TEACHING OF COMMUNITY MEDICINE TO UNDERGRADUATES IN INDIA - AN EXAMPLE AT LUCKNOW

(Paper for the Technical Discussions)

by

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1. GENERAL CONSIDERATIONS

The concept of teaching community medicine to the undergraduates in India is hardly 25 years old. With a view to achieving the goal of a social welfare State after Independence in 1947, the need to provide health care to the rural masses, constituting more than 80 per cent of the total population, was felt. The provision of such care was initiated as a part of the community development programme on 2 October 1952 in 55 community development project areas, as an experimental measure. The community development programme was adopted as a national programme, and in the first three five-year plans (1951-52 to 1965-66), the entire country was covered by over 5,000 community development blocks, each having a primary health centre.

A community development block is a service-cum-administrative unit of 100 villages covering 80,000 to 100,000 population, working for, among and with the people. It is based on democratic socialism, which has deep roots in India. Its success depends on the co-operation and participation of the people and the devotion of the government officers, including the medical officers, to rural work. Its administration is based on co-ordination of all developmental activities, including that of health.

By the end of the Fourth Five-Year Plan (1969-70 to 1973-74), the country will need nearly 10,000 doctors, male and female, for its primary health centres. Medical education thus has to be geared to produce community-oriented basic doctors who are professionally competent and emotionally prepared to serve the needs of the community in rural areas. The future expansion and success of the rural health services will depend largely on these doctors.

The number of medical colleges in India at the commencement of the First Five-Year Plan (1951) stood at 30, with an admission capacity of 2,500 students a year. By the beginning of the Fourth Five-Year Plan (1969), the number of colleges had risen to 93, with an annual intake of nearly 11,700 students. However, though the number of qualified doctors increased by 47,000 in less than two decades, yet only 20 per cent of the doctors are working in rural areas. The young doctor coming out of medical college greatly needs the attitudes, knowledge and skills necessary for community health care. Inadequate preparation and maldistribution of doctors have been worrying not only the planners, health administrators and medical educationists but also the leading clinicians in India. During the past two decades there has been a growing recognition that what is required to meet the needs of the people of India is a radical change in the training of the doctor so that he will be suited to practice community medicine.

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1Patel, B.P., Reorientation of medical education for community health services, Ministry of Health and Family Planning, Government of India, New Delhi, 1972


3Chandy, J., Note on medical education and community health, Medical Education Conference, 6-7 July 1970, New Delhi

4Sanjivi, K.S., Planning India's Health, Orient Longmans, New Delhi, 1971
The community medicine dealt with in this paper is a concept of community-oriented, community-based and family-centred medicine to deliver comprehensive health care through a health team. It is not synonymous with the subjects of preventive and social medicine, of community health, or of community medicine as defined by the Royal Commission on Medical Education of the United Kingdom.\(^1\) For its success as a teaching model, it is necessary that, besides the department of preventive and social medicine, the clinical departments participate in the programme in the community.

In India, since the 50's, there has been an increasing trend towards the teaching of community-based medicine for comprehensive health care, to provide promotive, preventive, restorative and rehabilitative aspects in addition to the traditional hospital-based curative medicine for individual patients. This emphasis on achieving positive health with special attention to health problems of the rural community has been the subject of several reports and of discussions at various conferences in India. Some of the important ones are listed in chronological order in Annex 1 to this paper.

Salient recommendations of various committees and conferences in relation to the teaching of community medicine emphasize that -

1. The contents of the medical curriculum should bear a direct relationship to the needs of the community.
2. The training of the basic doctor should include, as an inseparable component, education in the community, and promotive and preventive aspects of medicine.
3. The training should focus attention on local, regional and national health problems.
4. The student should come into contact with the living conditions of the people and should study health and disease in their natural setting.
5. The training should stress that the family is the operational unit and family health an important component in the practice of community medicine.
6. The teaching of community health, particularly in the curriculum for preventive and social medicine, should be spread over the pre-clinical, paraclinical and clinical periods, and during the rotating internship there should be a block placement in primary health centres for instruction for at least three months (which may be extended up to six months).
7. The teaching of community health should be need-based and problem-oriented and should be imparted in live situations; the learning should be in the context of solving health problems.

(8) Each medical college should have attached to it a rural field practice area as well as an urban one, if possible. The headquarters of the rural area should preferably be located in a community development block. There should be at least four primary health centres attached to a medical college for teaching purposes.

(9) In the pre-clinical period, the student should be oriented to the fundamentals of sociology, psychology, human ecology and demography in relation to community health.

(10) During the paraclinical and clinical years, the student should act as the family adviser for one or two families, so as to be able: (i) to comprehend the concept of the family as a unit of work, (ii) to study health and disease in their natural setting, (iii) to acquire intimate understanding of the relation of health and disease to the total life of the family through prolonged association with it, (iv) to appreciate the need for continuity in health care, and (v) to realize the importance of maintaining optimum health.

(11) The doctor should have managerial ability and should be able to lead the health team providing comprehensive health care by combining clinical and preventive aspects as well as community health.

(12) Integrated and team approaches should be given particular stress in the teaching of social obstetrics and social paediatrics for community health.

2. **TEACHING OF COMMUNITY MEDICINE AT LUCKNOW**

Efforts to organize teaching in community medicine were started in 1958 only after the establishment of a full-time Department of Social and Preventive Medicine at King George’s Medical College, Lucknow; (although the nucleus of such a department had been established in 1911, and before 1958, a part-time Department of State Medicine with two part-time teachers, was giving 36 lectures and eight demonstrations in hygiene to undergraduates). Since 1958, the Department has been able to develop:

(1) Field practice areas:

(a) a rural health training centre located at the headquarters of the Community Development Block, Sarojini Nagar, with a teaching primary health centre having twenty beds, 20 Km from the medical college.
(b) experimental teaching health sub-centres at Banthra and Mati, each having four beds (by upgrading two of the midwife sub-centres of the Primary Health Centre, Sarojini Nagar, into teaching health sub-centres), and

(c) an urban health centre at Alambagh, on the way to Sarojini Nagar, 8 km from the Medical College.

(2) A teaching programme, with emphasis on community medicine permeating the pre-clinical, paraclinical, clinical and internship periods, and

(3) Research in rural and urban communities, covering general and environmental health, the epidemiology of communicable and non-communicable diseases, diet and nutrition, maternal and child health, school health, family planning, morbidity, medical care, geriatrics, vital and health statistics, health education and beliefs, and customs and attitudes in relation to health and disease. The results of these studies are widely used to provide data on local health problems to the students in the teaching of community medicine.

The teaching programme in community medicine is gradually introduced to the undergraduates right from the impressionable phase of the pre-clinical period and extends through the internship level.

2.1 Pre-clinical Period

This is a period in which the new entrant, who is not yet disease-conscious and hospital-minded, can profitably be educated about the people, i.e., the community or society and the purpose and place of medicine in society. A good foundation laid at this stage paves the way for introducing the student, in a phased manner, in later years, to the community-based teaching exercises. Two lectures a week, spread over a year during the pre-clinical period of one and a half years, making a total of 50 hours, avoiding three months in the beginning and three months at the end, are given by the Department of Social and Preventive Medicine and its social sciences and statistics units and by the Department of Psychiatry, to cover the following course in relation to community medicine:

(1) Social Medicine

(a) Concepts of health, disease, environment, human ecology, social medicine, preventive medicine, community health, the health team, comprehensive health care, socialized medicine, whole man 10 hrs.

(b) Evaluation of medicine - ancient and modern - medical ethics, provisions on health in the Indian Constitution, five-year plans and health 6 hrs.

(2) Elementary Sociology

Society and culture, social institutions, social adjustment, social disorganizations and social pathology, family as unit of society and health care, the life cycle of man, family life education, prevention of family failure, industrialization and urbanization, socio-economic factors affecting health, multiple causation in disease, economic loss due to ill health, beliefs and customs in relation to health and disease, welfare institutions, social anatomy and social physiology, sociology of a village based on a village monograph.

(3) Elementary Psychology

Personality, perception, emotions, behaviour, intelligence, social psychology, dynamics of human behaviour, juvenile delinquency, drug abuse, relation between somatic, social and psychological processes demonstrated by a case from a child guidance clinic.

(4) Elementary Biostatistics, Social Statistics and Demography

Their application to the measurement of the health and welfare of the community, and to the population problem in the world and in India.

Total 50 hrs.

2.2 Paraclinical Period

Two innovations, i.e., (1) clinical demonstration conferences and (2) family studies, have been introduced in the one and a half-year para-clinical period to emphasize the concepts of community health.

2.2.1 Clinical demonstration conferences

Half a dozen clinical demonstration conferences are held periodically, in which a case of a disease with social pathology is selected from the rural


or urban community and demonstrated to the class. An introduction to the subject is given by the Professor of Social and Preventive Medicine; the clinical history is presented by a demonstrator, and the social history given by the medio-social worker. On special aspects of the disease, a teacher of the specialty makes observations, and a lecturer in social and preventive medicine discusses levels of prevention. Students are given brief notes on all these aspects. Ten minutes are reserved for questions by the students, and the professor then makes the concluding remarks and draws attention to the lessons learnt from the case presented.

The clinical demonstration conference is an attempt to bring out the totality of the health problem under discussion, the natural history of the disease process, including the role of socio-psychological factors in the causation, and the various levels of prevention which can be applied in the course of the disease. The student observes that diseases are multifactorial in origin, that they result in many social problems, and that many are due to failure of health care and could have been prevented or arrested. Suitable topics that have been used are ankylostomiasis, rickets, pulmonary tuberculosis, diabetes mellitus, hypertension, psychoneurosis, leprosy, occupational diseases and physical handicaps, e.g., blindness due to smallpox, loss of lower limb in a road accident, deafness and poliomyelitis.

Through these conferences, the students, early in their clinical years, are shown the need to study "man as a whole", to understand "man in disease", to comprehend "multi-factorial causation", to appreciate "totality in medicine", to realize the need for "continuity in health care" and to see the importance of "health team" in the everyday practice of community medicine. The total need of an illness situation is thus impressed upon the students, who are made to realize that, in the absence of supplementary social therapy, drug therapy alone may not be effective in many situations.

2.2.2 Family Studies

Soon after entering the paraclinical period each student is allotted for one year, a family in which there is a mother with a newborn infant. Thereafter a family having a chronic case, e.g., pulmonary tuberculosis, is allotted for four to six months' study and follow-up.

(1) The medico-social worker selects mothers with newborn infants from the maternity wards, and, if the mother is willing to have a year's follow-up by a student, she introduces the student to the mother. The student visits the family every fortnight to collect information on family

background, to study the beliefs and customs relating to child bearing and rearing and to observe normal growth and development, as well as any deviation from the norm. The student imparts health education to the family, acts as its adviser and guide and is present, whenever possible, when the mother attends the post-natal and the well-baby clinics and at other times when she visits the hospital.

(2) A family having a case of pulmonary tuberculosis registered in the tuberculosis out-patient department is assigned to each student for study and follow-up for a shorter period. This family study serves to bring out to the student various social, medical and emotional aspects of a chronic social disease in the community.

For both family studies, guidelines are given to each student. A team consisting of a lecturer in social work, two demonstrators and a medico-social worker visits the families with the students and each member of the team takes two students on each visit once a week to guide them in these studies. The students collect detailed socio-medical information on the cases and on the family, maintain follow-up records and submit reports for evaluation. So that a competitive spirit may be impressed among the students in this type of extra-mural learning, the student who obtains the maximum marks in the two family studies is awarded a gold medal.

2.3 Clinical Period

Inter-disciplinary teaching is recognized as being one of the best methods of training a doctor in the concept and practice of comprehensive health care. The demonstration in patients and in real situations of the socio-medical aspects of disease in relation to causation, medical care and after-care makes the subject more comprehensive, meaningful and realistic to the student. With this object in view, inter-disciplinary teaching of social obstetrics and social paediatrics was introduced in August 1969.

Mothers and children are particularly vulnerable to environmental influences within the family and in the community. The teaching of obstetrics and paediatrics, therefore, has an important social component which needs to be understood and emphasized. A "History Record for Social Obstetrics" and "Guidelines for History Taking in Social Paediatrics" (Annexes 2 and 3), devised on lines similar to that of clinical history taking, have been developed at Lucknow for use at weekly two-hour integrated teaching sessions. These sessions, held bi-weekly largely concentrate on providing answers to the following questions: (1) What is the present situation/condition? (2) How has it arisen? (3) How could it have been prevented? and (4) What is its management?

2.3.1 Social obstetrics

The session on social obstetrics is held weekly at neonatal-cum-immunization clinics on Monday mornings, which are attended by two teachers from the Department of Social and Preventive Medicine (an epidemiologist and a social sciences teacher) and by a paediatrician, an obstetrician and a medico-social worker, besides 10 to 15 students in the seventh to ninth semesters, posted for clinical duties to the Department of Obstetrics and Gynaecology. At the first session, briefing is given on the techniques of eliciting the social obstetrics history for the entire group. Two students who have earlier been allotted a suitable case are called upon to present the social, medical and obstetric history at subsequent sessions. The medico-social worker supplements the history based on the information which he/she has gathered after making a visit to the home of the patient's family.

After social and medical histories have been presented by the two students and the medico-social worker has given information on the home environment, the teachers in social and preventive medicine discuss the role of social variables relevant to the case. Such as family size, income, literacy, occupation, housing, and highlight the importance of prevention, antenatal care, nutrition, child bearing and rearing practices, beliefs and customs, the physical and socio-psychological home environment, acceptance and rejection of scientific medicine, family health and family life education, etc. The obstetrician discusses the clinical signs, symptoms and causes of the condition in the mother and the clinical management. The paediatrician discusses the newborn and its management, congenital abnormalities (when necessary), nutrition, growth and development, immunization, etc. Problems often discussed at these sessions include abortions, stillbirths, pre-maturity, full-term low birth-weight babies, anaemias in pregnancy, antenatal, natal and post-natal care, nutrition in pregnancy and lactation, repeated pregnancies, toxanemias of pregnancy, diseases accompanying pregnancy, congenital malformations, breast and bottle feeding, the need for family planning and post-partum family planning programmes.

2.3.2 Social paediatrics

This session is held weekly, on Thursdays, in collaboration with the Department of Paediatrics, on lines very similar to the social obstetrics session. It is attended by a group of ten students in the sixth and seventh semesters, posted to the paediatric in-patient ward. A suitable case from the paediatric ward is allotted earlier to two students for presentation of the social and clinical history at these sessions. The medico-social worker then gives additional information about the conditions prevailing in the patient's home. The whole case, including the home situation, is then discussed in the clinic in order to identify the socio-medical pathology, its diagnosis, prevention and line of management.

The usual topics discussed at these clinics are protein-caloric malnutrition, diarrhoeas and infection, tubercular meningitis, rickets, anaemia with hypoproteinaemia, rheumatic heart disease, mongolism, primary complex and poliomyelitis.
2.4 Internship Period

The Medical Council of India lays down for undergraduates a compulsory rotating internship of one year before graduation and full registration. They are posted to the Departments of Medicine, Surgery, Obstetrics and Gynaecology, and Social and Preventive Medicine for three months each. During their placement in the Social and Preventive Medicine Department, they are required to be posted to the primary health centres attached to the medical college for teaching purposes.

It is now well recognized that health centres, which provide field practice areas, are the logical field laboratories for extra-mural teaching of community medicine\(^1\). The health centre caters to the health need of a defined community. Family-based integrated comprehensive health care is its ultimate goal. The provision of rural and urban field practice areas, to serve as human laboratories, is analogous to that of laboratories and hospital beds for intramural teaching. Much care and thought need to be given to the planning, organization, staffing, equipping and day-to-day management of these areas. One may safely state that the success of teaching community medicine in any institution lies in the strength and effectiveness of its field practice areas.

The training of interns in health centres is not only community-based but is problem-oriented, with an emphasis on teamwork. Active involvement and participation in the field lead to better understanding of the community and its needs, providing first-hand knowledge of the health problems of the community and initiating thinking for possible solutions. Thus, this method of teaching community medicine is applied, practical and comprehensive. It develops in the students faculties of observation, critical thinking, judgement and initiative. It provides experiences in improvisation and develops confidence and maturity. By working among and with the people and as a member of the health team, the intern develops communication skills, managerial ability and competence in human relations.

The objectives of the training of interns in a health centre are\(^3\),\(^4\):

(1) To create an awareness and understanding of existing medico-social problems in the community;

(2) To demonstrate the organization and functions of a health centre and methods of integrated promotive, preventive, curative and rehabilitative health care through the team approach in the community.

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(3) To provide an opportunity for practical health work in the community;

(4) To give scope for creating health consciousness and motivation in the community for acceptance of health programmes, and

(5) To inculcate, among the interns, interest in community health work, particularly in work on rural health.

In Lucknow, the interns, in groups of twenty, are posted for three months to the Department of Social and Preventive Medicine to work in the health centres. For this work they are divided into two groups, one working in the field and the other from the health centres. Their training in community health is divided into four parts as follows:

2.4.1 First part: Observation and participation in health centre work in the field (10 days)

One group of interns is posted to learn, first, about the organization and functions of the community development block and its primary health centre, and is given an opportunity to observe and participate in various field activities of the centre's health team. Each intern is required to speak on one aspect of the work in a seminar held at the end of this part of the training.

2.4.2 Second part: Comprehensive community health practice - family surveys (20 days)

Each intern in the group completing the first part of the training is allotted three rural families for a detailed socio-medical survey. He collects data on socio-economic conditions, housing and sanitation, demography and vital statistics, the state of health of the members of the family, nutrition and diet. He observes, in the families, the customs, beliefs and attitudes in connection with health and disease. A population of 10,000 in a dozen villages around each health centre is used for family surveys. The interns carry a haversack containing medicine for common ailments for the families. The need for medical relief is the first felt need in the community; it is through treatment of common ailments that the confidence of the families and their co-operation in promotive and preventive health work are won. In the second seminar, the data for the three families are analysed and presented by each intern.

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2 Prasad, B.G.: Social medicine teaching in a rural health centre in India in "Epidemiology - Reports on Research and Teaching". Edited by John Pemberton, Oxford University Press, London
In the third seminar, one aspect of all the families covered by the group is presented by each intern. It provides the interns with an opportunity to analyse and present information on a small sample population of 100 to 150 from 20-25 families, and to compare it with the findings of more extensive surveys in the area and with that of the Census.

2.4.3 Third part: Comprehensive community health practice - community diagnosis and action programme (15 days)

The exercise on family surveys is essentially an epidemiological approach to identifying health problems in the community. The group of interns undertaking family surveys utilizes this period of their training for taking action on the problems identified earlier in the families, and they are also given an opportunity to make a community diagnosis of a health problem in a village. The following health problems are those usually identified and tackled:

(1) Health education

The interns working in the field soon realize the need for health education in the community and try to meet the need in the families, schools and villages, using simple audio-visual aids. Family health, immunizations, environmental sanitation, personal hygiene and nutrition receive special attention.

(2) Environmental sanitation

The interns find that there are hardly any measures being taken for environmental sanitation in rural communities. They therefore educate the villagers to accept, as far as possible, sanitary installations such as hand-flush latrines, smokeless ovens, kitchen safes, ventilators and hand pumps. An environmental sanitation workshop has been developed to demonstrate the use of these installations to villagers and to sell them at cost price. The interns not only motivate the villagers to accept some of these innovations but, before leaving, are sometimes able to see them being used, and thus have the satisfaction of knowing that they have helped to solve an important health problem identified as such in the community.

(3) Referrals

Cases requiring further investigation, treatment or specialized attention that are found in the families are referred to the primary health centre, to the departments in the medical college concerned or to any special clinic at the health centres such as maternity, child health, family planning and tuberculosis clinics.
Mass surveys, drives and coverages

Investigations of specific health problems are made in the village, and are followed by a mass drive or coverage to deal with them. In other words, a community diagnosis is followed by a community action. The usual problems dealt with are immunizations against smallpox, cholera and tuberculosis; the investigation and control of trachoma, scabies, diarrhoea and filariasis; a drive for better personal hygiene and improved environmental sanitation; maintenance of complete vital statistics; investigation of beliefs and customs in relation to health and disease; motivation for family welfare planning; the health of school-children; assessment of the utilization of health centre facilities by the community, etc. The data collected and action taken are analysed and presented by the interns at the fourth seminar.

2.4.4 Fourth part: Comprehensive community health practice - medical care and special clinics (45 days)

The second group of interns is posted by rotation at the primary health centre, at one of the two experimental teaching health sub-centres and, for a few weeks, at the urban health centre. At the urban centre, each intern visits ten families in homes in order to complete the record in the family folders of the 500 registered families. Besides carrying out general clinical work and attending special clinics at these centres, the interns take the responsibilities for comprehensive health care of a few patients attending the health centre. In the mornings they attend the health centre, and in the afternoons they visit the families. At the Primary Health Centre, Sarojini Nagar, which has 16 general and 4 maternity beds, the interns also look after the indoor cases. They carry out laboratory investigations, impart health education, give immunizations, motivate married couples for family planning, undertake loop insertions and vasectomies, attend to emergencies, deliver babies and pay home visits for follow-up. Specialists in obstetrics and gynaecology, paediatrics, maternal and child health, ophthalmology and dentistry visit the centres periodically and hold special clinics to guide the interns and see the referred cases. During this assignment three seminars are held, one on the work done at the primary health centre, another on the work at one of the sub-centres, and the third on the work at the urban health centre.

Each intern maintains a daily dairy of his work, observations and experiences and also keeps records of all seven seminars. This work is subjected to a pre-training and post-training evaluation through questionnaires, and he is encouraged to give suggestions for improving the training given in the seminars. The performance of each intern is assessed on the basis of field work, his presentations and participation in seminars, action programmes, work in the health centres, health education work and maintenance of the records in his daily dairy. The best intern of the year is awarded a gold medal as an incentive.
2.5 Summary

In studying the above programme, one can see that the teaching of community medicine at Lucknow is well developed and is integrated into the total teaching through a graded programme, to be absorbed through different phases, i.e.:

**Phase I (pre-clinical)** - The introduction of students to the concept of health, environment, ecology, man and society through a series of lectures in social medicine, social sciences and social statistics.

**Phase II (paraclinical)** - The study of real life situations in health through a series of clinical demonstration conferences and the study of two families to provoke the student into thinking not only medically but also socially and epidemiologically.

**Phase III (clinical)** - Weekly integrated teaching sessions in social obstetrics and social paediatrics on cases, to present the totality of medicine and the need for comprehensive health care.

**Phase IV (internship)** - Practical experience by means of carrying out intensive work in three rural and ten urban families, dealing with a health problem in a village, and being fully involved in the work of a primary health centre, a teaching health sub-centre and an urban health centre.

3. SUCCESS AND FAILURE OF THE PROGRAMME

The teaching programme at Lucknow is a phased one and is made comprehensive in order to prepare a young graduate to practice community medicine. The students have a stimulating experience and become familiar with the rural and urban society. The training, besides inculcating a preventive and social bias, promotes a community outlook in the students and helps them to interpret health and disease in relation to the social background of the rural and urban community. The training prepares them to carry out, with confidence, integrated preventive and curative work. It exposes them to the philosophy of community development and to the team-work method and spirit, so essential for the successful operation of the primary health centres in rural India.

In spite of what is being said and done, the greatest failure is that most of young doctors are not willing to settle down and work in rural areas. Even when they do work there, they do not like to go out into the field. They are deeply hospital-minded in their thoughts, action

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and work. Another failure has been that the clinicians do not set a good example in community work\textsuperscript{1,2}. In the absence of the clinicians' active participation in the work of the health centres, the interns tend to consider their assignment in the community less important than that in a teaching hospital.

Finally, we need to solve the following problems:

(1) How to give due weightage and prestige to the work in the rural community;

(2) Determining the minimum participation and responsibilities of the clinical departments in the service and training given by the health centres attached to a medical college, and

(3) Defining the area, number and kind of staff, physical facilities, equipment and transport in rural and urban centres which should be utilized for training purposes by a medical college admitting 100 students.

\textsuperscript{1}Taylor, Carl E.: Community medicine and medical education; \textit{Ind. Jour. Med. Educ.} 1970, 2, p.393

\textsuperscript{2}Taylor, Carl E.: Health team concept at the primary health centre level and staff pattern and their roles. Eleventh Annual Conference of the Indian Association for the Advancement of Medical Education, 24-26 February 1972, Poona.
LIST OF REPORTS

1. Report of the Health Survey and Development Committee (Bhore Committee), Government of India, 1946.

2. Conference of Teachers of Preventive and Social Medicine in Medical Colleges in India Organized by the Rockefeller Foundation, 21-23 March 1955, New Delhi.


5. Medical Education Conference, Ministry of Health, Government of India (Second Conference of Deans and Principals of Medical Colleges in India), 12-14 September 1960, New Delhi.


10. Sixth Annual Conference of the Indian Association for the Advancement of Medical Education on "Medicine and Society", 1-3 January 1966, Bombay.

11. Regional Seminar on Social and Preventive Medicine for South India, USAID, 4-7 May 1966, Trivandrum.


18. Seminar on Paediatric Education organized by the International Children's Centre and Indian Academy of Paediatrics, 3-8 February 1969, New Delhi.


20. Training Course on Maternal and Child Health Field Practice Programmes in Medical Colleges, WHO (SEARO), 17-28 February at Vellore and 11-22 March at New Delhi, 1969.


23. Seminar on Role of Epidemiology in Community Medicine Organized by the Indian Academy of Medical Sciences in Collaboration with the International Epidemiological Association and WHO (SEARO), 24-29 November 1969, Lucknow.

24. Ninth Annual Conference of the Indian Association for the Advancement of Medical Education on "The Role of Teaching Hospital, Health Centre and Health Services in Medical Education", 22-24 January 1970, Varanasi.


27. Recommendations of the Medical Council of India on Undergraduate Medical Education Adopted by the Medical Council on 12-13 February 1971.


29. Eleventh Annual Conference of the Indian Association for the Advancement of Medical Education on "The Concept of Health Team in Medical Education", 24-26 February 1972, Poona.
HISTORY RECORD FOR SOCIAL OBSTETRICS

Physician/Surgeon  Registration No.
Ward/Bed:  Clerk:

Name of Mother  Date and time of admission
Age
Religion  Caste
Literacy status  Occupation  Date and time of discharge
Marital status
Postal address  Diagnosis
Rural/Urban  Result

Section I. Mother's History

1. Past health status of mother including any specific illnesses

2. History of previous pregnancies:

<table>
<thead>
<tr>
<th>Result</th>
<th>Age &amp; Sex</th>
<th>Age and sex of dead child</th>
<th>Cause of death</th>
</tr>
</thead>
<tbody>
<tr>
<td>(abortion, stillbirth, complication)</td>
<td>of live children including</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(live birth)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

3. Menstrual history:- Duration, cycle, pain, quality, date of L.M.P.
4. Family planning practicing or not, if yes, by whom? (husband/wife) and what method?

5. Is the present pregnancy planned?

6. History of present pregnancy:
   A. Ante-Natal History:
      (i) Attended ante-natal clinic or not
      (ii) Date of first visit
      (iii) Frequency of visits: Any abnormal condition and treatment received.
            1st Trimester.
            2nd Trimester.
            3rd Trimester.
      (iv) Ante-natal examination:
            a. General physical examination.
            b. Obstetric examination including pelvic measurement.
            c. Weight, blood pressure:
               - RBC count
               - Hb %
               - Blood group
               - Rh group
               - Serological tests for syphilis
               - Urine testing
            d. Any abnormal findings: anaemia, toxaemias, infections; any other.
(v) Nutritional status:
  a) Daily diet during pregnancy - Total calories per day
     Nutrients particularly proteins, iron, calcium, vitamins.
  b) Weight gain

(vi) Personal habits and addictions if any

(vii) State of immunization of mother

B. Natal History:
  (i) Delivery: where, how and by whom

(ii) Date of delivery

(iii) Details about stages of labour including any complications
     1st stage
     2nd stage
     3rd stage

C. Post-natal history:
  (i) Complications, if any, in puerperal period
      e.g. puerperal sepsis

(ii) Presence of anaemia

(iii) Lactation

(iv) Dietary history (particularly in regard to intake of protective food)
Section II. General

1. Family History:
   (i) Nature of family: Unitary/Joint

   (ii) Size and composition:

<table>
<thead>
<tr>
<th>Age</th>
<th>Literacy status</th>
<th>Occupations (Employment)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Father</td>
<td></td>
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<tr>
<td>Mother</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Siblings</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Others</td>
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</tbody>
</table>

   (iii) Family harmony/disharmony

   (iv) Any past or present illnesses in family:

2. Economic Status:
   (i) Total family income per month (main source and other sources)

   (ii) Income per head per month

   (iii) Social class

3. Housing:
   (i) Locality: Open or congested

   (ii) Nature of dwelling: Pucca, Kutcha, semi-kutcha

   (iii) Number of living rooms

   (iv) Overcrowding: Yes/No

   (v) Water supply
(vi) Latrine
(vii) Electricity
(viii) Pet-animals
(ix) Any means of recreation in the house

Section III. Neo-nate's history

(i) Birth order
(ii) Period of gestation
(iii) Birth weight
(iv) Mature or premature (by period of gestation)
(v) Wanted or unwanted
(vi) Condition at birth:
   (a) Respiration
   (b) Degree of activity
   (c) Any abnormality such as jaundice, cyanosis, convulsions, paralysis, haemorrhage, stupor

(vii) Breast feeding history
     If bottle fed, what precautions are observed

Section IV

(i) Socio-cultural practices in family (in regard to pregnancy, delivery and post-natal care)

(ii) Any other information
**SUMMARY**

1. Pathology - if any observed

2. Analysis of the present situation
   (pathology - Medical and social)

3. Management of this case

4. Principles of social obstetrics that you learnt from this case
GUIDELINES FOR HISTORY-TAKING IN SOCIAL PAEDIATRICS

Physician: 

Clerk: 

Ward/Bed 

Name of Patient:  

Date & time of admission: 

Age: Yrs. Months Days  

Date & time of discharge: 

Sex:  

Diagnosis: 

Religion:  

Caste:  

Postal address:  

Results: 

Rural/Urban:  

Any advice given for future: 

Patient's complaints with duration (History given by:.............) 

1. 

2. 

3. 

4. 

Personal History of the Child 

1. Where was the child born, who conducted the delivery? 

2. Prenatal history (Mother's health): 
   (i) Diet and nutrition 
   (ii) Infection, trauma 
   (iii) Any other diseases
(iv) Planned

Yes/No

If yes, what methods used

(v) Any beliefs or customs in regard to pregnancy

3. Natal history:

(i) Conditions at birth (any abnormality, birth injuries or congenital malformations)

(ii) Period of gestation

(iii) Birth weight

(iv) Mature or premature (based on (ii) and (iii))

(v) (a) Birth order (b) Living order

(vi) Any beliefs or customs in regard to delivery

4. Post-natal history:

Feeding history

(i) Breast-feeding and breast care

(ii) Artificial (milk) feeding including care of feeding utensils and bottles

(iii) Weaning (when started and when completed)

(iv) Semi-solids

(v) Solids

(vi) Any beliefs or customs in regard to feeding

<table>
<thead>
<tr>
<th>State of immunization</th>
<th>First</th>
<th>Repeat</th>
<th>Booster</th>
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</thead>
<tbody>
<tr>
<td>(i) B.C.G. vaccine</td>
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<tr>
<td>(ii) Smallpox vaccine</td>
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<tr>
<td>(iii) Triple antigen</td>
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<tr>
<td>(iv) Polio vaccine</td>
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Growth and development

I. Physical

(i) Measurements

<table>
<thead>
<tr>
<th>Weight</th>
<th>Length</th>
<th>Head circumference</th>
<th>Chest circumference</th>
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</table>

(ii) Performance

(iii) Landmarks

Anterior fontanelle
Teething
Speech
Sphinotres

II. Mental

III. Psycho-social (relationships with parents, siblings and friends)

IV. Any beliefs or customs or practices in regard to growth and development or rearing

5. Family history:

(i) Nature of family: unitary/joint

(ii) Size and composition: age  Literacy status  Occupation (employment)

<table>
<thead>
<tr>
<th>Father</th>
<th>Mother</th>
<th>Siblings</th>
<th>Others</th>
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</tbody>
</table>
(iii) Any abortions, miscarriages, deaths of children
(iv) Family harmony/disharmony

6. **Economic status:**
   (i) Total family income p.m.
   (ii) Income per head p.m.
   (iii) Social class

7. **Housing:**
   (i) Locality: open or congested
   (ii) Nature of dwelling: **Pucca** **Kutcha** **Semi-kutcha**
   (iii) Number of living rooms
   (iv) Overcrowding: Yes/No
   (v) Any pre-school or school-age child sleeping with parents
   (vi) Children park used by the family
   (vii) Recreational outlets for mother and child
   (viii) Water supply
   (ix) Latrine
   (x) Electricity
   (xi) Pet animals
   (xii) Conveyance

8. **Socio-cultural practices in family (in regard to child care):**
   (i) Usual source of medical care in family
   (ii) If there is a family doctor
   (iii) Any particular child-bearing and child-rearing practice, customs or beliefs
(iv) Any doping practice

(v) Role of grandmother or other members in influencing child care; especially about immunization, clothing, feeding, changes of diet

(vi) Any ayah or baby sitter engaged

(vii) How the minor ailments are handled, e.g., cold, cough, and diarrhoea

9. **Past illness in the family (specify):**

10. **Past illness in the child (specify):**

11. **History of present illness:**

   (i) Time of onset of illness

   (ii) Relevant epidemiological information regarding source of infection, incubation period, spread in family and community

   (iii) Chronological advance of symptoms

   (iv) Mother's concern of child's sickness

   (v) Previous treatment taken including indigenous and ritual practices etc.

   (vi) Time lag between onset of illness and availing of modern medicine

   (vii) Motivating factors for admission to this hospital

12. Physical findings

13. Special investigations

14. Diagnosis

15. Conclusion
16. **SUMMARY OF THE CASE:**

Note: Please, try to answer the following questions:

(1) What is the present condition and position (medical and social diagnosis)?

(2) How the condition has arisen (medical and social pathology and natural history)?

(3) How could it have been prevented?

(4) What is its management (medical and social)?

(5) What health education advice is to be given to the family?

(6) What principles/lessons you learnt in social paediatrics in the present case?