is the science of wealth in the three phases of production, distribution and consumption. It is thus concerned with that part of individual and social action which is most closely connected with attainment and with use of material requisites of well being. Economics, in other words, is concerned with material welfare of the human beings.

The field of economics has a very close relationship with medicine. Economics deals with human relationship and medicine contributes its best to people to have and enjoy optimum health in their lives.

If healthy members of the population are replaced by sick members the economy is doubly burdened. First by the loss of productivity resulting from impairment or loss of labour and second, by the cost of curative medicine. Further, the current emphasis in high technology medicine has greatly increased the cost of medical care. This has led to the

application of economic concepts to health activities as subject now known as health economics.

Health economics are concerned with the optimum use of scarce resources for the care of the sick and promotion of health. The early studies in India, in the field of health economics were carried out by Sinton (1935) on the economic loss due to malaria, and the economics gains resulting from malaria control.

In recent years, three economic techniques applicable to the field of health have been widely discussed. These are: cost-benefit analysis, cost effectiveness studies and cost accounting or cost studies. These techniques are increasingly becoming an integral part of health planning, budgeting, management and evaluation of health programmes. They provide valuable checks to find out if the money allotted for a given programme is yielding optimum results.

Medicine And Computers

A computer is essentially a device for processing health information. The data to be processed constitutes the “input” and the manipulated information which is the end product is the “output”.

Computer has applications in almost all spheres of human activity an industrial or business enterprise, government office, bank, school health statistics and medical research. In some large hospital electronic computers have been commissioned to do complicated, routine administrative tasks, working out nursing schedules keeping track of free beds or operating schedules and even elaborating means and have been found satisfactory for such work when used on a large scale.

Electronic computers have also been used for more immediate medical purpose, as for example, automatic monitoring of ECG for critically ill patients. The computer compares the ECG which is recorded automatically at predetermined intervals and compares with a “standard ECG”. If the results, recorded from the patient vary more than accepted deviation from the model, an alarm is given and transmitted, for example, to the nursing station.

Computer technology is replacing human effort in handling and processing of data. Like many other modern inventions, the computer offers innumerable benefits. Computer activity is bound to increase in the coming years.

Many discussions during the past decade have considered the use of computers as an adjunct to the medicine. As an intellectual tool, it can reshape the present system of health care, fundamentally alter the role of the physician and profoundly change the nature of medical, manpower, and even medical education.

Nature Of Sickness

There have been many attempts to define disease by the primitive and the modern man. Webster defines disease as 'a condition in which body health is impaired, a departure from a state of health, an alteration of the human body interrupting the performance of vital functions. The Oxford English Dictionary defines disease as a condition of the body or some part or organ of the body in which its functions are disrupted or deranged.

From a sociological point of view disease is considered a social phenomenon, occurring in all societies and defined and fought in terms of the particular cultural forces prevalent in the society. The easiest definition is that disease is just opposite of health. These definitions are considered inadequate because they do not give a complete criterion of disease. The WHO has defined health but not disease. This is because disease has many shades, ranging from inapparent cases to severe manifest illness. Distinction is also made between the words, 'disease', 'illness' and 'sickness' which are not wholly synonymous. Disease: it is a physiological or psychological dysfunction. Illness: it is a subjective state of the person who feels aware of not being well. Sickness: it is a state of social dysfunction i.e., a role that individual assumes when ill which is called 'sickness role' or 'sick role'.

According to medical sociology, even a distortion of behavior may be regarded as illness. The values and customs of community or social group strongly influences their perception of the symptoms of disease, their interpretation of these symptoms and their techniques of treatment.

So in medical sociology, illness may be viewed as a deviant social state brought about by disruption of normal behavior through disease (a biological state) Sociologists generally prefer describing illness as a social rather than a biological event because the condition of suffering denoted by illness is a subjective experience that usually results in individuals modifying their behavior. Therefore, while a disease represents a medical entity that can be defined in terms of biological, physiological and psychological functioning, an illness can be regarded as a social entity definable in terms of social functioning.

The sociological view of illness as deviance was initially formulated by Talcott Parsons (1954) in his concept of the sick role – characteristic behaviors a sick person adopts in accordance with the normative demands of the situation. Parsons saw being sick as a disturbance in the “normal” concision of the human being, both biologically and socially. Parsons’ concept of the sick role represents the most consistent approach to explaining the behavior characteristic of persons in western society. It is based upon the assumption that being sick is not a deliberate and knowing choice of the sick person, though illness may occur as a result of motivated exposure to infection or injury.

Being sick Parsons argues, is not just experiencing the physical condition of a sick state; rather it constitutes a social role because it involves behavior based on institutional expectations and reinforced by the norms of society corresponding to these expectations. A major expectations concerning the sick is that they are unable to take care of themselves. It thus becomes necessary for the sick to seek medical advice and cooperate with medical experts. This behavior is predicated, upon the assumption made by parsons that being sick is an undesirable state and the sick person wants to get well.

Illness in society

According to Parsons, illness is not a biological state but as a social role-namely the “sick role” – and this role distinguishes those who are healthy from those whom society and the medical profession in particular classify as being sick. The purpose of this distinction Parsons argues to ensure the cohesion of society the sick role maintains the cohesion of society since those who are incapacitated are given the privilege of having

their conventional day to day responsibilities and duties suspended in order to allow them to restore themselves to health and expedite their return to the “social system, with its obligation duties and role”. Parsons, however, insists that illness is dysfunctional because it represents a mode of social responsibilities. Therefore, some persons may desire to retain the sick role more or less permanently because of what Parsons calls a “secondary gain” which is the exemption from normal obligations and the gaining of other privileges commonly accorded to the sick.

Parsons concept of sick role included the following postulates: an individual's illness is grounds for exemption from normal responsibilities and obligations. An individual's illness is not his fault and he needs help in order to get well. The sick person has an obligation to get well because being sick is undesirable. The obligation to get well subsumes the more specific obligation of the sick person to seek technically competent medical help.

Once admitted to this role, the patient thus gains two benefits: the patients are temporarily excused of their normal role. The patients are not held responsible for their illness. In return for these benefits patients are expected to fulfill two obligations: patients must want to get well and should recognize that the sick role is only a temporary state, which they must want to leave behind. Patients must cooperate with technically competent medical help.

Despite considerable criticism, Parson's sick role concept and model represents a significant contribution to medical sociology. Parsons insists that illness is a form of deviance and that as such it is necessary for a sociology to return the sick to their normal social functioning. Thus, Parsons views medicine as a mechanism by which a society attempts to control deviance and maintain social stability.

Parsons concept of the sick role is a useful sociological approach to illness because it views the patient physician relationship within a framework of social roles, attitudes, and activities that both parties bring to the situation. The patient physician role involves a basic mutuality, i.e., each participant in the social situation is expected to be familiar with both his own and other's expectations of behavior and the probable,

sequence of social acts to be followed. The sick role evokes a set of patterned expectations that define the norms and values appropriate to being sick, both for the individual and for others who interact with the person.

According to parsons, the patient is expected to recognize that being sick is unpleasant and that he has an obligation to get well by seeking the physician's help. The patient –physician role relationship is therefore, not a spontaneous form of social interaction. It is a well-defined encounter consisting of two or more person whose object is health tended by society to be therapeutic in nature. And the goal is to promote some significant change for the better in the health of the patient.

Psychological Factors Of Illness

Though we may think of health and illness in terms of physical processes and the field of medicine. We now know that psychological factors affect all aspects of our physical well being. Stress refers to the responses elicited by physical or psychological events that an individual perceives to be harmful or emotionally upsetting. The most common sources of stress are occupational threats and family threads as stress increases, illness becomes more common.

Stress is unavoidable in our lives, so what can we do to reduce its harmful effects? A common recommendation is to stay as healthy as possible through a sensible pattern of diet, sleep and regular exercise. The result is an increase in fitness the maintenance of good physical condition as evidenced by endurance and strength.

Beyond one's physical condition, there is the psychological factor of 'hardiness' This involves a sense of commitment, a perception that difficulties represent a challenge that can be overcome and a belief that you have control over your life.

In addition to hardiness several personality variables also predict what is likely to develop or not develop illness. For example, neurotic individuals react more negatively to stress than those who are not neurotic, and they are also more likely to become ill as a result.

Even psychological factors affect the probability of becoming ill, only physiological factors are of importance once illness strikes. Indeed, when illness comes, physical symptom such as fainting or vomiting is unlikely to go unnoticed by anyone, but less-obvious changes in our physical state could not be simply ignored. A plenty of time may go on, before we notice a slight pain in our lower back, and a rash on our chest. One's mood also affects how much attention one pays to symptoms. In the beginning people tend to use a common sense in self diagnosis. Some elderly people may assume that every ache and pain is simply due to old age. This assumption may convince them not to visit a physician. Thus if a given symptom has been noticed and self diagnosed, the person either ignores the problem, tries to treat it himself or seeks professional help.

The process does not end when the individual decides to seek medical help. The patient has to interact with a physician, undergo necessary test and receive treatment.

Patient- Doctor Interaction

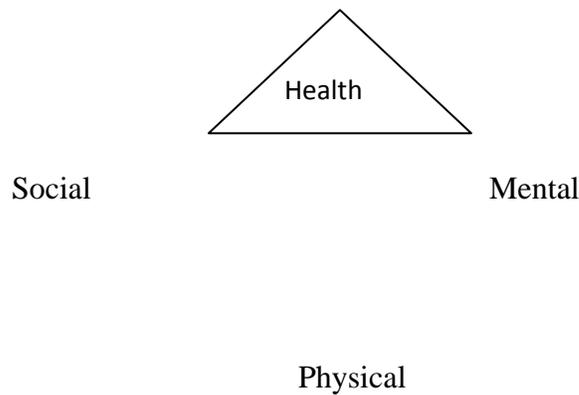
Medical procedures are often frightening and mysterious. The patient benefits both emotionally and physically from being given details about what is happening and what is going to happen, what a patient doesn't need is 'fear' based on a lack of knowledge.

The patient is generally often sufficiently anxious and fearful that crucial symptoms go unreported or important questions are not asked. It helps to rehearse or even to write down what he wants to say. A related problem arises when the physician is abrupt or disinterested or maintains control of the interaction by talking too much and interrupting. Such behaviour can discourage or prevent patients from describing and discussing their concerns.

Doctors differ in their ability to communicate. A patient is most satisfied and most likely to carry out the treatment plan if the physician is good at both sending and interpreting nonverbal messages. They also need to learn how to present medical information to their patients. In the modern scientific society diagnostic tests and medical treatment are stressful and patients must somehow cope with them.

Health Promotion

The world health organization defines health as a “state of complete physical, mental and social well being and not merely the absence of disease or infirmity. A person can be described as healthy provided, the three sides of the triangle- social, mental, physical remain intact if the natural equilibrium is damaged then a state of ill health results.



The risk to health in society today differ greatly from those of the past. Diseases which were once major threats to life at all stage have been either eradicated or controlled i.e., smallpox, cholera, T.B and diphtheria.

Medical advances such as the development of new drugs improved health services and high technology have not managed to deal with a new generation of diseases-the chronic degenerative diseases: Heart disease, Cancer, Strokes, Arthritis etc., In addition new bacteria and vires like HIV have emerged with in the last 25 years.

Health education is method of self empowerment and it enables the people to take more control over their own health and over the factor which affect their health,” health promotion “ is a term used to include all aspects of health education, but placing greater emphasis on change in health policy.

The Role Of Physician

When the patient and physician come first together it often happens that there is an unconscious struggle who is to be dominant. Many patients may come full of their own ideas about their complaints. Quite often, a patient with nothing wrong for various compelling reasons may be referred for investigation or to a physician or surgeon. If nothing positive is found, he may then be referred to a psychiatrist. If the patient is really ill at the out set he approaches the primary care doctor, when his illness is still in an unorganized state, offering various complaints the doctor, the illness enters upon its organized phase. Doctors train their patients for a frank discussion of their personal problems as part of their routine examination and also train them to adopt the right attitude towards their illness. An excellent way of treating chronic patients is to enable them to meet similar patients with good adaptation. In chronic illness, patients attitude to illness is very important in therapy. A general practitioner establishes a friendly working relationship with a known specialist to avoid professional conflicts and disagreements. Doctors take patients anxiety in to account seriously and treat it accordingly. The doctor establishes a good report with a patient and much time is spent on him baling calls it a mutual investment company the various types of relationships between the patients and his illness.

The Primary Health Centers

The concept of “primary health centre” (PHC) as an institution to provide both curative and preventive service is not new to India. The Bhore Committee in 1946 gave the concept of a primary health centre as a basic unit, to provide, as close to the people as possible, an integrated curative health care to the rural population with emphasis on preventive and promotive aspects of health care. Thus it is an institution for providing comprehensive, integrated, preventive promotive and curative services to the people living in a defined geographical area. It seeks to achieve its purpose by grouping under one roof or co-ordinates in some other manner, under direction of a medical or health officer all the health work of that are.

The primary health centers function as peripheral institutions for providing comprehensive health care in an attempt to move away from the hospital-based curative services, which were found inadequate to meet the health needs of the vast majority of rural population.

The functions of the primary health centre in India as outlined below cover all the 8 elements in WHO's definition of primary health care : medical care, mother and child care including family planning, Safe water and basic sanitation, Prevention and control of locally endemic diseases , Collection and reporting of vital statistics, Education about health, National health programmes as relevant, Referral services, Training of health guides health workers, health Assistants and local dais.

The primary health centers adopt the new philosophy of 'primary health care', as described in the Alma-Ata Declaration. PHCs are trying to reach the entire population with primary health care which has been defined as essential health care, Universally accessible to individuals and families in the community, in an acceptable and affordable way with their full participation.

Expansion Of Health Infrastructure

There was virtual absence of basic health services for a large section of the population of India at the time of independence in 1947. However, after independence , there was political commitment to boost health status and a systematic programme for the establishment of primary health centers and sub-centers began in 1952 in the community development areas. Over the years a lot of primary health centers and sub centers have been opened. At present primary health centers form the nucleus of health services in rural areas.

Following the acceptance of the WHO goal of "Health for all", the ministry of health moved rapidly to formulate its 'National Health Policy', which was approved by the parliament in 1983. It resulted in tremendous expansion of health infrastructure for achieving the objectives of the National health policy. At the end of March 1992, there were about 22,441 primary health care centers and 1,31,318 sub- centers, and many more are on the way to be established, however the basic requirements for health , are lagging

behind in both rural and urban areas. A major requirement in developing an adequate health infrastructure is health manpower which must be adequate both as regards quality and quantity. More medical colleges and training centers should be established to bridge the gulf of manpower .but it is quite convincing that the current overall manpower situation in India in regard to population per physician and nurse midwife is higher than the norms set by Mudaliar committee in 1961 which were 3500 and5000 respectively.

However, there are inequalities between rural and urban areas in the distribution of health manpower, no doubt, the primary health care approach seeks to redress these inequalities. Hence it is evident that notable progress has been made in the health status of the people of India during the last three decades . but there are some hurdles to be overcome in the path of our progress. High rate of population growth, High rates of mortality and morbidity especially among women and children, continued high prevalence of malnutrition, Spreading of communicable diseases, Lack of safe drinking water and basic sanitation, low levels of literacy.

The health care facilities of particular interest are the four states i.e., uttar Pradesh, Madhya Pradesh, Bihar and Rajasthan which have been described as the “Waterloo” of India’s health and family welfare programme.

India has a more pluralistic political set-up than many of the developing countries in her neighbourhood. She has a long-standing commitment to social equity. Our failure to attain this objective has been attributed to a combination of the following ‘non-health’ factors: political turbulence, the vested interest of the medical profession, rapid population growth, inequitable social structure, uneven economic development. Whatever be the condition in India, the present concern in both developed and developing countries is not only to react the whole population with adequate health care services but also to secure an acceptable level of health for all by the year 2000 AD period, through the application of primary health care programme.

Planning For Changes In The Field Of Health

To plan for the needed changes and improvements in the field of health. Also the right type of health services and programme which will be most effective in reaching the goal of 'Health for all by 2000 AD.

It is much imperative for us to understand how community services fit into the regional and national plans for health and development. In planning for the required changes we to consider the following important factors: National policies and local policies, Local population, Climate and geography, Water supply, Housing and overcrowding, communications- road and transport, postal and telephone services, Extent of health, services (both govt. and private), Existing health, welfare and development programmes, Money available (Govt., community, international agencies etc.), Personnel, government, private, traditional healers, community health workers, Attitudes of the community towards traditional and modern medicine.

In the community, social medical workers will need to develop simple plans with the community. These are the steps in planning with the community: Collection of facts and analysis, Identification of problems and their arrangement in order of priority, Identification resources, Defining goals and discussing alternatives, Planning the programme, Implementation of the programme, Evaluation for quality, effectiveness and efficiency, Adjusting goals and replanning.

Epidemiology

This is the study of study of disease in the community. In order to plan for effective control of communicable diseases, to find out on what conditions certain disease are more often scan, who is affected, at what period of time what is the source and how is the disease spread.

Epidemiological Method Can Be Applied

To find out about health needs of the community, to decide on objectives- targets such as bringing down the number of deaths and incidence of deaths and incidence of

various diseases, to meet the needs by means of suitable health services, to evaluate the quality and usefulness of community health care.

Animal, rodents and insects

Animal, rodents and insects carry disease to man. To check this problem we have to plan adequately as under : Studying the local animal population, Keeping records of persons infected animals and rodents, Finding out breeding places of insects, keeping records of cases of diseases, planning with veterinary surgeon for effective immunization programme for domestic animals and poultry, Educating people and obtaining their co-operation in implementing the plans.

Environmental Health

The purpose of environmental health is to bring about conditions suitable for health promotion. Principles of prevention in environmental health include: safe water supply, good sanitation and housing, food hygiene, disinfection to kill harmful organisms by use of heat, sunlight and chemicals, control of disease including immunizations.

Occupational Health

Some health problems are directly attributed to occupations and conditions of work. Principles of prevention in occupational health include: Control of environment, over crowding in factories cleanliness, ventilation and lighting. Prevention of accidents by means of adequate protection. Training and supervision of workers. Regular health check-up and emergency health care. Cases of occupational disease should be reported to the health authorities. Education about health hazards and their prevention.

Health Programmes In India

Several steps have been undertaken by the National Government to boost the health of the people. "The National Health programme" Launched by the central Government have been an important measure taken for the control and eradication of communicable diseases improvement of environmental sanitation, nutrition, control of

population and rural health. Also multifarious international agencies like WHO, UNICEF, UNFPA WORLD BANK have been providing technical and monetary assistance in the implementation of these projects.

Implementation Of Health Plans

Health plans and programmes are carried out at various levels as under : National, State, district, Block, Village success depends on the mutual team work at every stage be virtue of hard work and co-operation. Every one should have a sense of begin involved in reaching the plan targets. Once the plan has been accepted, no changes of additions are possible thereafter. The money allotted may be used only for the purpose intended in the health programmes.

For each plan there is a strict time frame for implementation, (whether it is central government of state government) Funds are procured on annual basis and are used within the stipulated time. There is supervision and reporting at every stage to ensure that for each schema the targets are achieved in time cost and service. At village and block levels, we have panchayat raj, but in addition, various voluntary organization that enable in implementing the health and welfare plans of the government.

National Health Problems And Programme

Health problem	Health programme
Malaria	(NMEP) National Malaria Eradication Programme (1958)
Filaria	District Malaria units (1977) National Filaria control programme (1955)
Tuberculosis	1) NTCP National Tuberculosis Control Programme (First five year plan) 2) District Tuberculosis Control Programme(1962)
Leprosy	National Leprosy control programme(1954-55)

Veneral diseases (V.D) or sexually transmitted diseases (STD)	National V.D control programme
Water supply and sanitation	National water supply and sanitation programme (1954)
Family welfare	1) National family planning programme(1953) 2) Postpartum programme (1970)
Nutrition	1) Applied Nutrition Programme (1963) Assistance from F.A.O , UNICEF and W.H.O 2) Nutrition included in the minimum needs programme 3) “Food for work” programme included in the New National Rural Employment programme (VI plan) 4) The special Nutrition Programme 5) The mid-day meals programme
Blindness	National Trichoma control programme (1963)
Coitre (deficiency of iodine)	National coitre control programme (1962)
Cholera	Cholera control programme
Small pox	National small pox eradication programme

Multi-Purpose Health Worker’s Scheme

Many attempts have been made to meet the health needs of the people of India by means of primary health centers and sub-centers and the training of auxiliary nurse Midwives to go out from these centers to the homes of the people. The number of auxiliary nurse Midwives were never sufficient and more than half of them after training

was given mainly in the hospital environment with meager experience and understanding of health needs of people, families and communities in urban areas

.Drug And Drug Industry

The drugs and cosmetics act, 1940, as amended from time to time regulates import, manufacture, sale and distribution of drugs and cosmetic in the country. Under the act, import, manufacture and sale of substandard, spurious, adulterated or misbranded drugs, are prohibited. Government is empowered to check the quality of imported drugs, co-ordinated the activities of the state, lay down regulatory measures and standards of drugs and grant approval for the import or manufacture of new drugs. The control over the quality of drugs which are manufactured sold and distributed in the country is exercised by state government. Zonal offices of the central drugs standards control organization at Bombay, Calcutta, Ghaziabad and Madras maintain close liaison with state organization for enforcement of the provisions of this act. Central drugs laboratory, Calcutta functions as the testing laboratory for imported drugs and analytical quality control of drugs manufactured in the country on behalf of the central and state drugs control authorities. It is the appellate laboratory under the drugs and cosmetics act to test samples of drugs sent to it by courts. Central Indian pharmaceutical laboratory, Ghaziabad tests samples of non-biological drugs included in the Indian pharmacopeia.

Drug's and pharmaceutical industry in India, during the last 40 years has shown tremendous progress if one takes into consideration the growth rate as seen in other developing countries. Today, India is in a position to meet 70 percent of its requirements. The industry continued to maintain the steady growth in terms of production as well as range of products in 1993-94 also. This year the production of bulk drugs and formulations were estimated to be of the order of RS1320 Crore and RS 6900 Crore respectively, showing a growth rate of 15 percent over the previous years production. In the case of individual drugs, while decrease in demand and obsolescence have a significant impact.

The pharmaceutical industry in India today has the capability of producing a wide range of bulk drugs, covering a larger spectrum of technologies and almost all formulations. In fact, the country is almost fully self-reliant in terms of formulation technology. In the case of bulk drugs, the technologies include those for sulphadiazine, vitamins, hormones and a number of new synthetic drugs like flumequine, pefloxacin, Ramipril, Ketiofloxacin, Lisinopril among 'the bulk drugs' which are critical to the country's health needs, the two most important ones are penicillin and Rifampicin. Penicillin is being manufactured in the country mainly by the two public sector undertakings. Considering the growing need for this drug it was debarred from the public sector and seven private sector companies were given industrial approvals for its manufacture. Some of them have made progress in implementing their projects. The two public sector undertakings have also progressively enhanced their production. The country has for a number of years been on the look out for a technology for the manufacture of Rifampicin from the basic stage of fermentation. The indigenous need for this drug was being met through manufacture from penultimate's and intermediates.

Drug Control

The purchase and inventory control of pharmaceuticals is a special and important phase of the operation of a successful pharmacy. Apportionment of the purchases, narcotics and alcohol, is rigidly controlled by Federal regulation which in reality provides the means for accurate purchase and inventory control. These two classes of products constitute a relatively small portion of the overall purchases of an institutional pharmacy. In view of the fact that the three words "purchase" inventory and 'control' will be in constant use it is felt that these terms should be defined. The word 'purchase' as defined in the dictionary, has numerous meanings the most appropriate being to obtain by paying money or its equivalent to buy for a price the word 'Inventory' is defined as an itemized list of goods with their estimated worth specifically an annual account of stock taken in any business. The word 'control' is defined as follows- 'to exercise' dissecting, guiding or restraining of power over.

Concept Of Health Care

Health has been declared a fundamental human right. Health is influenced by a number of factors such as adequate food, housing, basic sanitation, healthy lifestyles, protection against environmental hazards and communicable diseases, the frontiers of health extend beyond the narrow limits of medical care. The term “medical care” is not synonymous with “health care” It refers chiefly to those personal services that are provided directly by physicians or rendered as the result of physicians instructions. Medical care is subset of health care system. Health service are designed to meet the health needs of the community through the use of available knowledge and resources. It is not possible to define a fixed role for health services when the socioeconomic pattern of one country differs so much from another. The health services are delivered by the “health system”, which constitutes the management sector and involves organizational matters. Health services should be organized to meet the needs of entire populations and not merely selected groups. Health services should cover the full range of preventive, curative and rehabilitation services. Health services are now seen as part of the basic social services of a country.

Health Planning In India

Health planning in india is an integral part of national socioeconomic planning .the guide-lines for national health planning were provided by a number of committees dating back to the Bhore committee in 1946.These committees were appointed by the government of India from time to time to review the existing health situation and recommend measures for further action. A brief review of the recommendation of these commitees, which are important landmarks in the history of public health in India, the Aima Ata Declaration on primary health care and the National Health Policy of the Government gave a new direction to health planning in India, making primary health care the central function and main focus of its national health system. The goal of national health planning in India is to attain Health for all by the year 2000.

Bhore Committee, 1946

The government of India in 1943 appointed the Health Survey and Development Committee with Sir Joseph Bhore as Chairman, to survey the then existing position regarding the health conditions and health organization in the country, and to make recommendations for the future development. Committee which had among its members some of the pioneers of public health met regularly for 2 years and submitted in 1946 its famous report which runs into 4 volumes. Integration of preventive and curative services at all administrative levels

The committee visualized the development of primary health centers in 2 stages: (a) as a short-term measure, it was proposed that each primary health centre in the rural areas should cater to serve as a supervisory, coordinating and referral institution. For each PHC, two medical officers, 4 public health nurses, one nurse, 4 midwives, 4 trained dais, 2 sanitary inspectors, 2 health assistants, one pharmacist and 15 other class IV employees were recommended (b) a long-term programme the 3 million plan of setting up primary health units with 75-bedded hospitals for each 10,000 to 20,000 population and secondary units with 650-bedded hospitals, again regionalized round district hospitals with 2,500 beds

Mudaliar Committee, 1962

By the close of the second five year plan (1956-61) a fresh look at the health needs and resources was called for to provide guidelines for national health planning in the context of the five year plans. In 1959 the government of India appointed another committee known as "Health Survey and Planning Committee", popularly known as the Mudaliar Committee after the name of its chairman, Dr. A. L. Mudaliar) to survey the progress made in the field of health since submission of the Bhore Committee's development health services. Consolidation of advances made in the first two five year plans. Strengthening of the district hospital with specialist services to serve as central base of regional services regional organizations in each state between the headquarters organization and the district in charge of a regional deputy or Assistant Directors- each to supervise 2 or 3 district medical and health officers, each primary health centre not to

serve more than 40,000 population to improve the quality of health care provided by the primary health centres integration of medical and health services as recommended by the Bhore committee and constitution of an all India Health Service on the pattern of Indian administrative service.

Chadah Committee, 1963

In 1963 a committee was appointed by the government of India, under the chairmanship of Dr.M.S.Chadah, the then Director General of health services to study the arrangements necessary for the maintenance phase of the Nation malaria Eradication programme.the committee recommended that the “Vigilance” operations in respect of the National Malaria Eradication programme should be the responsibility of the general healthservices, primary health centres at the block level. The committee also recommended that the vigilance operations through monthly home visits should be implemented through basic health workers. One basic health worker per 10,000 population was recommended. These workers were envisaged as “multipurpose” workers to looks after additional duties of collection of vital statistics and family planning. In addition to malaria vigilance. The Family Planning Health Assistants were to supervise 3 or 4 of these basic health workers. At the district level the general health services were to take the responsibility for the maintenance phase.

Mukerji Committee, 1965

Within a couple of years of implementation of the chadah committees recommendations by some states, it was realized that the basic health workers could not function effectively s multipurpose workers, and as a result the malaria vigilance operations had suffered and also the work of the family planning programme could not be carried out satisfactorily. This subject came up for discussion t a meeting of the central Health Council in 1965. A committee known as Mukerji, the then secretary of Health to the government of india, was appointed to review the stategy for the family planning programme. The committee recommended separate staff for the family planning programme. The family planning assistants were to undertake family planning duties only.

Jungalwalla Committee 1967

The central council of Health at its meeting held in Srinagar in 1964, taking note of the importance and urgency of integration of health service, and elimination of private practice by government doctors, appointed a committee known as the "Committee on integration of Health Service under the chairmanship of Dr. N.Jungalwalla, Director, National Institute of Health Administration and Education . A service with a unified approach for all problems medical care of the sick and conventional public health programmes functioning under a single administrator and operating in unified manner at all levels of hierarchy with due priority for each programme obtaining at a point of time unified cadre, common seniority, recognition of extra qualifications, equal pay for equal work special pay for specialized work, no private practice, and good service conditions

Health Policy Of The Government Of India

National Health Policy(1983) lays stress on preventive, promotive, public health end rehabilitative aspects of health care and points to the need for establishing comprehensive primary health care service to reach the population in the remotest areas of the country, the need to view health and human development as a vital component of over all integrated socio-economic development, and the need for a decentralized and regionalized, system of health care delivery with maximum community and individual self-reliance and participation. The policy lays stress on adequate nutrition, safe drinking water supply and improved sanitation, health education and population stabilization and also on the need for a separate medical and health education policy. Development of health facilities under different systems of medicine would be planned end coordinated that they would support and complement and not compete with each other in the provision of care.

National Health Policy

Primary Health care involving urban guides, community participation establishment referral system, sanitary with epidemiological station domiciliary care and field camps utilization of untapped resources specialist service and programmes for disabled Reorientation of existing health personnel, restriction of private practice by

government functions. Utilization role of indigenous practitioners and other systems of medicine in health care. Problem requiring urgent attention, nutrition, prevention of food adulteration and maintenance of quality of drugs water supply and sanitation, environment protection immunization programme ,school health programme and occupational health services, health education health information system medical industry, health insurance, health legislation medical research and health policy.

Food Surveillance

Food surveillance is essential for the protection and maintenance of community health. Broadly it implies the monitoring of food safety/food hygiene. The WHO has defined food safety/food hygiene as “all conditions and measures that are necessary during the production, processing storage, distribution and preparation of food to ensure that it is safe, sound, whole some and fit for human consumption. The declaration of Alma Ata considered food safety as an essential component of primary health care. The importance of surveillance of food borne diseases has been underlined in the WHO sixth general programme of work for the period 1978-1983. The most important international programme carrying out activities in the field of food hygiene is the joint FAO/WHO food Standard programme.

Food Hygiene

Food is a potential source of infection and is liable to contamination by microorganisms, at any point during its journey from the producer to the consumer. Food hygiene, in its widest sense, implies hygiene in the production handling distribution and serving of all types of food. The primary aim of food hygiene is to prevent food poisoning and other food-borne illnesses. Food hygiene milk hygiene milk is an efficient vehicle for a great variety of disease agents. The sources of infection or contamination of milk may be the dairy animal human handler or the environment contaminated vessels, polluted water, flies dust, the safety and keeping quality of milk are related to its microbial content. The first essential in the production of clean and safe milk, is a healthy and clean animal Milk from a healthy udder contains only a few organisms, and these are relatively unimportant. The premises where the animal is housed and milked should be

sanitary the milk vessels must be sterile and kept covered. The water supply must be bacteriologically safe. Milk handler must be free from communicable disease, and before milking they must wash their hands and arms, where possible milking machines must be used. Milk should be cooled immediately bacterial growth.

Pasteurization Of Milk

Pasteurization maybe defined as the heating milk to such temperatures for such periods of time as are required to destroy any pathogens that may be present while causing minimal changes in the composition flavor and nutritive value holder method in this process, milk is kept at 63-66 deg C for atleast 30 minutes, and then quickly cooled to 5deg C. Vat method is recommended for small and rural communities In larger cities, it is going out of use. HITST method: Also known as "High Temperature and short time method milk is rapidly heated to a temperature and nearly 72 deg C, is held at that temperature for not less than 15 seconds, and is then rapidly cooled to 4deg C. This is now the most widely used method. Very large quantities of milk per hour can be pasteurized by this method. Pasteurization is a preventive measure of public health importance and corresponds in all respects to the modern principles of supplying safe milk. Pasteurization kills nearly 90 percent of the bacteria in milk including the more heat resistant tubercle bacillus and the Q fever organisms. In order to check the growth of microorganisms, pasteurized milk is rapidly.

Meat Hygiene

Animals intended for slaughter are subjected to proper ante mortem and postmortem inspection by qualified veterinary staff. The principal causes of ante mortem rejection of animals are emaciation, exhaustion, pregnancy, sheep-pox, foot-rot, actinomycosis, brucellosis, febrile condition, diarrhoea and other diseases of an infectious nature rendering meat unfit for human consumption. The main causes of the postmortem rejection are cysticercus bovid, liver fluke, abscesses, sarcocystis, hydatidosis, septicaemia, parasitic and infections of liver nodular cellulose. Fruits and vegetables: Fruits and vegetables constitute another important source for the spread of pathogenic organisms, protozoans and helminthes. The vegetables which are consumed raw in the

from of salads pose a problem in food sanitation. People should be educated to wash the vegetables before eating them raw. Vegetable which are cooked are free from this danger. Sanitation of eating establishments is a challenging problem in food sanitation. Restaurants and eating houses in india under the model public health act1955. Location : shall not be near any accumulation of fifth or open drain, stable, manure pit and othersources of nuisances. Floors: To be higher than the adjoining land made with impervious material and easy to keep clean. Rooms where meals are served shall not be less than 100sq provide accommodation for a maximum of 10 persons. Lighting and ventilation nature lighting facilities aided by artificial lighting with good circulation of air are necessary. Kitchen: Floor space minimum60sq window opening to be 25 percent of floor area. Floor to be impervious, smooth, easy to keep clean and non-slippery doors and windows to be rat-proof, fly-proof, and of the self-closing type. Ventilators 2percent of the floor area in addition to smoke pipes. Storage of cooked food: Separate room to be provided for long storage, control of temperature is necessary. Water supply: To be an independent source, adequate, continuous and safe. Washing facilities: To be provide cleaning of utensils and crockery to be done in hot water and followed by disinfection.

Mental Health

Health is defined as a state of complete physical, mental and social well being and not merely the absence of disease a sound mind in a sound body has been recognized as a social ideal for many centuries. Organic condition neurological diseases heredity social pathological causes combination of genetic and environmental factors.

Prevention Of Mental Ill Health

Working for better living conditions and improved health and welfare resources in the community. Early diagnosis family based health services, case work or counseling reducing the duration of mental illness and stress and preventing futher break-down and disruption. Early diagnosis and treatment rehabilitation group and individual psychotherapy mental health education use of modern psychoactive drugs after care services. The psychiatric service have been integrated with other health services. The community mental health programme includes all community facilities in any way to

prevention, treatment and rehabilitation the philosophy of community mental health programme. In patient services, out-patient services, partial hospitalization, emergency services , diagnostic services, pre-care and after care service's care placement and home visiting, education services, training, research and evaluation.

Radiation Hazards

A number of industries use radium and other radio-active substances, painting of luminous dials for watches and other instruments, manufacture of radio-active paints. Exposure to radium also occurs in mining of radio-active ores, monazite sand workers and handling of their products X-rays are used both in medicine and industry. Exposure to ultraviolet rays occurs in other electric welding processes. Infrared rays are produced in welding, glass blowing, foundry work and other processes where metal and glass are heated to the molten state and in heating and drying of painted and lacquered objects. Occupational hazards due to ionising radiation may be acute burns, dermatitis and blood dyscrasias: chronic exposure may cause malignancies and genetic effects. Lung cancer may develop in miner working in uranium mines due to inhalation of radio-active dust.

Preventive Measures Radiation

Inhalation swallowing or direct contact with the skin should be avoided. In case of X-rays, shielding should be used of such thickness and such material as to reduce the exposure below allowable exposures. The employees should be monitored at intervals not exceeding 6 months film badge or pocket electrometer devices. Suitable protective clothing to prevent contact with harmful material should be used. Adequate ventilation of work-place is necessary to prevent inhalation of harmful gases and dusts. Pregnant women should not be allowed to work in place where there is continuous exposure.

Communicable Disease

Communicable diseases continue to be a major problem in India. Diseases considered to be of great importance today are: MALARIA: Malaria continues to be a major health problem in India. With the implementation of modified plan of operation in

1977, the upsurge of malaria cases dropped down from 6.75 million cases in 1976 to 2.1 million cases in 1984. Since then, the epidemiological situation has not shown any improvement. Although total malaria cases has declined compared to previous years, the proportion of *P. Falciparum* has increased. Malaria cases has increased in Goa, Madhya Pradesh and Orissa. During 1998 there were an estimated 20,000 malaria deaths in the country. The estimated incidence is about 0.91 million cases with slide positivity rate of about 1.84. There appears little prospect of malaria eradication in the foreseeable future.

Tuberculosis: Tuberculosis is another leading public health problem in India. About 36.5 percent of the total population are infected tuberculin positive 1.5 percent have radiologically active disease of the lungs of which 0.4 percent are sputum-positive cases. According to official estimates, India has nearly 12.7 million cases of pulmonary tuberculosis of which about 3.4 million are sputum-positive. The number of deaths is estimated to be nearly 50,000 every year.

Diarrhoeal diseases: Diarrhoeal diseases constitute one of the major causes of morbidity and mortality, specially in children below 5 years of age.

low birth weight: This is a major public health problem in many developing countries about 30 percent of compared to about 4 percent in some mainly responsible for this condition.

Xerophthalmia : about 0.04 per cent of total blindness in India is attributed to nutritional deficiency of vitamin A. Keratomalacia has been the major cause of nutritional blindness in children usually between 1-3 years of age.

Subclinical deficiency of vitamin A is also widespread and is associated with increased morbidity and mortality from respiratory and gastro-intestinal infections.

Problem Of Malnutrition

Malnutrition has been defined as ‘a pathological state resulting from a relative or absolute deficiency or excess of one or more essential nutrients. It comprises four forms undernutrition, overnutrition imbalance and the specific deficiency. Under nutrition: This is the condition which results when insufficient food is eaten over an extended period of time in extreme cases, it is called starvation. Overnutrition: This is the pathological state resulting from the consumption of excessive quantity of food over an extended period of time. The high incidence of obesity, atheroma and diabetes in western societies is attributed to overnutrition. Imbalance: It is the pathological state resulting from a

disproportion among essential nutrients with or without the absolute deficiency of any nutrients .Specific deficiency: It is the pathological state resulting from a relative or absolute lack of an individual nutrient. There are about 460 million people-15 percent of the world's population excluding China who are malnourished, of which about 300 million live in South Asia where they constitute one third of the population malnutrition's main victims are children under the age of but children under the age of 5 years are the hardest. On a global scale the five principal nutritional deficiency diseases are being accorded the highest priority action are kwashiorkor marasmus, xerophthalmia, nutritional anaemias and endemic goiter diseases represent the tip of the "Iceberg" of malnutrition which is not easy to diagnose. The tragedy is that most of the diseases can be either easily prevented or treated with minimum input of resources. In fact, most of the developed countries of the world have overcome many of these problems by such measures as manipulation of practice of systems of medicine and improvement of standards of medicine. Medical care in India is majority of the people based on Western medicine. With the advancement of technology, medical care has become costly. Increased public awareness of the potentialities of medical care has increased the demand. The Government of Tamil Nadu is also implementing lot of medical care programmes through medical care organizations. So far no attempt has been made to analyze the use of various systems of medicine Madurai District. Therefore, the scholar thought that a research study on this topic could be a valuable contribution to the studies on use of various systems of medicine on society people.

REFERENCES BOOKS

1. Siegerist, Henry (1951). A History of Medicine.,Vol.Oxford University press, London.
2. Dubos R.J. (1969) Man. Medicine and Environment, New American Library, New York.
3. Dr. John Everett Park and K.Park (1989), Essentials of Community Health Nursing, Banarsidas Bharat Publishers, Jabalpur.
4. Gokhlae, B.V(1960) Swasth Hind, 4.165.
5. Smith, A.J.(1974) British Medical Journal 2: 367-370.
6. Schwanz, W.B(1960),N ENG.J.MED 283:1237.
7. Macmahan.B and T.F.Pugh(1971).”Epidemiology: Principles and Methods,”Little Blown &Co.,Boston.
8. J.E Park .K.Park (1983)”Text Book of Preventive and Social Medicine”,Nineth Edition , M/S. BanarsidasBhant.Jabalpur, India,
9. Suchman.,E.A.(1963) Sociology and the field of public Health, RusselSageFoundation, New York.
10. Lilienfeld .A.MandLilenfeld D.E.,(1980)”Foundations of Epidemiology”.Oxford University Press.
11. Roht,L.H..(1982).”Principles of Epidemiology”.,A. Self teaching guide, London. Academic Press.
12. Leaval. H.and Clark.EG. (1965).”Preventive Medicine for the Doctor in his Commnity”’.McGraw Hill,New York.
13. Dubos, R.(1965). Man Adapting, New Haven. Yale,Uni press.

14. Frank E. Chapman, Hospital Organisation And Operation New York :The Macmillan Company,1224
15. MaryRisley,House of Healing,Garden city, N.Y .Doubleday &Co,1961.
16. WHO Expert Committee on Organisation of Medical Care (1957)Role of hospital in programmes of Community Health Protection,Geneva,
17. Dr.J.B Shrivastava,"Hospital Administration in developing country".A paper presented at NITTE (National institute for Training in Industrial Engineering) at Bombay.
18. Report of the Health Survey and Planning Committee (Mudaliar Committee) Volland II 5962 Ministry of Health Government to India, New Delhi.
19. KeithDavio Human Bahaviour at Work Organization Behavior Tata Me Graw Hill publishing Company Ltd New Delhi THM edition Sixth edition.
20. Perrodin ,Cecilia M. Supervision of Nursing Service Personnel,New York: The Mac Millan Company 1954.
21. W.Barret. Jean."The Head Nurse-Her Changing Role"Second edition New York Appleton Century Crofts.1963.
22. Basil S. Georgopolous and Floyd C.Mann, The Community General Hospital, Macmilan Publishing.1970.
23. Stieglitz,Edward J.(1949) in Social Medicine:It's Derivatives and objectives.Ed. Leugo Gladstone, The Common Wealth Fund New York.