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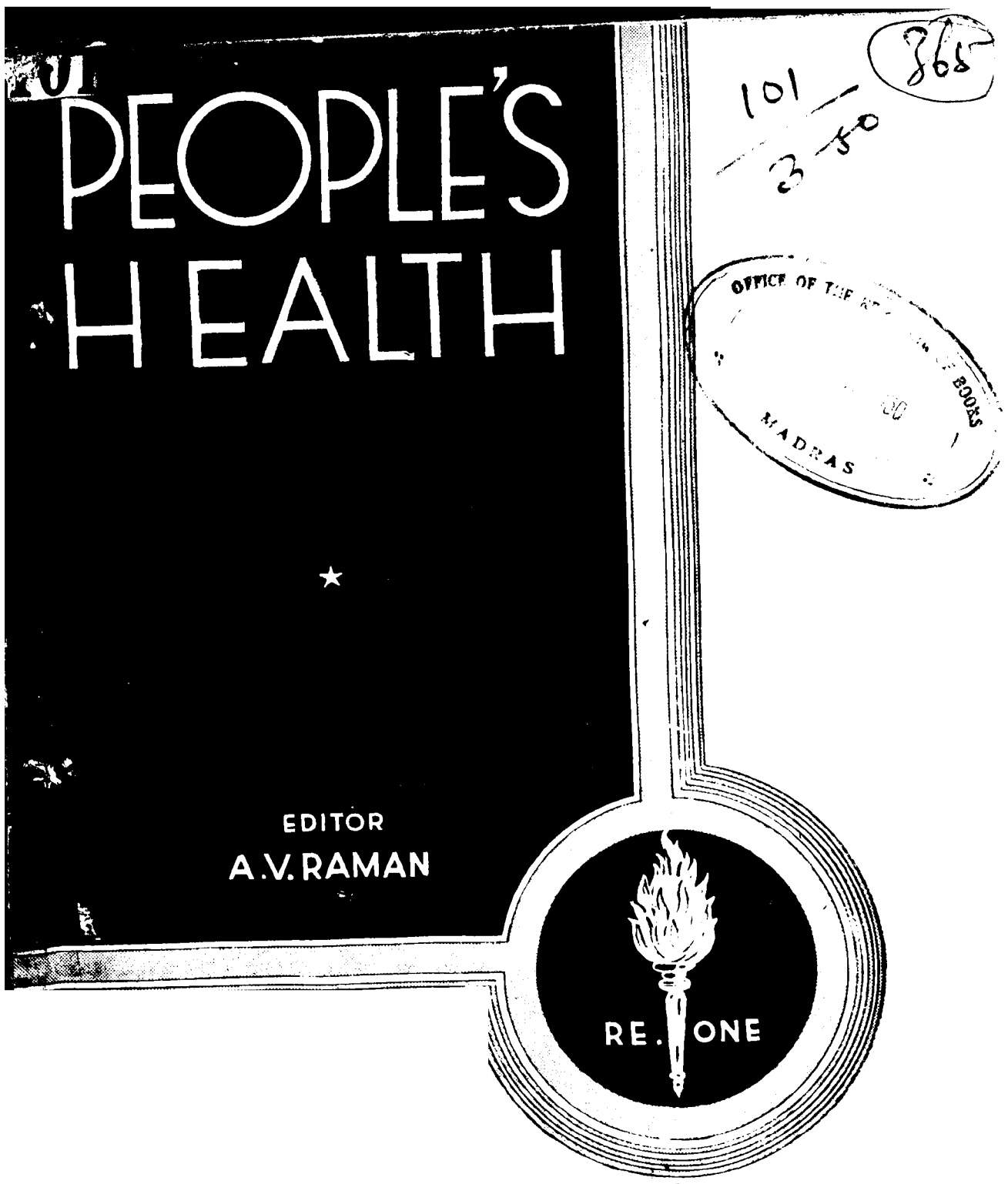
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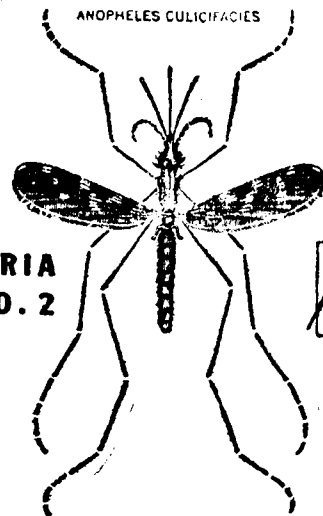
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PEOPLE'S HEALTH

A Pioneer in the Field of Public Health

Vol. IV

JUNE, 1950

No. 9

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THE SILVER LINING!



VOL. IV No. 9

JUNE 1950

ISSUED MONTHLY

EDITORIAL . . .

THE SILVER LINING!

WHEN people say that every black cloud has a silver lining, they usually forget that the cloud appears all the blacker when juxtaposed with the bright streak. The gloomy picture at home is not at all illuminated by the Minister's peregrinations abroad. The glory of India's Health Minister, consequent to her recent coronation as President of the WHO will not, therefore, enthuse the dying, unhealthy millions of the land; it may probably create further discontentment in the already disgruntled hearts of those who see in the personal honour done to their Minister, no cure for their maladies, and no prophylactic against the preventible diseases that go on unpreventably killing them. After a strenuous session, made all the more taxing with Presidential duties, the hon. Rajkumari Amrit Kaur was reported to have explored the Alpine slopes (did not some thin-gummy say that a permanent solution to all the problems of India, including Kashmir, was to be got on the snow-clad heights of that mid-European range?). Our Minister did not fail to visit Great Britain on her way back to India from Geneva (taking Columbus' route, of course) and she has made no secret of the magnetic pull that that country exercises on her. It appears, she finds "something new" to interest her each time she goes there. So she went there. And now she is back to her homeland, where the same old scene awaits her. Disgusting, what? If only they spent more time in the office room, *with competent technical men*, and less in the aeroplane, even our ministers would be able to show "something new" to foreign visitors. Had Bevan spent his hours in futile discussion at international meetings, instead of deputing some subordinate to the task, and frittered his minutes away in oral effervescence, then Rajkumari would

have had nothing new to interest her.

Sedulous Aping

When a lady goes out window-shopping, in her eyes each article exhibited appears to have been manufactured specially for her and she desires to get it for herself. She loses her sense of values, and her imagination makes up for what she lacks in judgement.

When our Rajkumari went out on her foreign travels she found that everything she saw, was "so applicable" in India. She saw the old folks' homes built in the new London county council and fell into raptures over it. We, in India, have our old folks' houses, too. New Delhi, where the Cabinet Ministers are housed, is a regular colony for septuagenarians, who (unlike the old lady whom our Rajkumari saw "managing her little three roomed suite,") are actually managing the *country's* affairs!

India's Health Minister is now envisaging a plan for *nationalisation of health services*! Just because she saw it working so nicely in England, she wants to have it here. We may warn her, that India is not yet ripe for nationalisation of medical aid, and that an NHS here would not work for two days. It is only when we have an abundance of medical men, and an environment that does not allow diseases to breed faster than can be

managed, that a State Health scheme will be successful. Here, in India, where dearth of medical men is a serious problem, it would be an unforgivable blunder if the State undertakes to ensure every citizen of free medical assistance. We are not holding a brief for Indian doctors, but we cannot possibly bear to see an already overworked profession subject to still more work.

Substitution of imitation for originality is not a device that is adopted by the really capable, and to copy everything that is done elsewhere without planning what is best locally, is the recourse of those that cannot be classed among the competent.

The Sad Picture

Our cartoonist is an imaginative man and he sees Rajkumari Amrit Kaur as a silver lining to the dark clouds whence she emerges. Lo! what a sight she has to gaze at—tens of thousands of Indians fallen victims to the unrestricted ravages of cholera in the Deltaic areas. The pleasure of globe-trotting should have evaporated when she saw the way in which her beloved people were transported to Hades by the speedy vehicle of cholera. But no such remorse or grief is stamped on her visage which, surprisingly enough, radiates self-satisfaction, if not pride. May be, our cartoonist had got it all wrong and forgot what he was doing. May be not.

We get no particular thrill and certainly no advantage by having our monthly dig into our Health Minister. As Mahatmaji's foremost disciple she had earned a name in India as a patriot and a self-sacrificing devotee of the Father of the Nation. We respect her for all that. But as is not uncommon with most of our ministers, their pre-office eminence is not sufficient to hide their failures in office. As Health Minister, Amrit Kaur has been a washout and there is no denying that. For one like her, she should have at least gathered around her, men of undisputed ability, in advisory capacities. Then, acting on their advice, she would have been able to achieve something. As at present, no such useful assistance is forthcoming from her immediate advisers who are themselves in need of assistance. It is not, therefore, surprising to see India's health going the way it is. Our regrets.

VANA MAHOTSAVAM

On July 1, 1950, when he plants a tree near the *Samadhi* of the Father of the Nation, the President of India would have inaugurated the *Vana Mahotsavam*, or tree planting week. Our new Food Minister is a man for spectacular ideas, and so soon after his much placarded eight points, he has now launched this tree-planting week and our thanks are due to him for not forgetting the trees, when

being bothered about the crops. Dr. Rajendra Prasad, who will plant the first tree, by the resting place of the Master, made some remarks worth repetition, in the course of his acceptance of the Minister's invitation. Necessarily a brief talker, our President mixes commonsense with a Gandhian love of Nature, and we find him speaking little but wisely. He said:

" It is sad to think that these once prosperous forests have been allowed to suffer decay during recent years particularly on account of indiscriminate felling of trees the public must co-operate with the Government in a common endeavour not only to rehabilitate our denuded forests but also plant trees wherever necessary "

Utilise Catchment Areas

Our plea is that the catchment areas of our water works which are extensive, ill-kept, denuded of trees, should be fully utilised for a tree planting campaign. The advantages are obvious. For one thing, the erosion of the catchment area which is now going on unchecked, could be controlled:—The flood flow would be checked and water could be allowed to move steadily. Moreover, the existence of forests, according to scientific opinion, attracts clouds and indiscriminate deforestation is beginning to tell on the already meagre rainfall of many areas.

ANEURIN BEVAN

(Britain's Health Minister)



TO those that hold the view that the Health portfolio is better handled by a woman or a medical man, one need only point to the world's greatest Health Minister ever—Aneurin Bevan of England—a he-man and not a doctor either. The “gentler sex” can never be expected to face, much less overcome, the organised opposition of vested interests that continually haunt the path of a Health Minister. No medical man, heedless of his own future,

will set afloat as Minister, plans calculated to tackle disease at its source, or nationalise medical aid, so that it may be of greater service to the people and less lucrative to the profession. Since he took office in 1945, Bevan has exhibited a drive and courage that has won the hearts of his people, and a place in the memory of posterity.

“Bevan flies at a problem like a jaguar . . . he utters the names of his political opponents as if he were crushing a bone

between his teeth”. This was written in 1929, and is still as true today. He is still an outspoken critic of whatever he thinks is wrong,—and how he says things!

In August 1945, when he became Britain's first post-war Minister of Health, he was not new to the public. He had hit the headlines even earlier as a brilliant and forceful member of the Opposition, as an outstanding member of the Labour Party's National Executive, and as a man with a great future. This round-faced, raven-haired M.P., from Ebbw Vale, is today the most discussed man in England, and one of the finest administrators in Europe.

Born in humble surroundings (he is a miner's son) Bevan left school at 13. (Here is an excuse for truants who leave school even earlier!) He then became a miner, but never got far in that direction. At 19, he was elected Chairman of the largest Miner's Lodge in South Wales. At 31, he contested Ebbw Vale in the general election and got returned with a majority of 11,164. In the general elections of 1931 and 1935 he kept his seat when so many other Labour members lost theirs. In 1945, his majority passed the 20,000 mark. It is not generally known that Bevan had had a prosperous but fleeting time in Fleet Street as well.

Aneurin Bevan's Parliamentary career has been marked by his forceful attacks on outstanding figures; he had little time for minor adversaries. In 1929, he surprised the House with an unexpected attack on Lloyd George. In later years, he challenged Baldwin and Chamberlain. During World War II he was a constant critic of Winston Churchill who hurled at him, the Churchillian

epithets of “that architect of disloyalty” and “a merchant of discourtesy”.

Often described as the ‘stormy petrel’ of the Labour Party, Aneurin Bevan on many occasions came into conflict with his colleagues. This family quarrel came to a head in 1939 when he was expelled along with Sir Stafford Cripps for his participation in the ‘popular front’ movement—an activity which the party regarded as a breach of discipline. Bevan made his peace sooner than Sir Stafford, and was received back into the fold nine months later.

Aneurin Bevan has come to be recognised as one of the great orators in the House, and is the accepted demagogue of his party. He mixes short sharp phrases with the employment of spell-binding technique that have always characterised his speeches. “Unconditional surrender”, he once said, “is a schoolboy's phrase, a childish phrase, a phrase of a man in the field, a general's phrase, a tactical phrase, the phrase of a man dealing with troops immediately in front of him, but not the phrase of a statesman”.

In conversation, he has a reputation for ‘that devastating quality of thinking three jumps ahead.’ He is as fluent with his pen as with his tongue; his vigorous writings bear the imprint of his lively mind. He has no false ideas about gallantry and in the 1950 elections, he roused popular surprise by asking a lady heckler to shut up; he called her a ‘tiresome virago’.

Aneurin Bevan has spoken in Parliament on many subjects. He is keenly interested in foreign affairs; during the war years, he always had something to say about the progress on various fronts. But the subject

nearest his heart is the welfare of the nation, especially of the poorer classes. As Minister of Health he not only looks after the well-being of 50 millions; but is also responsible for their housing. When Bevan took over the Ministry of Health in 1945, he accepted an unspoken challenge. He realised the magnitude of his task and the responsibilities of the "stickiest office in the Government."

Aneurin Bevan can look back with pride at what has been achieved so far and look ahead with hope at what can still be done in the future. In spite of shortage of men, material and money new homes have been provided for well over four million people. In spite of a dislocated, war-shattered economy, Britain has the best health service in the world.

It cannot be gainsaid that Bevan's greatest achievement and possibly that of any Minister, anywhere, is the Nationalisation of Britain's Health Services. Speaking to the Royal College of Physicians in October 1945, this is what Prime Minister Attlee said about the N.H.S.:

"What is it we seek? A service which will be comprehensive in the double sense of being available to every member of the population and of covering every form of medical allied activity. We intend to have a service in which no patient shall be without the treatment he needs through lack of money, and no patient shall be without the treatment he needs through deficiency in or lack of organisation of the necessary facilities. We need, too, a service in which professional men and women will be able to devote themselves to their great calling without financial anxiety and without

in any way feeling cramped and overcontrolled by regulations.

"We need a great improvement in our hospital service, in the facilities for diagnosis and treatment outside hospitals, in the number and distribution of medical men, both consultants and general practitioners, and, perhaps, above all in the planning and organisation of all the different branches into what must in fact be a single integrated whole, a real National Health Service. The task is not easy, but we are going to do it. Above all we realise, no one more keenly than my friend the Minister of Health who is here this evening, that for this to be successful we must have the help and cooperation of the profession itself. The profession is, I know, as eager as the Government to see that we have a really good service."

Of course, the Prime Minister was not being frank but polite when he said the profession was as eager as the Government. It was not; and our thaumaturgus had to fight and squelch the rebellious medical men, who rose to a man against the scheme of nationalisation of health services. It must be admitted, however, to the infinite credit of British character that agitation before the passing of a law has never given place to non-cooperation afterwards. Once passed, despite strong opposition, the law is supreme, and the Britisher bows to it. The medical men, who were so angry once, are now working with a smile in the new set-up and save occasional jokes which they manufacture at the expense of Socialised Medicine, they do nothing to hamper the smooth operation of Bevan's revolutionary reform.

Oh, for a Bevan in India . . .
 . . . or atleast an allotrope!

THE WORLD. HEALTH ORGANISATION AND ENVIRONMENTAL SANITATION

by

Dr. S. F. Chellappah,

Deputy Regional Director of WHO for S.-E. Asia.

MORE than three-quarters of the world's population are still the victims of diseases resulting from poor excreta disposal, unsafe water supplies, uncontrolled insects, and inadequate protection of milk and food. In vast areas of the world, despite great medical and public health progress, morbidity and mortality rates from typhoid fever, dysentery, cholera, hookworm, typhus, plague and other resultants of poor sanitation are at a level which has not been experienced in more favoured countries since 1900.

The ravages of water-borne, insect carried and excreta-transmitted diseases probably outweigh in economic and public health importance almost any other group of diseases. The correction of these disabilities rests upon known, and universally accepted, principles of sanitation and hygiene. The origins of these diseases are established, and the cost of controlling them, although significant, is not insurmountable. Indeed experience in the last ten to twenty years

in many areas has disclosed that community systems for water supply and sewerage are frequently cheaper for a population than the previous loose and unsafe individual services.

Importance of Sanitation

What is certain is that more return per unit of expenditure is obtainable by sanitation than by almost any other activity.

These facts have long been recognised by enlightened public health workers everywhere. Indeed, the facts are now so familiar that there has been a tendency to overlook their significance. Among the reasons for slow and unsatisfactory development in environmental sanitation are apathy and ignorance on the part of the public, lack of trained health workers and adequate national health services, unsuitable or ill-developed systems for financing public sanitary works, and lack of technical information. Against these obstacles public health enthusiasts in many countries are tirelessly crusading,



more or less, in isolation and too often in comparative obscurity.

A powerful reinforcement in the struggle for improved sanitation in the world comes from the World Health Organisation, one of whose important functions it is to stimulate health administrations and the public to a realisation of the fundamental importance for health of sanitation and hygiene. At the base of the policies and programme of the World Health Organisation is the concept of "positive health" and of prevention rather than cure. Nowhere is this concept more strikingly expressed than in the revolutionary definition of health incorporated in the WHO Constitution: "Health is a state of complete physical, mental and social well-being". The "public health approach" of WHO to the health problems of the world is one of the main reasons for the enthusiastic welcome given to this newcomer in the international field.

What is WHO?

WHO is a co-operative enterprise in which more than sixty countries are combining in an effort towards "the attainment for all peoples of the highest possible level of health." It is a co-operative whose members are governments. Its policies and programmes are decided by an Assembly of delegates from all its Members. International and national medical bodies have no representation in WHO and, needless to say, no commercial interests can have any influence on it.

One result of this is that WHO is essentially an agency of service to its member governments. Another result is that WHO can undertake a programme in a country

only on the request and with the full co-operation of that country's government.

No international organisation, no matter how powerful, can provide any country with a ready-made solution to all its health problems. Especially is this so in India where the problems are essentially ones of environmental sanitation demanding considerable expenditure over a long period.

What WHO can and does do, however, is to provide guidance, expert advice, training facilities for national health workers, and demonstrations of public health techniques which have proved their worth in other countries. In this way it accelerates health progress, and enables governments to spend what money they are able to devote to health improvement in the most economical and effective way.

It may be stated in passing that WHO member countries contribute according to their means, and benefit according to their needs. Canada, France, the United Kingdom and the U.S.A., for instance, contribute between them more than half the total budget, but receive in return practically no direct assistance at all from WHO. All the S.-E. Asian Member States, on the other hand, receive from the Organisation services of a value much greater than the amount of their contributions. This is the essence of international co-operation for health.

WHO'S Activities

Already WHO, in co-operation with UNICEF (United Nations International Children's Emergency Fund), has four field teams working on the control of malaria in different rural areas of India. One WHO team in Delhi Province is at present giving practical

field training in the latest methods of maternity and child care, while in the Himachal Pradesh a Venereal Disease Control Team is teaching and demonstrating modern diagnosis and treatment techniques. Eighteen Fellowships, a number of them in public health subjects, were awarded to Indian health workers in 1949. During 1950, it is expected to launch projects for the eradication of plague in a defined area, and for the study of practical methods of cholera control. Directed almost exclusively toward the prevention of disease, the work of these teams has an important bearing on environmental sanitation problems.

WHO is planning to provide further direct assistance to its member countries in overcoming the lack of trained health personnel, without which any large-scale public health programme is impossible, and in evolving balanced national programmes and priorities in environmental sanitation.

The Expert Committee on Sanitation

In order that WHO's services in this field shall be best adapted to the needs of its Member Countries, it appointed six Professors of Hygiene and Sanitary Engineering from North and South America, the United Kingdom, Eastern and Western Europe and India as an Expert Committee on Environmental Sanitation. At its first meeting last September, this Committee surveyed the world situation of environmental sanitation and laid down the main lines which WHO's environmental sanitation programme should follow. The report of the Committee is shortly to appear as No. 10 (1950) in the *Technical Report Series* of WHO publications.

The Expert Committee considered that the general objectives of WHO in controlling the diseases due to insanitary environments should be (i) complete international control of cholera, plague, epidemic typhus and other major pandemic diseases as well as general control of all the major endemic and epidemic diseases in this group; and (ii) the encouragement of sanitary measures of all types with the object of promoting general well-being as well as limitation of disease. It noted that multiple, combined attacks of different professional groups would be necessary, and that environmental sanitation was an important element in such groups.

The highest priority, in the Committee's opinion, should be the strengthening of governmental agencies responsible for initiating, promoting and persisting in environmental sanitation. The Committee repeatedly emphasised the urgent need for a strong professional engineering organisation placed at a suitably high level in national governments and able to influence policy. This organisation should be composed of people specially trained for their functions, key posts at least being held by qualified engineers.

Of particular interest to the countries of South-East Asia is the following passage in the Experts' report: "The Committee considers that the knowledge and experience gained in the last hundred years can be applied to backward countries in such a way as to secure their improvement in a very limited time. It considers however that the following factors are essential: the development of sound national sanitary organisations; the provision of adequate numbers of

(Continued on page 366)

MOUNTING COSTS AND RECEDING HOUSES



THE SCANDAL OF PRE-FAB HOUSING SCHEME

by

H. V. Kamath, M. P.

PREFABRICATED houses have not so far been familiar in our country. The Housing Factory, set up in Delhi by Government over a year ago, has been promising to turn out such houses since September, 1949, but nothing has been produced by the Factory so far. In this connection it is well to remember that what is going to be prefabricated in this Factory is only a small portion of the whole house. The so-called, "Prefabricated House" consists of three parts; the first part consists of the traditional type of construction known in this country for thousands of years, namely, the foundations, plinth, flooring, and compound wall of the whole building, and in the rear the bathroom and the water-closet including its roofing.

The second part is made up of imported materials which include aluminium roofing materials, roof trusses, hard board, and fibre-glass insulation, and also soft pine wood, doors and windows imported from Finland. The third and last part comprises light weight cement mortar wall panels, which is the only stuff to be manufactured in the Government Housing Factory.

From the above it would appear that the name by which this Factory is known—"Government Housing Factory"—is a misnomer, inasmuch as what is actually manufactured in the Factory is a fraction of the whole house. For the matter of that Public Works Departments of Government at the Centre and in the States may be called, with equal justification, Housing Factories.

This scheme for the manufacture of pre-fab houses was submitted in 1947 to the Government of Mysore jointly by Mr. A. F. Hare, of Messrs. Structural and Mechanical Development Engineers Ltd., and Dr. O. H. Koenigsberger, the then architect to the Government of Mysore. The Mysore Government rejected the scheme because, firstly, heavy capital outlay was involved, secondly, the houses produced would be more costly than traditional construction from locally available material, and, thirdly, it involved the import of materials from abroad, which would have unduly strained our foreign exchange resources.

The failure to push the scheme through in Mysore was, however, a stepping-stone to success in Delhi. The mass influx of refugees in the wake of partition created conditions of acute housing shortage, and Dr. Koenigsberger was deputed by the Government of India to the United Kingdom to report on the

feasibility of adopting in India the large scale manufacture of pre-fabricated houses, based on the model in vogue in England. The gist of a long report that he submitted to Government was that the scheme, which had been earlier rejected by the Mysore Government, should be taken up here, and the task of executing the project be entrusted to Messrs. Structural and Mechanical Development Engineers, Ltd.

An agreement was concluded between the India Government and Messrs. Structural & Mechanical Development Engineers, Ltd.—hereafter referred to as the Consulting Firm—by which Government agreed to pay a heavy royalty for the use of the patent held by the Consulting Firm. The amount of royalty works out at about six per cent of the cost of production of wall panels. When it is borne in mind that large industrial concerns, with heavy capital investment, are not able to declare a dividend of six per cent, the enormous sums that have been agreed to be paid by Government to the Consulting Firm for the mere use of a patent are exorbitant.

It would be interesting to note that the process of manufacturing light weight foam concrete panels which will be adopted by the Delhi Factory is no new invention of the Consulting Firm. On the contrary, it is widely believed that the same, or a similar process, was perfected in Sweden and Germany. In the report of the British Intelligence Objectives Sub-committee final report No. 603, item No. 22, published by H. M. Stationery Office, London, and entitled "The Investigation in Germany of Technical Developments in Prefabricated Housing", the details of a process, similar to the one

to be adopted in the Delhi Factory, are found. It is also significant to note that Mr. A. F. Hare, architect of the Consulting Firm, was one of the members of the British team which produced this report. In the circumstances, it is difficult to understand why heavy royalties have been agreed to be paid for the use of a patent whose process is by no means new or original.

It is also not quite certain whether the Consulting Firm has much experience of the manufacture of light weight foam concrete panels by the autoclave curing process. This process, it would appear, was in vogue only in Germany and Sweden, and has not been adopted so far in the United Kingdom.

The agreement concluded by Government with the Consulting Firm is heavily weighted in favour of the latter. Under the agreement, Government cannot even question the validity of the patent, and, further, Government has bound itself not to make modifications in design or material of the house without the prior approval of the Consulting Firm. It will therefore be open to the Firm to refuse adoption or adaptation of indigenous substitute materials, which our scientists and technicians may evolve as a result of research, and which will save us foreign exchange. The Consulting Firm appears to be keenly interested in the sale of aluminium alloy structurals, in view of the fact that they are associated with British Almins Ltd. The agreement also lays down that the aluminium parts of the houses shall be purchased through the Consulting Firm, an advantage to them which is too obvious to be stressed. This dependence on foreign countries for such primary requirements when building materials are

available here in abundance, is, to say the least, unpatriotic. It is tragic that, while herculean attempts are being made to conserve our foreign exchange resources, aluminium roofing and the wooden doors and windows should be imported from abroad, considering that our local materials have served us very well for these purposes for thousands of years. Apart from that, the utilisation of our own resources in this connection would have provided considerable employment to displaced carpenters, who are today jobless for no fault of their own.

According to the original estimates submitted by the Consulting Firm, the cost of a house was Rs. 2,460. The latest figure given by the Health Minister in Parliament is in the neighbourhood of Rs. 4,000. The increase, it is stated, is due to the rise in the cost of aluminium as a result of devaluation. If, however, this statement were scrutinised carefully, it is obvious that the increase in cost, owing to devaluation, would amount to about Rs. 204, on the basis of a thirty per cent increase in the price of aluminium parts, which originally were estimated at Rs. 680. The explanation adduced for the inordinate increase in the cost of the house cannot, therefore, convince anybody.

Another aspect of the matter is the service charges of the Consulting Firm. They have risen from ten thousand pounds as provided in the original estimate to nearly forty-seven thousand pounds, which, I understand, is the latest bill submitted by them in this connection. Many drawings were bandied to and fro between Delhi and England for the third or fourth time, and Government have been saddled with these expenses for the acts of commission and

omission, of the Consulting Firm. A firm of standing and repute would never have been so inefficient and unmethodical in this matter. The conclusion is irresistible that the firm had no accurate idea, or much previous experience of the work they have undertaken here.

It is also well known that the erection of buildings and machinery was all done by Indian engineers and technicians. Two experts, "so-called", came to India in July last, but the Factory has not yet started production. One wonders what the need was for importing these experts when the time was not yet quite ripe.

The estimate of capital expenditure, which initially stood at Rs. 30 lakhs, has now risen to about fifty lakhs. Though production was promised as far back as September, 1949, there is no house in sight even at the end of April, 1950. "Mounting costs and receding houses" seems to sum up the position with regard to the Factory today.

Having failed to produce houses so far, it would appear that the Consulting Firm and the management of the Factory are resorting to fresh devices in order to gain time and save face. Two more experts have been imported from the U.K. for a period of six months to redesign the roof. It is an insult to the ability and intelligence of Indian builders and engineers to be told by Government's Health Minister that there is no Indian engineer who can design the roof. Many Indian engineers have resented this aspersion, and have expressed painful surprise at the gullibility of the Minister in this regard. I maintain that it will not be at all difficult to get the whole roof designed within a fortnight or a month by Indian engineers.

It looks as though our country is going to be a dumping ground not merely for foreign building material, but also for the surplus personnel of the British Consulting Firm. I have heard it said that one of the experts, who is a mere surveyor in the U.K., has been passed off as a qualified architect and mechanical engineer, for the purposes of the Housing Factory. I have no doubt that the redesigning of the roof will provide an excellent opportunity to the Consulting Firm for presenting another heavy bill of service charges to Government.

I cannot help feeling that Government have been badly misled and bamboozled by grandiose paper schemes of prefabricated houses. It was only the other day that Professor J. D. Bernal, one of Britain's leading scientists, observed at a Press Conference in London, that "he was surprised to note that the Indian Government were building a Prefabricated Housing Factory in Delhi, when, even in this country, it was found that prefabricated houses were too costly and beyond the means of people for whom they were primarily intended". He further remarked that little effort was being made to evolve large scale plans of housing based on available indigenous materials. He commended the effort made in this direction at Roorkee, but regretted that administrators generally were drawing "grandiose" plans on the model of European conditions totally unsuited to India. He concluded by saying that plans should be based on self-help and proper use of local man-power, and full exploitation of indigenous resources, thereby cutting down to the minimum our dependence on foreign exchange. The recent remarks of Dr. Trone about the common tendency

in India to be credulous about dubious foreign "experts" and dependent upon them are also quite apposite in this connection.

Lastly I would commend the good work done by our own engineers at Nilokheri in the Punjab, not far from Delhi, where a new township is being built. The houses at Nilokheri are of the traditional type of construction involving no problems of foreign exchange, and built at a reasonably low cost of Rs. 1,500 or thereabout. In the circumstances it should occasion no surprise if increasing numbers of people are heard accusing Government of reckless expenditure on worthless schemes. *There is no doubt whatever that with the time, money, energy, and organisation expended on the Government housing factory, thousands of cheap houses could have been built long ago for displaced persons and a sound building industry established. As it is, the houses will be produced,*

if at all, by the factory, long after the acute housing crisis will have passed; even then, the houses will be so expensive that they will be beyond the means of the common people of this country. Moreover, the suitability of these prefabricated houses for Indian conditions, climate and other, has yet to be proved.

It is but right, therefore, that the prefabricated housing scheme of Government should have evoked widespread attention, and, latterly, anxiety, all over the country. Many have gone to the length of even remarking that Government is afraid or reluctant to retrace its steps merely out of hollow considerations of prestige. Whatever this aspect of the matter may be, I have no hesitation in asserting that only a full and impartial enquiry into the various matters detailed above will be able to allay public fears and suspicions about the Government Housing Factory, Delhi.

(Courtesy: India, May 17.)

The WHO and Environmental Sanitation

(Continued from page 361)

trained staff; education of the people; and the promotion of research into many problems."

Facilities for Professional Training

Great stress was given to the importance of professional training, and the Committee recommended that WHO should give high priority to providing fellowships, travel grants, teaching materials and laboratory equipment and facilities for regional and international conferences on sanitary engineering education and research.

The Committee devoted great attention to methods of developing and financing sanitation projects in countries at different stages of development. It was felt that every national government should evolve its own

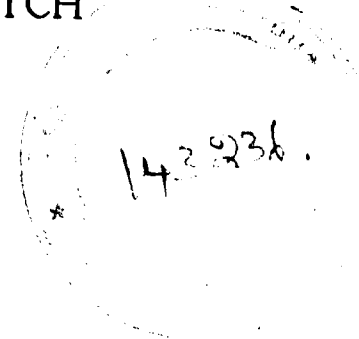
5-year or other convenient programme of environmental sanitation suited to its needs and to its resources, using whatever public health engineering organisation it may have or with the aid of expert assistance from WHO, if necessary. "While the urgency of other problems of national rehabilitation in a country may be a reason for slowing down a sustained programme of environmental sanitation, it cannot at any time justify a complete cessation of efforts", declared the Experts.

These then are the lines on which WHO will work in 1950 and 1951 in aiding and stimulating national governments in their efforts to develop and improve their public health and sanitation services.

SIR EDWARD MELLANBY

(Director of India's National Drug Institute)

A SKETCH



SIXTY-SIX-YEAR-OLD Sir Edward Mellanby, who has been appointed Director of the Central Drugs Institute, Lucknow, is one of Britain's foremost medical scientists. Three years ago he was awarded the Buchanan Medal of the Royal Society "for his services to medical science and in recognition of his outstanding researches on dietary factors."

He has been a pioneer in the study of diet and nutrition and for the last 16 years he has carried on his work concurrently with directing medical research throughout Britain, for he is Secretary of the Medical Research Council.

Born at West Hartlepool, County Durham, in 1884, he was educated at Barnard Castle School and Emmanuel College, Cambridge, where he was a scholar, research student from 1905 to 1907, and later an honorary fellow. He took his M.A. and M.D., doing his hospital course at St. Thomas', London,

where he afterwards began his teaching career as Demonstrator in Physiology. From 1913 to 1920 he was Lecturer and later Professor of Physiology in London University (King's College for Women); he then went to Sheffield as Professor of Pharmacology until 1933, when he received his appointment as Secretary to the National Medical Research Council. He had been a member of the Council for two years. In 1935, he was elected Fullerian Professor of Physiology to the Royal Institution.

Research on Rickets

One of Dr. Mellanby's early pieces of research concerned the physiological effects of alcohol, an investigation which he undertook for the Government during the first World War. Around this time the late Sir Frederick Gowland Hopkins was carrying on his research which led to the determination of the vitamins, and Dr. Mellanby also

did pioneer work in this field. By dietetic experiments on puppies he found that rickets was caused by an absence from their diet of a fat-soluble substance which controlled the deposition of calcium in the bones. This anti-rachitic substance later received the name of Vitamin D.

In 1925 the Medical Research Council published a report of further experiments by Dr. Mellanby on these lines, establishing the fact that bread and cereals tended in themselves to cause rickets; later he identified the rachitic substance in a cereal diet as phytic acid, and found that it could be counteracted by adding Vitamin D or extra calcium. A later series of publications demonstrated that actual bone changes in shape could be caused by faulty diet; following up this line Sir Edward—he received the K.C.B. in 1937—proved that lack of Vitamin A causes abnormal bone growth and neurological disorders due to pressure of the overgrown bone.

His investigations have included a study of the effects of lack of iodine; and one of his researches demonstrated that bread made from flour bleached chemically by the Agene process (NC13) can cause the condition in dogs known as canine hysteria.

In 1925, Dr. Mellanby was elected a Fellow of the Royal Society. He had become a recognised authority on nutrition, and was member of successive committees appointed to advise the Ministry of Health. He worked

for the League of Nations, was Chairman of two International Conferences for the Standardisation of Vitamins and of the International Technical Commission on Nutrition.

Sir Edward Mellanby was Honorary Physician to the King from 1937 to 1941. He held many other important positions during World War II. He was chairman of a committee which investigated and advised on the health of Flying and Naval personnel and has been since 1940 a member of the Scientific Advisory Committee to the Cabinet. In 1941 he was appointed a member of the Colonial Products Research Council, and in 1945, Chairman of a Medical Research Committee to advise on colonial problems.

Lady Mellanby's Work

Sir Edward Mellanby's wife, whom he married in 1914, is a distinguished scientist, like himself.

Lady Mellanby has specialised in research on the effect of diet on dental health; the Medical Research Council published a three-volume report by her on this subject between 1931 and 1934. Her work on the teeth of London school children has been outstanding.

She is an honorary member of the British Dental Association, and an investigator for the Medical Research Council; in 1935 she and her husband were jointly awarded the Charles Mickle Fellowship of the University of Toronto.

Try the rough water as the smooth. Rough water
can teach lessons as well as the smooth.

No man can learn what he has not preparation for
learning, however near to his eyes is the object.

—EMERSON.

PRINCIPLES ON THE EDUCATION AND UTILIZATION OF SANITARY ENGINEERS*

ON January 15–16, 1950, under the sponsorship of the Division of Engineering Resources of the Public Health Service, a group of 36 persons, including 9 from the Service, met in Washington to discuss, on a broad basis, the education and utilization of sanitary engineers. This group was representative of both the “producers” and the “consumers” of young men educated in sanitary engineering. The views of those connected with universities and colleges, Federal agencies, State and local health departments, and industry were all heard and general agreement among those present was reached on the following principles:

1. Future programmes of study at the university level that are to be pursued in preparation for the practice of sanitary engineering should encompass a minimum of 5 years of study of mathematics, the basic sciences, and the engineering disciplines. This can be accomplished through 4 years of study leading to a bachelor's degree in engineering followed by one year of study leading to a master's degree in sanitary engineering, this additional year to include sanitary engineering subjects and adequate instruction in the principles of public health. It is desirable that this be a programme of continuous study.

2. Programmes of study at the university level that are pursued in preparation for sanitation practice should include instruction in mathematics and the basic sciences adequate to form the foundation for later study

in the sciences, the engineering disciplines, or the medical disciplines by those individuals who are qualified to benefit by graduate study.

3. Field training programmes can be a supplement but never a substitute for rigorous academic education.

4. No substitution can be made for the skills that the qualified sanitary engineer brings to his work.

5. The procurement of young men for the sanitary engineering profession rests on the intellectual and financial attractions of the job.

6. There is evidence that increased opportunities in public health beyond the technical sanitary engineering field are available to qualified and capable sanitary engineers.

7. It is desirable that the Public Health Service make studies of (a) the need for sanitary engineering personnel in all areas of work where engineering disciplines may contribute to the promotion of health, which study should be sufficiently broad to include both current and future needs, and (b) the rate of loss from the sanitary engineering field, after graduation, of those receiving academic training in sanitary engineering.

8. The principle is reaffirmed that the planning and direction of local environmental sanitation programmes should be by competent sanitary engineers and that organization and employment to that end should be advocated and promoted by all public health agencies.

—P. H. Reports, Mar. 17, 1950.

* Report from the Division of Engineering Resources, Bureau of State Services, Public Health Service.

NEED FOR CONTROLLED BCG TRIALS

It has been argued, sometimes with fervour rather than with scientific evidence that carries conviction, that the time for controlled trials of BCG is over and past and, indeed, that to carry out any such trial today would be unethical. This view is, very clearly, not held by Dr. Carroll Palmer, co-author of one of the most widely quoted trials of BCG,¹ and now in charge of the anti-tuberculosis mass vaccination programme in Europe. In a prospectus of research presented to the Joint WHO and UN International Children's Emergency Fund Committee and to the Executive Board of WHO, he prefaces his admirable account of an extensive research programme by a statement that two basic facts must be recognised:

"First, it must be admitted in clear and unequivocal terms that strict scientific proof of the effectiveness of BCG vaccination in the control of human tuberculosis is not available. This is true despite the fact that millions of persons have been given BCG during the past 20 years and despite the very suggestive evidence of a few small-scale studies. It may still be true 20 years from now, unless an energetic and careful evaluation of the effects of BCG programmes are undertaken.

"Second, it must be realized that a major responsibility for studying the effects of the programme will fall upon national and local groups. An international research organization can only advise and assist in a long-range programme of evaluation and research."²

This research programme, Palmer places under three major headings: first, the some-

what prosaic but highly important investigation of techniques, procedures, and results of tuberculin testing and immunization; secondly, basic epidemiological research on tuberculous infection and illness; and, lastly, but obviously the *sine qua non*, the measure of the results of the BCG programme in terms of the prevention of tuberculosis morbidity and mortality.

Another urgent step is to determine the allergy-producing qualities of different vaccines, fresh and preserved, and with different methods of administration. The assumption is that the most effective vaccine and method of administration are those which produce the highest degree of allergy for the longest period of time—but Palmer is careful to point out that that is only an assumption. In thus assessing two and more vaccines he envisages a careful statistical trial in which the persons to be vaccinated would be separated by a "purely chance selection scheme," each group to receive a different vaccine or a vaccine given by a different method. Subsequent observation he seems to limit to post-vaccination tuberculin testing and the incidence of complications of the vaccination. A measure of the actual incidences of tuberculosis morbidity and mortality in the groups should, surely, be sought at the same time to prove or disprove the assumption that has been made. In short, has one vaccine any more potency than another?

The problem of revaccination Palmer also faces squarely with a proposed rigidly controlled trial. The routine programme of tuberculin testing and vaccination would be carried out in study areas, and post-vaccination

tuberculin tests on the vaccinated then made at stated intervals up to five years. Whatever the result of these tuberculin tests, "revaccination must not be done"; the frequency of morbidity and mortality could then be measured among different groups of the vaccinated population, separated according to the degree and duration of allergy produced by one vaccination. These results may, too, throw some light on the general value of BCG, though they are in no sense a true trial of it. A further indirect but still stronger test that Palmer puts forward is the repeated tuberculin testing and revaccination of a population on a large scale, until the whole group of vaccinated is made highly allergic to tuberculin. In such a vaccinated group, he argues, there should be practically no disease or death due to tuberculosis—if current theories on the value of BCG are correct. There should, he believes, be no difficulty in finding a number of areas or communities ready for these "superlative demonstrations of the preventive potentialities of BCG."

It is generally held that comparison of the vaccinated with those who refused to be vaccinated is valueless. Palmer boldly develops some defence of it. His proposal is to obtain information from the two groups which will allow an assessment to be made of their epidemiological equality or inequality. Thus data on history of contact with tuberculosis obtained from the parents of each child would show, for instance, whether those who volunteered and those who declined have had a similar past exposure. Some observations of this kind from Germany suggest that those who accept vaccination have more often had

contact with tuberculosis than those who refuse. If we can presume that more frequent past contact means more frequent future contact, then the BCG group is at a disadvantage in terms of exposure to risk. If, in spite of this disadvantage, the group shows an appreciably lower attack-rate from tuberculosis, then clearly we have strong presumptive evidence in favour of BCG vaccination. Observations made in this way are better than none at all, but their grave weakness is obvious. Suppose the results show little or no advantage to BCG? We certainly cannot then argue that it is useless. In short, only if the result is of one particular kind can we have any basis for drawing even a tentative conclusion. Carroll Palmer is himself very clearly under no illusions about that. Indeed, he appears more than a trifle uneasy about the conclusion reached at the sub-committee meeting in Paris last June that strictly scientific control studies of the value of BCG are impossible in the Joint Enterprise programme. Not only does he feel that the importance of the matter justifies its reconsideration, but he urges that "some way must be found to carry out such studies in some place, and soon." In other words, a very experienced worker in this field, with great responsibilities in the mass use and development of BCG vaccination, still pleads for an exact trial of how much BCG can do in such a community as ours—before it is too late. *It has rightly been said that Britain has been backward, even negligent, in the field of BCG. It seems that we have yet time to make fundamental studies which may effectively counter that reproach.*

Courtesy—B.M.J.

¹ *Publ. Hlth Rep. Wash.*, 1946, 61, 802.

² *Ibid.*, 1949, 64, 1250.

WHAT ABOUT POLIO? SOME COMMON QUESTIONS

by

Morris Greenberg, M. D.

(New York City Department of Health)

EVERY year, at about this time, questions come pouring into the Department from physicians, nurses and parents who want to know whether poliomyelitis will be epidemic this year, and what to do about it. It should be pointed out at the outset that it is rarely possible to make any prognostication about the incidence of poliomyelitis before some time in July. Even in epidemic years the number of reported cases in the first six months may give no indication of what is to follow.

There are certain questions which people frequently ask about poliomyelitis. The questions and answers that follow are intended to help physicians in their replies.

1. What is the incubation period?

This has not been definitely established. The period usually given is one to two weeks. It probably may be as short as three to four days and as long as three weeks.

2. What is the period of isolation?

Since the exact method of transmission of the disease is not known, since many more carriers than cases occur in a community, and since there is no easy way of culturing an individual to determine whether he is still excreting virus, the Board of Health has adopted a resolution making the acute stage of the disease the isolation period rather than setting an arbitrary number of days. The Sanitary Code reads, "Isolation—until the end of the febrile stage."

3. What restrictions are imposed on contacts?

None. Wherever poliomyelitis occurs, the incidence of carriers is very high. It does not appear reasonable to restrict the movements of members of the family who may or may not be carriers and to allow other carriers in the community to mingle freely.

4. How is poliomyelitis spread?

In the present state of our knowledge this cannot be answered. There are three theories: (1) That it is spread by contact through discharges from the oropharynx; (2) that it is spread by fecal discharges; (3) that it is spread by flies. Epidemiologic evidence suggests that while the second and third methods serve occasionally as means of spread, the first is the common one.

5. How long does virus remain in the human body?

Virus has been recovered from the oropharynx for only a few days after onset of illness. From the feces, virus has been obtained as early as two weeks before onset of illness and as long as several weeks, and occasionally months after.

6. Should the discharges of a poliomyelitis patient be disinfected?

The discharges from the nose and throat should be treated as in acute respiratory infections. Stools may be passed into sewer-connected toilets. There is no practical method of disinfecting stools.

7. Should children be kept out of schools, nurseries, etc., during the poliomyelitis season?

There is no good epidemiologic reason for keeping children out of schools. Experience does not indicate that the closing of schools causes an epidemic to abate, nor that opening of schools during an epidemic causes an increase in the number of cases.

8. Should children be permitted to go bathing?

There is no good evidence that poliomyelitis is spread by water. The crowding of children should be discouraged, whether in swimming pools, at parties, picnics, etc. There is no objection to swimming or bathing *per se*.

9. Should children be permitted to travel during July and August when poliomyelitis is prevalent?

There is no objection to travel as such. It appears unwise to take children from a community relatively free of poliomyelitis to one where there is a high incidence of poliomyelitis. Long travel may cause physical exhaustion, which should be avoided during the polio season.

10. Should children be permitted to go to camps in the summer?

Yes. Outbreaks have occurred in camps just as they have occurred in other small or large communities. The occurrence of such outbreaks is not frequent enough to indicate that camps are a special hazard.

11. If cases of poliomyelitis occur at a camp, should the children be sent home?

This will depend on the number of cases, the spread, the opportunity for isolation, etc. It is wise to discuss the situation with the health officer of the state where the camp is located. Generally, there is no

good reason to bring the contacts home, unless cases keep cropping up. One should keep in mind that the contacts have already been exposed and that bringing them home does not expel the virus if it has lodged in the body of the contact.

12. What years have been epidemic years in New York City?

The epidemic years were 1916 with 9,023 cases, 1931 with 4,138 cases, 1935 with 2,054 cases and 1944 with 1,890 cases.

13. What is the ratio of paralytic to nonparalytic cases?

This varies in different communities and at different times. In New York City, from half to two-thirds of the reported cases are paralytic. One should keep in mind that many abortive and non-paralytic cases are not reported, particularly in epidemic years. The ratio of paralytic to non-paralytic cases is probably smaller than the figures indicate.

14. What is the age distribution of poliomyelitis?

There has been a gradual shift in cases to an older age group, although most of the cases are still in children.

Age Distribution of Poliomyelitis

Year	Age by Percentages.		
	0-9	10-19	20+
1916 (epidemic year)	95	3	2
1931 (epidemic year)	84	13	3
1938	74	14	12
1940	65	24	11
1944 (epidemic year)	63	32	5
1946	62	29	9

15. Are there any specific measures to be taken in order to prevent poliomyelitis?

No. General measures of hygiene and sanitation should be followed, including the

NEW WEAPONS FOR FINAL CONQUEST OF MALARIA

SUCCESS OF CAMPAIGNS IN CYPRUS AND CEYLON

New drugs and insecticides for the final conquest of malaria are now available and have proved their efficacy in Cyprus, British Guiana and Ceylon.

It now remains for enlightened Governments, says Dr. R. Ford Tredre, to take advantage of these weapons to eliminate the scourge from their countries. Dr. Ford Tredre is Deputy Director of Britain's Ross Institute, centre of malaria research in the United Kingdom.

IN Cyprus, one of Britain's island Colonies in the Mediterranean, a three-year campaign has successfully eradicated malaria-carrying mosquitoes, and unless infected mosquitoes are accidentally conveyed there, by ship or aircraft, it will be impossible for the disease to recur.

The method employed to achieve eradication was the application to the surface of all mosquito breeding waters of an oil in which the insecticide, DDT, (dichloro-diphenyl-trechlorethane) had been dissolved; mosquito larvæ were thus killed.

Adult female mosquitoes have the habit of resting on walls inside dwellings and animal outhouses. These wall surfaces can be treated readily and economically with a solution which, after drying, would leave a fine deposit of insecticide; mosquitoes resting on such a surface might be irritated and fly outdoors, but in any event they will die within a few hours. The attraction of the essential feed of blood lures the young female mosquitoes to the death-trap. To maintain the death-dealing properties of

these wall surfaces only two or three treatments with insecticide are necessary for an eight-month mosquito season.

This residual insecticide method was used in the coastal zone of British Guiana, in tropical South America, where the extensive irrigation system of the sugar-cane plantations produced millions of mosquitoes. The dramatic reduction in the mosquito population has transformed, within a few years, a malaria-ridden country to one in which the disease is no longer an insoluble public health problem.

No more Epidemics

The history of Ceylon has been punctuated by devastating epidemics of tropical malaria. Such catastrophes are now a thing of the past; the prevalence of malaria has fallen to levels which suggest the elimination of the disease within a few years. These results have followed the adoption by the Government Health Department of the residual insecticide method as a routine and island-wide measure of sanitation.

Britain's scientists have been investigating the effect of this method of insecticide application on the vector mosquitoes of malaria in Central Africa, Malaya and Assam. It has been found that some species of mosquitoes may enter dwellings, obtain a feed of blood and leave without resting on a wall, thus evading contact with the insecticide. This may be due to habit or to a repellent effect of that insecticide; a different insecticide may not have this effect on the same species of mosquito.

The complete eradication of all vector mosquitoes is the ideal result to be aimed at, but is not essential for the elimination of malaria from a community. Residual insecticides can reduce the mosquito population so drastically that the numbers of mosquitoes which are actually infected with malaria, become almost negligible. Indeed, the stage is set for the elimination of malaria as a major public health problem in both temperate and tropical climates.

How Britain Fights Small-pox Outbreaks

(Continued from page 375)

department and between the other central departments is maintained.

Emergency Arrangements

Where other cases remain related to the original case and to each other the above procedure is extended until the outbreak is considered under control. Steps that are taken include a warning by the Medical Officer of Health concerned to all general practitioners to watch for fever cases particularly those with a rash; if need be, consultative advice is offered in any case of doubt; arrangements are made for special laboratory services so that clinical diagnosis can be confirmed by laboratory methods; in addition emergency vaccination centres are set up as required.

The available insecticide armament of DDT benzene hexachloride and chlordane, which are all efficient when used in a scientific manner, will doubtless be followed in the course of time by even more efficient chemical compounds.

For years chemists have sought the perfect antimalarial drug and it has yet to be found. In 1946, United Kingdom scientists produced proguanil (paludrine) which has proved to be an efficient anti-malarial and does not cause any unpleasant side-effects. A mosquito taking blood from a person under treatment with this drug, does not become infective or capable of transmitting the disease.

For the conquest of malaria, excellent weapons are available, powerful insecticides to destroy mosquitoes and efficient anti-malarial drugs. It remains for enlightened governments to permit the reasonable recurring annual expenditure and to train staff in the performance of new and skilled duties.

Mass vaccination is not resorted to unless cases appear in any significant number which are not traceable to a known focus of infection. When this happens, any Medical Officer of Health in an affected area may start mass vaccination at once.

A great deal of time and thought have gone into making this organisation a success. But there is another side of the story. The people have realised that it is in their own interest to see that they are vaccinated regularly and not wait until an outbreak occurs. Every mother makes sure that her children have been vaccinated. This done, the risk of epidemics is much less and the task of the Public Health Departments made infinitely easier if and when an epidemic occurs.

screening of windows and getting adequate rest.

16. *Is there a relation between activity and the occurrence of poliomyelitis?*

There is an apparent relationship between fatigue and lack of resistance to poliomyelitis. It is wise, therefore to prevent children from becoming overfatigued during the polio season. Parents should be cautioned, however, not to restrict their children's ordinary activities.

17. *Is there an increased risk to pregnant women during the poliomyelitis season?*

Some authorities believe that pregnant women are more susceptible to poliomyelitis than non-pregnant women. The difference is not great enough to discourage child-bearing in the summer months. Children born to women who have poliomyelitis during pregnancy or labour are normal.

18. *Is there a relationship between tonsillectomy and poliomyelitis?*

There is good evidence to indicate that the bulbar type of poliomyelitis is more common in persons who have recently had an operation in the head region (tonsillectomy, adenoidectomy, tooth extractions, plastic operations). It is, therefore, advisable to discourage elective operations in the head region during rising or high prevalence.

19. *How can a physician get a spinal tap done in the home?*

The Health Department's Division of Acute Infectious Diseases of the Central Nervous System (Meningitis Division) renders a consultation service to private physicians on all suspected cases and will do a spinal tap whenever indicated. The physician should call GR 3-3100 to arrange for a consultation.

20. *Are cases of poliomyelitis admitted to general hospitals?*

Yes. The Sanitary Code states that "cases may be admitted to a general hospital ward, provided the patient is adequately isolated by a cubicle or screen."

21. *What facilities are there for the treatment of poliomyelitis cases?*

Medical care is available in approved hospitals. Nursing and physical therapy are available in the home. Payment for such care may be arranged through The Division for Physically Handicapped Children. Request for it should be made through the district health officer.

22. *Are there second attacks of poliomyelitis?*

Second attacks have been described. They are extremely rare, however. For all practical purposes an attack of poliomyelitis confers immunity.

23. *Is there any vaccine or serum which is effective for the disease?*

No, there is not.

(Quarterly Bulletin of Dept. of Pub. Health of N.Y.)

FIGHT AGAINST POLIOMYELITIS

Food contaminated by flies, it has been experimentally proved, can produce the disease. Therefore, flies being important carriers, all edibles, the statement says, should be protected from flies. Every effort must be made to destroy flies. Garbage heaps foster fly-breeding. These and all dust bins

should be sprayed with 5 to 10 per cent DDT solution.

"Complete isolation of the patient is necessary for three weeks and segregation of contacts is essential."

(Rajkumari Amrit Kaur, India's Health Minister)

HOW BRITAIN FIGHTS SMALL-POX OUTBREAKS

by

G. d'Arnaud-Taylor

The recent outbreak of small-pox in Glasgow has focussed attention on the fact that disease has been almost unknown in Britain in this century. In the article below, G. d'Arnaud-Taylor describes what measures are taken to localise fresh outbreaks, if any.

WHAT happens when a doctor discovers a suspected case of small-pox in Britain? How is the public protected from the spread of this infectious disease? Who decides if general vaccination is necessary and what should be done to check up on contacts? How, in short, is the machinery of Britain's Public Health Departments set in motion?

As soon as a general practitioner discovers a case of suspected small-pox, he notifies the Medical Officer of Health for his area who then takes charge. The patient is taken immediately to a special small-pox hospital (previously chosen by the Regional Hospital Board) in which the staff are always in a good vaccinal condition.

Next, the Medical Officer of Health finds out from the patient the names and addresses of all contacts and promptly offers vaccination to those in his own area. Where the patient has been using public transport, an appeal to all who travelled on the buses or trams concerned to come forward for vaccination, may be issued. The other Medical Officers of Health are immediately

notified of any contacts who have proceeded to their areas.

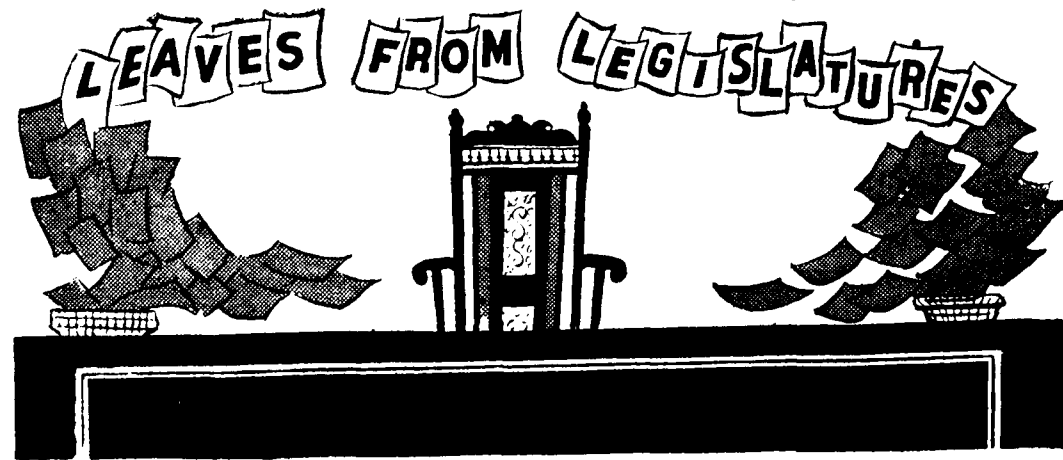
Careful Disinfection

Contacts are kept under careful observation until the incubation period (14 to 16 days) is over. The point of this is that while vaccination before exposure to infection usually prevents small-pox, vaccination after exposure may prevent or sometimes modify an attack.

The belongings of a patient are carefully disinfected or burned and the Medical Officer of Health attempts to trace back the origin of the infection so as to ensure that no cases are missed.

The Central Department (the Department of Health in Scotland; and the Ministry of Health in England and Wales) is now notified. They keep a watch on the national situation and arrange for adequate supplies of lymph vaccine. They also inform the World Health Organisation and may make special arrangements for travellers on international journeys. A close liaison between the Medical Officers of Health and their central

(Continued on page 377)



Parliament of India

WHO Teams for Cholera and Plague

* 659. *Shri Sidhva* : (a) Will the *Minister of Health* be pleased to state whether the World Health Organisation in India has made any recommendations regarding steps to be taken for eliminating cholera and plague from the country ?

(b) If so, what steps have so far been taken in this direction and what measures have been taken to combat these diseases ?

(c) What is the amount set aside for this purpose and will the amount be contributed by the WHO or the Government of India ?

(d) What will be the cost on the staff and medicines ?

(e) Will the scheme provide for educating the public or for active steps to combat the diseases ?

The Minister of Health (Rajkumari Amrit Kaur) : (a) to (e). A statement is placed on the Table of the House.

Shri Sidhva : What is the amount, as stated in part (c), that was set aside for this purpose and how much was contributed by the WHO ?

Rajkumari Amrit Kaur : Two teams are coming out next year, one for plague and one for cholera, and the estimated expenditure on each of them is Rs. 51,000—that is from the Government of India. And the expenditure to WHO is estimated at \$62,500, that is, in the neighbourhood of Rs. 3 lakhs. In addition to this, the expenditure on insecticides will also be met by WHO.

Shri Sidhva : With reference to the Study Groups that came to India for cholera and plague, may I know what was the result and what was the cost ?

Rajkumari Amrit Kaur : There was no cost to the Government of India with regard to the Cholera Study Group: all expenses were met by WHO. This Group came out here, visited several Provinces, actually went to villages where cholera is endemic, and they submitted their report which has just been placed before the Executive Board of the WHO. When the report is received by the Government of India we shall see what action can be taken on it.

Shri Sidhva : What is the proportion of the cost incurred by the Government of India as compared with that of the WHO ?

Rajkumari Amrit Kaur : From the figures just given in regard to these two teams that are coming out this year for plague and cholera it will be seen that the Government of India expenditure will be one lakh of rupees and WHO will be spending more than three.

Shri P. G. Sen : Is there any recommendation from the WHO in regard to malaria ?

Rajkumari Amrit Kaur : Several teams are working today in India in order to eliminate malaria from those areas.

* * *

BCG Vaccination

* 661. *Shri Kesava Rao* : Will the *Minister of Health* be pleased to state how many Indian physicians are trained in BCG vaccination and how many are to be trained in future ?

The Minister of Health (Rajkumari Amrit Kaur) : Sixty-four Indian doctors were trained in BCG vaccination up to the end of December, 1949, and forty-one more are proposed to be trained by various State Governments during 1950.

Shri Kesava Rao : May I know the total expenditure incurred for training these physicians ?

Rajkumari Amrit Kaur : I would have to have notice of that question, but I do not think there is much expenditure incurred.

Shri Kesava Rao : What help is given by WHO for training these physicians ?

Rajkumari Amrit Kaur : WHO arranged for us to send two of our own men abroad. WHO has given us experts that have enabled us now to produce our own vaccine. And they send out experts with the teams that come and those people train our men.

Shri Kesava Rao : May I know in what part of the country these sixty-four trained physicians are working now ?

Rajkumari Amrit Kaur : Well, the places where this BCG campaign has been carried out are Bombay, Baroda, Ahmedabad, Kamrup, Gauhati, Jorhat, Shillong, Nowgong, Rajkot (Surashtra), Calcutta, Delhi, Madras, Madanapalle, Trivandrum, Hyderabad, Patna, Tatanagar, Patiala, Lucknow, Kanpur, Amritsar, Rohtak, Moga, Ferozepur, Simla. And it is proposed to extend this vaccination to Agra, Mysore, Indore and Gwalior as well as a few other places in the near future.

Shri P. G. Sen : May I know if the Hon. Minister is aware of the fact that medical experts of the foreign countries of U.S.A. and England have expressed their doubts about BCG vaccination on a mass scale ?

Rajkumari Amrit Kaur : On the contrary the United Kingdom has just undertaken BCG vaccination on a fairly intensive scale.

Shri A. Joseph : May I know the number of females out of the sixty-four physicians trained ?

Rajkumari Amrit Kaur : I could not tell the Hon. Member offhand but I could find out and let him know.

Shri Poonacha : Is there any proposal to extend this to the Centrally administered areas ?

Rajkumari Amrit Kaur : But it is existing already in the Centrally administered areas. I have mentioned it.

Shri Poonacha : Excepting Delhi I did not hear any of the places.

Rajkumari Amrit Kaur : Ajmer also.

We have italicised the reply of the Minister of Health, to direct your attention specially, to the way in which the Treasury Bench silences Opposition, by the very simple process of *suppressio veri, suggestio falsi*. An authoritative British journal is certainly better informed than the Indian Health Ministry, regarding the policy of the British Government, and we present with our compliments to the Members of Parliament who allowed themselves to be gagged by a mendacious, if ministerial, statement, an article extracted from the *B.M.J.* (see p. 370). Merely putting a question is not enough. The M.P.'s should be armed with facts to be able to see through the replies given to them, and get the Ministry into a vice-like grip, when anything but the Gandhian truth is spoken.

—Ed., P.H.

Material for Manufacturing Prefabricated Houses

* 665. *Shri Kamath* : Will the Minister of Health be pleased to refer to the answer given to starred question No. 639 asked in the Constituent Assembly of India (Legislative) on the 15th December, 1949, and to state :

(a) whether in other countries which manufactured or manufacture prefabricated houses, only such materials as are locally available have always been made use of ;

(b) if so, why there has been a departure from such practice in India ;

(c) the various types of foamed-concrete in vogue in pre-war Germany, and how far the foamed concrete used in the Delhi Housing Factory differs from the German types ;

(d) when Indian Patent No. 36001/46 referring to light weight foamed concrete was applied for, and when granted ; and

(e) whether before the process was patented the matter was fully investigated

by an expert committee of engineers or scientists and, if so, by whom ?

The Minister of Health (Rajkumari Amrit Kaur) : (a) and (b). Government have no detailed information in the matter about other countries. It is understood that in the United Kingdom imported materials have been used for aluminium and timber components of prefabricated houses. As regards the Government Housing Factory in Delhi the house as designed requires the use of aluminium alloy which has to be imported. Efforts are, however, being made to redesign the roof to substitute indigenous products for imported components.

(c) A note on the subject is laid on the Table of the House.

(d) The application for this Patent was filed with the Patent Office of the Government of India on the 7th November, 1946 : the application was accepted on the 28th April, 1948, and the Patent was finally sealed on the 5th January, 1949, with effect

from the 7th November, 1946, under the provisions of the Indian Patents and Designs Act.

(e) No. The Patent was granted by the Controller of Patents under the provisions of the Indian Patents and Designs Act.

Shri Kamath : Has the hon. Minister herself or any of her experts or officers compared the process for which patent has been granted with the various processes described in this booklet issued by the British Intelligence Sub-Committee regarding Technical Developments in prefabricated housing with a view to finding out whether it is a new process or the old process rehashed ?

Rajkumari Amrit Kaur : The information available to Government in this matter is that this is entirely a new process, and when the hon. Member studies the note that I am laying on the Table he will realise that the progress that has been achieved by this particular company with which we are dealing is such that it is actually turning out a structure which is much stronger. Their method of making foam concrete is very different from anything that has ever been done before.

Shri Kamath : Is it a fact that the process at present being followed in the Prefabricated Housing Factory in Delhi does not completely tally with the process described in this specification of the patent of which I have got a copy here ?

Rajkumari Amrit Kaur : I am not aware of that. I think the process that is developed here is absolutely the same as is done by this factory in England.

Shri Kamath : Does the Minister propose to have this matter examined, in view of

the fact that the patent mentions an outer layer of heavy concrete and this part of the process is not being followed in this Factory ?

Rajkumari Amrit Kaur : I am not prepared to have the matter examined now, unless specific complaints or allegations are made. I am quite content with the investigations that the Controller of Patents has made and on the basis of which he has issued the patent.

Shri Kamath : On what grounds has the work of redesigning the house been recommended to the consulting firm ? What are the reasons for redesigning the house ?

Rajkumari Amrit Kaur : There is no proposal of redesigning the house. In order to avoid the high cost of the aluminium, it has been decided to investigate—and I hope that investigation will be successful—some substitute for aluminium, with the foam concrete itself.

Shri Shiva Rao : May I ask the hon. Minister whether this Housing Factory has gone into full production and, if so, what is its producing capacity ?

Rajkumari Amrit Kaur : I am afraid I cannot give the exact date when the factory will go into full production, because of the delays that have taken place in the delivery of the machinery. As I informed the House the other day, when it does go into full production, it will turn out one hundred houses a week.

Shri Deshbandhu Gupta : May I know whether the Government have examined the question of costing and come to the conclusion that if this process which has been patented in India is followed the cost would not be lesser than what it is at present ?

Rajkumari Amrit Kaur : As I have already said the Government is looking into the question of cost. The cost has gone up mainly because of the aluminium alloy and when that is eliminated cost will definitely come down.

Leprosy

* 684. *Shri Kshudiram Mahata* : Will the Minister of Health be pleased to state whether it is a fact that the monetary help from Government (either Central or Provincial) which the Purulia Leper Asylum used to get has been stopped and, if so, why?

The Minister of Health (Rajkumari Amrit Kaur) : No grant was given by the Union Government to the Purulia Leper Asylum. I have no information regarding any grant given by the State Government.

(Vol. 1, No. 23.)

Madras Legislative Assembly

Drainage Schemes

Sri A. Kaleswara Rao :

"Coming to my own home, Vijayavada I am living in a substantial building; and I am sleepless on account of mosquito trouble. (Laughter.) Vijayavada is the biggest town—here I do not want to go into competition with my young Friend, the Hon. Sri Sanjeeva Reddi, who will say, Anantapur is the biggest town. But my point is, the drainage question in Vijayavada has been put off for years together. What I am told is this: and I want the Hon. Ministers to examine it. Sanctions are being made for drainage schemes in Andhra districts as well as for Tamil districts. While executions are going on in certain parts, only paper sanctions are

being made from year to year in certain other parts, and so amounts are being carried on from year to year. So, that is the belief; and that is also what is actually taking place to the best of my knowledge. Long ago, we gave priority in our provincial water-works drainage schemes to the Vijayavada drainage scheme; and yet, nothing has been done. Recently, some investigation staff was put in, and it was also suddenly removed; and then, one subdivisional officer was appointed, but within three months he was also transferred. I had a talk with the Chief Engineer in the matter, and he said 'We are passing orders'. I am told the matter is pending on the table of the Hon. Finance Minister, Sri Gopala Reddi Garu. (Laughter.) I request the Hon. Finance Minister to look into the matter and do what is possible in the matter. I also appeal to the Hon. Health Minister.

(Vol. 1, No. 5.)

Medical Relief

Begum Sultan Mir Amiruddin :

"Coming to medical relief, we find that relatively a small proportion of the State's revenues has been allotted for this purpose. It is only 4 crores of rupees, which means that only three pies in the rupee is being spent on public health and nine pies on medical relief. The apathy of the Government towards medical relief is notorious. Hence, almost every hospital presents the pathetic sight of men, women and children lying on the floor in the verandahs because of the paucity of accommodation. While the Government are so niggardly in the matter of making provision for the public

health and for preventive and curative medicine, they are most generous to the Police and Jail departments. The fundamental duty of a Government, no doubt, is to maintain law and order. But it is surprising to find a national Government spending more on this item than was done by the foreigner. We feel that if the Government would take steps to improve the lot of the people and make available to them the elementary necessities of life—food, clothing and shelter—at fair prices, the subversive elements would find little scope for their activity. After all their promises to make this State a welfare State, is the Congress Government to allow this State to remain a mere Police State as it was under foreign domination?

(Vol. 1, No. 6.)

Housing

Mr. T. S. Avinashilingam Chettiar :

"We are all thinking about providing facilities for the poor man and rightly so. But I find in the budget speech delivered by the Hon. the Finance Minister, under Housing, that Rs. 45 lakhs were sanctioned as loans for the construction of 622 new houses and for the completion of 319 houses commenced in the previous years, making up a total of about 1,000 houses. The cost of a house is about Rs. 4,500 or Rs. 5,000. We have been saying and rightly so, that lakhs of people in this very city have no houses and are living on the pavements. But if we provide houses only for people who can afford to borrow Rs. 5,000, the provision will be only for the higher middle class and rich people. I have heard that a

rich mirasdar of Tanjore, a multi-millionaire with properties inside and outside this country, has applied for a loan of Rs. 15,000 for building a house. Ultimately, it is only this type of people who profit by many of the plans that we make. Let us have a plan from the point of view of the common man about whom there is much talk. Let it not be mere talking. Let it be something which we can implement. Let us have a plan of building houses for Rs. 1,000 or Rs. 500 which can be repaid in twenty instalments. This planning must be from the point of view of a philosophy which we will have to accept.

(Vol. 1, No. 6.)

House-sites for Harijans

Sri V. Kurmayya :

"I now come to house-sites. The Hon. the Finance Minister has stated that 100 thousand house-sites have been given to the Harijans. Madam, these 100 thousand house-sites have been given to the Harijans for the last 30 years. This work began in 1921. For the last thirty years one lakh of house-sites were given. Per year it will be 3,333 or roughly 4,000 for the whole of the State. Every district per year gets only 133 house-sites. This means we are getting, on an average, house-sites for two villages per year. There are about one thousand villages in a district. At this rate it will take 500 years to provide house-sites for houseless Harijans in the State. I do not want this condition of things. I am thankful to the Government for what has been done to the Harijans. But I want to draw the attention of the Government to the fact that within two or

three years every houseless Harijan should be given a house-site. The Hon. the Finance Minister stated that Rs. 92 lakhs have been provided in the Budget for 1950-51. It is all well and good. We all agree that help should be given to the Harijans. I do not exactly agree with the hon. Member Mr. Gopalaswami that more than education Harijans should be economically helped. Education is the most important thing, and that is why I attach so much importance to it. Education should be given greater importance. Besides education, every Harijan must be given a house-site free. No Harijan who is in occupation of Government land should be evicted. That is why I urge on Government that they should take vigorous steps and see that houseless Harijans are given house-sites and landless labourers are not evicted from the occupation of their lands.

(Vol. 1, No. 6.)

Homes for Villagers

Sri V. M. Ramaswami Mudaliyar:

"What has been done to provide the villager with proper homes? It is said that a provision of one crore of rupees has been made, that six hundred houses have already been built and that four hundred more houses will be built through house building co-operative societies. For whom do these buildings cater for? Not for the poor people and the peasants, not even for the middle classes but for the higher middle classes. The housing schemes have totally failed to meet the situation and lakhs and lakhs of people are homeless and without shelter, and the Madras Government can-

not take pride in saying that they have built six hundred houses and are going to build four hundred houses more. For whose needs are the houses in Gandhinagar and Shenoyanagar built? Cheap houses are only few and the costly houses are more. I submit that we have totally failed to solve both the food problem and the housing problem by our policy of inanition and vacillation.

(Vol. 1, No. 6.)

Condition of Hospitals

Sri P. Natesan:

Then, Madam, there is provision for medical relief. What is that provision, I do not understand. Of course, Mr. Kala Venkata Rao read figures. You say that 200 lakhs is a big thing, but actually what is the position? If you go to the General Hospital in this Presidency town itself, or to the Tuberculosis Hospital, or to the Kasturba Hospital which was formerly called the Gosha Hospital, you will find there is absolutely no accommodation and the sick, wounded and maimed are lying on the floor. What is the good of your saying, we have provided money and when you are not able to do anything in the Presidency town of Madras, how are you able to do it throughout the country? I ask, why could you not afford it? Otherwise, what are you here for if you are not able to run the hospitals for the sake of the people, especially when you say, we are here for the common good of the common man? There is no common good and there is no common man here.

(Vol. 1, No. 7.)



by

A SANITARIAN

PRINTERS DO MAKE MISTAKES!

From line 22, col. ii of page 343 of the May issue of "People's Health," should have read thus:

"Modern sanitary science has devised methods by which scavenging as such, could be abolished. I use the word scavenging in the sense in which one human being is made to carry the excreta of another. But I do not want you to look down upon scavenging as something demeaning, as a job for inferiors."

ONE Miss Mayo came to our country some years back. She came here to understand the conditions of life of Indians. As a result of her observations she wrote a book called "Mother India." In that book she painted the dark side of our life. A perusal of the book should make every Indian bend his head down in shame. All that she said was not wholly true or applicable to all Indians generally. Instead of admiring the valuable flower beds in a garden she went about digging the manure heaps. She described in her book the dung heaps. She overlooked the better side of Indian life. But one thing she said, was wholly true. We look upon the Ganges as a sacred river. We consider that bathing in it would wash out our sins, but the way in which we maintain that sacred river is disgraceful. Miss Mayo said in her book that the banks of the Ganges are littered with solid filth and the water in it is liquid filth. Mahatma Gandhi has repeatedly asked us not to defile the banks of our

great and sacred rivers, nor the water in them. But all his appeals to us have gone in vain. So much so any foreign visitor to our country is struck by the insanitary conditions in which we maintain our rivers. At the same time we attach sacredness to the waters in them.

As a nation we have won a notoriety for being dirty. It is a common sight to see our people defecate everywhere. We have acquired this bad habit. We observe mothers removing the excreta dropped by their children in a heap of straw and throwing it by the roadside. We see children using the road margins for defecation. We observe men and women of all ages using every open space as a latrine. We do not seem to have even a sense of shame. We do not seem to realise what injury we are doing to the society as a whole, by such insanitary and disgusting habits.

Self-respect should be developed in every individual. Without clean habits and a sense of all round cleanliness we cannot develop that self-respect. When individuals do not develop self-respect the nation cannot develop it. And what is the result? Foreigners look down upon us as a nation of inferiors; they look down upon us almost like veritable infectious diseases. So much so, the Western Nations treat us as though we were barbarians. The South African Whites would not allow

us to live among them. They want to confine us in a restricted area. When we ask them why we are treated as inferiors they tell us that we defile the entire area in which we are permitted to live. As an independent nation if we want others to respect us, we should develop sanitary habits.

Let me put to you another aspect of the question. We do not seem to realise the great injury we are doing to our society by our insanitary habits. We hear that cholera is raging and sweeping our villages: we hear of tens of thousands of people falling victims to the epidemic; we lose our relations also; we feel greatly grieved. We do not know at what moment we would ourselves become victims to the disease. Now let us think for a moment and see whether such a calamity cannot be avoided altogether. Yes, it can be avoided; it can be avoided easily, too. If we give up that disgusting habit of defiling every piece of open ground, the banks of our rivers and tanks, we can cut out altogether the source of infecting our drinking water-supplies. We do not think for a moment how defiling of the ground affects our drinking water-supplies. You all know that cholera is primarily a water-borne disease. It is only through water and through infected food that cholera is spread. If our drinking water-supplies are kept free from infection there is no fear of

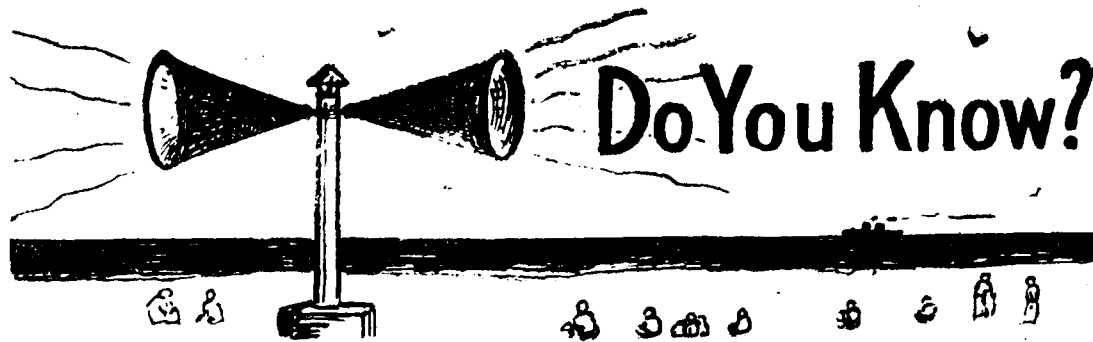
cholera. There are other water-borne diseases, too. They are dysentery, diarrhoea and typhoid. These diseases are brought about by contaminating our drinking water. The primary source of contamination is the faecal matter dropped all over the place. The faecal matter so deposited, contains all or any of these organisms of diseases. We may have an erroneous belief that these organisms cannot be kept alive long under the sun. It is partly true, but not wholly so. Rain water may wash down the filth to our tanks and rivers and even to our wells.

The first and foremost step to be taken to avoid epidemics of this kind is to see that every house is provided with a sanitary latrine. It must not be of the usual conservancy type. This type necessitates the services of scavengers. As I told you already, in my first address to you, modern sanitary science has developed methods of construction of latrines avoiding altogether the services of scavengers. There are many types of latrines. Which one would be suitable at a particular place requires some thought. It is not possible for every layman to decide it. But by simply asking the nearest official in the Health Department you can get all advice necessary. It is not expensive either. By providing every dwelling with a sanitary latrine

we attack the source of infection at its root.

You must have seen eatables being sold in the streets near the schools. In fact, everywhere eatables are sold. You would also have noticed that swarms of flies cover these eatables. You purchase them and eat them. You may not realise the dangers to which you may expose yourselves. But what will your horror be when you think of the possibility—these flies might have sat on faecal matter just a while before they settle on the eatables. Is it not disgusting that eatables with faecal matter should be eaten! It should be shocking to any one. Without realising these dangers, people buy and consume eatables indiscriminately, wherever they are sold. Disgust apart, such infected food carries with it germs of diseases like typhoid, dysentery, diarrhoea and cholera.

Flies breed in dung, manure and excreta. It is best to avoid fly-breeding. Flies by themselves cannot do injury to man; but when they gain access to faecal matter, they become dangerous to man. You must have observed how flies rush to the slimy spit thrown out by a person. The sputum might have come from a person suffering from tuberculosis. Flies rest on it and infect eatables. Thus tuberculosis infection also may spread in this way.



BEE STINGS AND BLINDNESS

Q.—Would the sting of either a large hornet or a honey bee cause blindness in a human eye, if the sting penetrated the eyeball right in the pupil of the eye?

A.—Stings of bees or hornets on the front of the eye may cause serious damage. Bee stings are very toxic and usually set up a violent inflammation. If the stinger can be removed, the inflammation usually subsides, but there is often more or less permanent scarring at the site of the sting. If the stinger cannot be removed, the inflammation is more violent, lasts longer and causes more scarring. If such an injury to an eye were promptly and adequately treated, one would not expect blindness to result, but in all probability there would be some loss of vision under the best of circumstances.

SKULL BUMPS

Q.—What can you tell me about the so-called "knowledge" bumps on the human skull? Why do some people have more prominent ones than others? Aside from the foolish belief that these bumps denote some special talent or wisdom, I have been curious to know why some skulls have these strange formations and if, when these bumps

are pronounced, the condition can be considered normal or abnormal.

A.—The bumps observed on the average skull may sometimes be referred to as "knowledge" bumps, but this is simply a casual description because such bumps have no direct relation to the brain or to intelligence. Bony prominences may develop in the skull as a result of a specific disease, such as rickets. In another rare condition, known by the technical name of Paget's disease, general size of the skull may gradually increase. During birth the skull often is pressed into unusual shapes, but in most instances it quickly returns to a normal contour.

If one feels any doubts about prominences that are present, it probably would be wise to obtain the opinion of a physician regarding their possible significance. This would be especially advisable if the bumps show an increase in size, or if they are painful.

"BROKEN HEART"

Q.—I have heard people state that some one "died of a broken heart." Is that possible? Is there actually a physical change that takes place in time of grief, or is it wholly mental?

A.—"Broken heart" as it seems to be used here refers to a severe emotional state

resulting from mental shock or worry. It is a well known fact that emotional upsets of severe degree may aggravate existing physical defects such as various types of organic heart disease. This emotional burden super-imposed on an already damaged heart may be "the straw that breaks the camel's back." Cardiac death following emotional stress in a person with an otherwise normal heart is extremely unlikely.

ORAL TICS

Q.—What causes a person to bite the flesh on his lips, and especially the interior of his mouth? Is there a way of breaking the periodic and excessive practice of this habit? Are there any harmful results from its continuance?

A.—This habit is one of the large group of oral tics such as twisting or pursing the lips and making movements with the mouth and tongue. These tics are all firmly fixed habitual acts arising in childhood as a result of emotional stresses which have later become unconscious. They are usually harmless, though socially undesirable, but constantly repeated biting of the lips and mucous membranes of the mouth might very well become harmful. The proper treatment can be given by a qualified psychiatrist who will uncover the emotional stresses back of the habit, bring them and their origins into consciousness, and attempt to resolve them. This is a highly individual matter, and must be solved for each person individually.

SACCHARIN

Q.—I have heard that saccharin is a coal tar product. Is this true? Are there any harmful effects from using it? Could it cause gastric ulcer?

A.—It is correct that saccharin is a coal-tar product. However, taken in the amounts normally employed when it is used to replace sugar, it has never been found responsible for any harmful effects on the body, including gastric ulcer.

DENTAL PROPHYLAXIS

Q.—What is the value of dental prophylaxis (cleaning of the teeth by a dentist or a hygienist)? Can the teeth be damaged by prophylaxis?

A.—Dental prophylaxis removes deposits and stains from the teeth, thereby helping to prevent disease of the gums. After removal of the deposits the dentist may detect cavities and other defects. There is no evidence that dental prophylaxis as usually given at intervals of six months is harmful to the teeth.

—*Today's Health*, (May, 50)

FOOD SANITATION

Q.—Why food sanitation is important?

A.—Tuberculosis, measles, common colds, diphtheria, scarlet fever, Vincent's angina, German measles, Lobar pneumonia, cerebro-spinal fever, mumps, influenza, whooping cough—may be contracted by direct personal contact, by droplet infection or indirectly "in food and drink, by hand to mouth infection, or by such vectors as cups, spoons and other things that are mouthed."

—*Preventive Medicine and Hygiene*—
—M. J. Rosenau.



*Wit's an unruly engine, wildly striking,
Sometimes a friend, sometimes the engineer.*

—George Herbert.

Which to Prefer ?

The faith-healer was waxing eloquent to his latest patient.

"Pretend you haven't got toothache. Persuade yourself it's just imagination. Say "Get thee behind me."

"Yes," said the patient, "and have it turn into lumbago. Not likely! I'd rather have toothache."

* * *

Timely Warning

"Now frankly" the surgeon warned, "I must inform you that this is a very serious operation. Four out of five patients die under it. Is there anything I can do for you before I begin?"

"Yes," said the patient, "help me on with my shoes and pants."

* * *

Some Medical Howlers

When you breathe, you inspire; when you do not breathe, you expire; if two people breathe together, they conspire; if somebody breathes alone, he perspires.

* * *

If you are sick, a physician must be insulted and a sturgeon employed!

* * *

Cure for toothache: Take a mouthful of cold water and sit on a stove till it boils.

* * *

Natural immunity has been defined as an ability to fight the disease and not the cure.

* * *

The function of the stomach is to hold up the trousers.

* * *

The Secret of Longevity

The literature of longevity is full of advice, recipes and precepts for the attainment of long life. Yet study of our collection of our life records of nonagenarians and centenarians leads to the conclusion that these people exhibited substantially the same range of variation relative to personal hygiene as is found amongst people in general. Some were light eaters; others on the gluttonous side; some used tobacco; others didn't; some had been in robust health all their life; others had been ailing a great part of the time . . . But, the

vast majority of these longevous folk were of a placid temperament, not given to worry. They had taken life at an even, unhurried pace . . . The more rapid the pace of living is, the shorter the time that life endures.

—Prof. Raymond Pearl.

* * *

The Exception

"In this country", shouted the temperance reformer, "there are 150 public houses and I am thankful to say that I've never been in one of them . . ."

"Which one is that?" asked a heckler.

* * *

How to impoverish the Doctor

Dr. Herman Boerhaave of Holland (1668--1738) was one of the greatest physicians of his time. When he died, his effects were sold by auction. Among his manuscripts, was a sealed book for which there was a heated scramble. It was sold for £2,000 in gold, and when opened was found to contain all blank pages except one, one, which the doctor had written:—

"Keep your head cold and your feet warm, and you'll make the best doctor poor".

—Ripley.

* * *

Wisdom and Statesmanship

Preventing Disease is Wisdom; Conserving Public Health is Statesmanship.

—NTA Reporter.

Some Deft Definitions

A Program—Any assignment that can't be completed by one phone call.

To Expedite—To confound confusion with commotion.

To Activate—To make carbons and add names to the memorandum.

Under Consideration—Never heard of it.

Under Active Consideration—Were looking in the files for it.

A Conference—A place where conversation is substituted for the dreariness of labour and the loneliness of thought.

Synthesis—A compounding of detailed bewilderment into a vast and comfortable confusion which offends no one.

A Survey is Being Made on this—We need more time to think of an answer.

Further Substantiating Data Necessary—We've lost your stuff. Send it again.

Research—Copying from one book is plagiarism; copying from two books is research.

A Statistician—A man who draws a mathematically precise line from an unwarranted assumption to a foregone conclusion.

An Expert—A person who avoids all the small errors as he sweeps forward to the grand fallacy.

—Jerry Klutz.

* * *

Retiring

"Take a hot bath before retiring and you will sleep well."

"Before retiring, doctor? I shouldn't be retiring for five years more!"

APHA meeting, is composed of representatives of four sections: Engineering, Health Officers, Laboratory, and Food and Nutrition. The purpose of this Committee is "to prepare a manual of effective, reasonable, and workable sanitary practices for the guidance of those engaged in, or dealing with the food industry." An agreement has been reached as to the form the manual will take and the assignment of about half of the subject matter to be included in the manual

—W. B. SCHREEDER.

—(P. H. Engng. Absts.)

COCKROACHES FOUND TO HARBOUR FOOD POISON

(Sci. News Let, Feb. 5, 1949).

This is a resume of a report by Dr. Theodore A. Olson of the Univ. of Minn. to the milk and food sanitation symposium, held in Washington, D.C. on the ability of the cockroach to harbour *Salmonella* organisms under laboratory conditions. Dr. Olson is said to have reported that if *Salmonella*-containing excreta is deposited on food or dishes, the bacteria may remain alive for as long as 1 mo.

Included is a report on a paper by Irving Olitsky, Mich. State College, on the prevention of surface-contamination of carbonated beverage bottles, stored in water coolers, by means of weekly changes of the water and the addition of sanitizing agents to the cooling water.

—FELIX BRONNER.

—(P. H. Engng. Absts.)

TRANSFORMING REFUSE COLLECTION

(Thomas Vicerks. *The Surveyor*, (Jan. 21, 1949).

After a brief discussion of current methods of household refuse collection and a critical analysis of a more efficient service in Tottenham, the author describes a new system of refuse collection and disposal provided for 938 flats newly constructed in Leeds in 1935. The new system, which the author describes as successful, comprises an especially designed refuse container in each kitchen into which household refuse, including ashes, cans, bottles and such like, up to 6" in dimension, is fed and then discharged by water-carrier system to an underground collecting chamber; thence to the receiving tanks at the disposal station. The author appears to think that this latter method is vastly superior to any now in use, and recommends that the example be followed in all new urban construction.

—A. M. RAWN.

—(P. H. Engng. Absts.)

LANGUAGES OF THE WORLD

The actual number of languages spoken and written in the world is estimated by the French Academy as 2,796.

The English language is used by more than 270,000,000 people. Of these, 150,000,000 are residents of the United States or inhabitants of its territories, 1,000,000 are Liberians, and 118,500,000 are either citizens of Great Britain and its dominions or inhabitants of its dependencies.

The Chinese language and its dialects are used by nearly 500 million people.

Hindu and Indian dialects are used by nearly 333 million people.

The Russian language and its dialects are used by 166 million people.

Spanish, 93 million; African 93; Japanese 97; German, 78; French, 68.—NTA Reporter.

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WHAT DO THEY SAY ABOUT IT?

Readers can contribute to this section. They are requested to send extracts of current literature which, in their view, would interest the people. —Ed., P.H.

HOUSING

A Yardstick for Slums.—Alfred H. Fletcher. *Eng. News-Record*, Vol. 119, No. 9.

A scoring system of slum classification has been developed by the Memphis Health Department. The system places a numerical value, or sanitary rating, on each house, based on the per cent of perfection as compared with a set minimum standard house. The key facts for judging the dwellings are: (1) Location, condition, and use of toilet; (2) location, condition, and use of water and sink; (3) condition of screens, roofs, floors, walls, ceilings, and chimneys; (4) the number of families provided for by the dwelling; (5) the number of persons housed per room; and (6) the position of the dwelling on the lot (front or rear). These factors are assigned arbitrary numerical values with deductions being made for unsatisfactory

conditions. By applying a factor known as the rear dwelling factor, a housing index can be determined for any block or group of blocks.

As rated by this system, the worst areas show a high per cent of vacancies, a low average weekly rent per unit, a low average number of rooms per unit, a low average weekly rent per room, but a high average number of persons per room.

The plan in Memphis, at this time, is to adopt and enforce a housing code beginning in the better slum areas and working towards the worst conditions. When the point is reached where further enforcement will result in slum clearance, some form of subsidized public housing at present seems to be the only plan for taking care of the remaining class of slum dwellers.

—V. M. HYNES.

—(P. H. Engng. Absts.)

NEW RAT CONTROL EFFORTS IN MARKET AREAS

(*Baltimore (Md.) Health News*, (February 1949).

"In an effort to improve general sanitation in the city markets and as a major step in the elimination of rat infestation, a new plan for disposal of refuse from eight of the city markets was recently placed in operation on the recommendation of the City Rodent Control Co-ordinating Committee. After months of study, the committee suggested the use of the Dempster Dumpster equipment, which includes a large modern design closed receptacle to receive the refuse from the market stalls. Empty containers are provided at several convenient locations in each market and are serviced by the City Bureau of Sanitation. Stall operators are required to deposit garbage and trash in their own covered metal cans and these cans are emptied into the Dumpster receptacles.

"Elimination of the large supplies of food which rats have found in market areas due to improper sanitation will do much to reduce the rat population. This type of environmental control has been emphasised in the programme of the Health Department's Division of Rodent Control. The new sanitation plan for markets is a joint undertaking of the Police Department, the Bureau of Markets, the Bureau of Sanitation and the Health Department.

"Excellent co-operation has been received from most of the market stall operators and from the merchants near the markets. However, five cases were brought to the City Housing Court on December 28, in which two stall operators and two merchants were found guilty of depositing trash and

other debris in the streets. Fines were imposed on four of the five defendants. These cases served as a warning and have resulted in improved sanitary conditions."

—W. H. B.

—(P. H. Engng. Absts.)

ELIMINATION OF STORM WATER FROM SANITARY SEWERS AT WADSWORTH, OHIO

(Frank G. Randall. *Sewage Works Journal*, (March 1949).

The City of Wadsworth in 1931 had to face the common problem of the surcharging of sanitary sewers by storm waters from roofs, etc., through improper connection of the downspouts. Either relief sewers had to be constructed or the storm waters eliminated.

The latter procedure was adopted and a survey made using rubber balls in downspouts and basement drains to locate and eliminate improper connections to the sanitary sewers. A two year programme was successful in restoring the sanitary sewer system to the purpose for which it was intended.

This is not a one time job. During the past year there are again indications of the misuse of the sanitary sewers. "Storm water elimination from a sanitary sewer system is an endless problem but one that can be controlled by diligent work on the part of the city."

—H. H. WAGENHALS.

—(P. H. Engng. Absts.)

SANITARY PRACTICES IN THE FOOD INDUSTRY

(Food & Nutrition Section. *Amer. Jour. Pub. Health Year Book*, 1948-49, Part 2, (May 1949).

The Committee on Sanitary Practices in the Food Industry, formed after the 1947,



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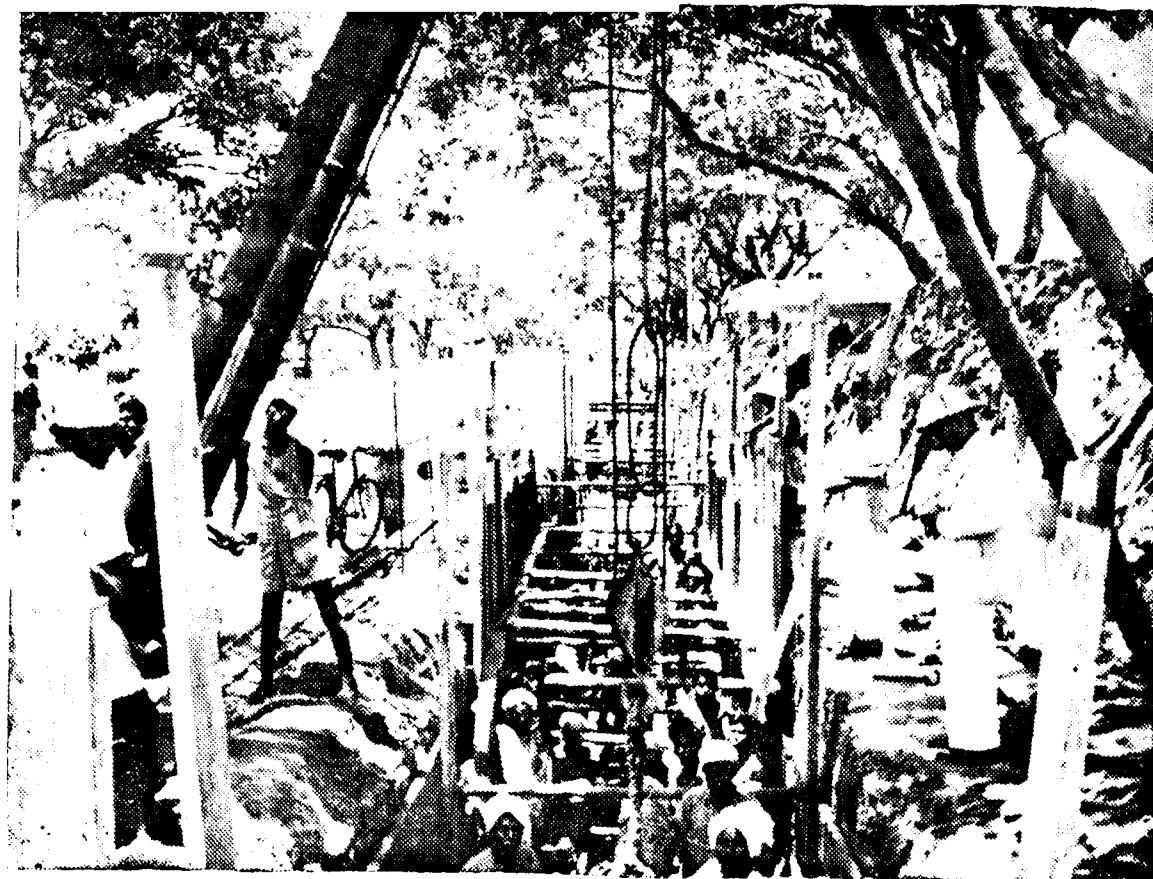


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