NEWS AND NOTES

HANDICAPPED CHILDREN IN U.S. LEARN THROUGH SPECIAL EDUCATION

Special educational services for sick and crippled children are a part of the free education provided by the states of the United States. The first publicly financed school for crippled children was established in the state of Illinois in 1899. Since then, aid to handicapped children has been expanded to provide them with educational opportunities whether they are home-bound, hospitalized, or require special schools or special services in regular schools.

These programmes benefit victims of cerebral palsy, poliomyelitis, amputations, congenital malformations, tuberculosis, heart trouble asthma, rheumatic fever, or less serious, short-time illnesses.

There is no federally supported programme for the education of these handicapped children, since in the United States each of the 48 states operates its own educational system. Most of the children helped are of elementary and secondary school age, but some are older and some younger.

Large numbers of crippled children, particularly those with lesser handicaps, attend regular day-school classes. For many of these boys and girls, special services must be provided, such as transportation, rest periods, physical therapy, and guidance.

Children more seriously handicapped attend special day-school classes. These are sometimes held in separate schools with special equipment and specially trained teachers. A few states provide schools in which handicapped children live. In these schools the children not only are educated but are treated for their ailments. Whatever **the** form of instruction, the school **programme** is arranged to meet the needs of the students.

The U.S. Office of Education reports a big increase during the past 10 years in **the** number of sick or crippled pupils who are taught in their own homes or in hospitals. Teachers visit homebound children regularly, usually from two to five times a week. The courses in general are the same as those in regular schools. When the condition of the handicapped children permits, they are encouraged to make friends with pupils from school classes that are doing the same academic work. Letters are exchanged, visits are made to the handicapped, and occasionally the handicapped attend classes in the regular schools.

Some schools broadcast educational radio programmes for children unable to attend schools. Others use a two-way communication device that enables the home bound children to hear regular class sessions and to take part in them. Both devices are intended to supplement and not to replace instruction by the home teachers.

Many local school systems also provide teachers for hospitalized children. Because of the psychological benefits of group activity, an increasing number of classes are organized for all children who are able to participate. Patients are wheeled to rooms set aside as classrooms. Those who are well enough to study but unable to take part in class activities receive individual instruction.

In addition to these educational services provided by publicly financed school systems, there are also some private schools for the treatment and education of sick and crippled children.

INDUSTRIAL MEDICINE—ITS ECONOMIC ASPECT

Dr. H. P. DASTUR

Health is wealth. Industrial medicine builds its economic structure around this axiom. It certainly values money, but people carry a higher value. Modern civilization revolves round its industries, and they are to-day in utter chaos. If there is one thing more than any other likely to restore peace and order, and revitalize them for higher efficiency, it is the new economy of a better place to work and a healthy personnel to man it, the new method which controls work for people and not people for work.

Industrial medicine is something new to India, and the only way to sell it to its businessmen is to convince them that it is an investment and not an expense. Industrial medicine is concerned with the preservation and improvement of the health of operatives of different personalities, and its gains are better morale, improved management-labour relations, incentives, motivation, rehabilitation of the handicapped as gainful workers, elimination of waste, especially human, and similar other advantages.

One definition of economy which Webster's dictionary gives is a frugal and judicious use of money, which expends money to advantage and incurs no waste. When a doctor who practically knows very little about the abstruse theories and principles of economics, applies his mind to the economic structure of a factory, he cannot help concluding that the system is a short-sighted policy which does not conform to the above definition of economy. It may be just the thing for gathering immediate cash benefits, but it does not seem to go far towards developing the factory's inner growth upon which ultimately depends all benefits, cash or otherwise, and for all times, present or future.

It is bad economy to kill the goose that lays golden eggs, but this is just what the *bhaiya* in the milk trade generally does. He is only interested in immediate cash benefits; he will not grudge the buffalo such food as is likely to increase the immediate yield of milk, but at the same time has no scruples about starving the calf, sometimes even unto death, so that he may have some more milk to sell.

It is not unusual to come across an industrialist, who like the above type of the *bhaiya*, is for building an economic system for his business round immediate cash benefits even at sacrifice of its inner vitality and stability. Such a one will readily undertake illumination of his workshop at any cost for running a second night-shift to meet a growing demand for his goods. It however makes no impression on him when told that as seeing is dependent as much on the sight of his operatives as on the light in his workroom, he should get his operatives medically examined to match their sight with the light. As long as he gets immediate profit he refuses to accept that things half done are in the end wholly uneconomic.

A psychologist has said that "Management is development of people, and not direction of things." Speaking generally, an industry is composed of three main parts,—"Men, Methods and Materials," and the complaint is that while methods and materials receive full attention from professional economists, men enter very little in their calculation, despite the fact that this factor is more important to industry than any other, for, "Production comes from people—not machines." The economist however is not in a position to apply his principles to men without the help of medicine, and medicine

is today in a challenging position to deliver the goods.

The national wealth of a country is not made up only of material resources like minerals, coal, oil, seeds, etc., but also of its people, their health and their culture. In fact the former without the latter is no better than scrap of no use to any body. The real assets of an employer are not the factory building and machines, but the operatives and their health. Medicine does not pretend to understand the full implications of the economic structure of industries, but feels bewildered that it is not based on spiritual values, for it sees a gold mine hidden behind the health of workers, and only spiritual values can draw it out on the surface, and industrial medicine can supply them.

If a machine develops a minor fault technical experts are always on the spot to remove it before it develops into a major defect. A minor grievance of an operative however is very much like a minor machine defect. If not resolved immediately, it may lead to a major grievance, affect a whole group of workers and may even lead to strike, and nothing ever leads to a bigger all round waste than a strike. Just as it is wise and economic to correct minor machine defects there and then, so must also minor grievances of operatives be liquidated before they develop any malignity in the body politic of the production machine. This is what industrial psychology, an important branch of industrial medicine, attempts to do through the personnel management department of a factory.

The wage rate of an operative noted in the time-keeper's books is a nominal wage. His real wage is his working capacity, the number of days he actually works and the quality of work he puts forth. American statistics go to prove that the gross income that accrues to an employer through the efforts of his employee is one and a half-times his wages. Every day the worker is absent from work he loses the whole of the day's wage, and the employer half of it. This has its repercussions on the finances of the state also. The economy that industrial medicine can practise is reduction of absenteeism through improved health of the operative.

The National Association of Manufacturers, New York, in 1941, made a survey of 2,064 establishments to study costs of their medical programmes and estimated that the gross profit on each worker's effort averaged one and one-half times his daily wage rate. The Report of Bhore's Health Survey & Development Committee, 1946 has stated that there are about seven to eight million workers in factories, mines, plantations, transport, etc. Of this about 2.5 millions are employed in large scale factories. The data relating to the incidence of sick ness in India are extremely scanty. The Indian Labour Gazette publishes every month figures relating to absenteeism for certain industries. The percentage of absenteeism due to sickness and accident is available only for a few industries: Cotton Mills in the Madras Province, Iron & Steel, Cement, Match and Ordnance Factories for all provinces. The percentages of absenteeism may be roughly taken at 10, sickness and accident accounting for 3 per cent. According to the data collected by Prof. B. P. Adarkar in connection with his report on Health Insurance for Industrial Workers, the maximum rate of sickness is 14.6 days per year per worker.

The present minimum rate of Indian worker including dearness allowance is seldom below Rupees $2^1/_2$ per day. If the American estimate stated above is followed, and if calculations are based on the minimum rate of absenteeism of 10 days due to illness, regulated factories lose **every year**

about 3 crores of ruppes in their gross income due to workers' illness. If an industrial health programme can lower the average by one day only, the savings to industries would amount to 30 lacs of rupees. Dr. Heiser after studying records of more than a thousand companies, has indicated that health programmes that are well-planned and administered have time and again decidedly cut absenteeism rates. He found that in 234 companies, the average reduction in absenteeism was 29 *percent* and that a reduction occurred in 9 out of 10 of the companies studied. The National Association of Manufacturers, New York, referred to above after analyzing losses in plants without a health programme and comparing them with monetary benefits realised from the programme have come to the conclusion that it was not a question whether or not one could afford a programme but that one could not afford not to have a health service.

The economy that industrial medicine understands is that of increasing an operative's working and earning capacity. The grinding wheels of mass production have a tendency to convert human beings into robots of ever decreasing efficiency. Helpful administrations of industrial medicine can however successfully counteract this vicious tendency.

Life is never static. It must move forward or fall backward. Its progress however depends on development of people, and people are made up of individuals, and as each individual has his own distinctive make of body and mind, individual care is necessary. Moreover man is a social animal with herd instincts, and as the methods of mass production of a modern industry tend to engender a feeling of insecurity, its workers see safety in herding together and seek security through forming unofficial groups within the workshop and trade unions outside it, and so their development depends as much on due respect for their associated as well as individual sense and sensibility. This is what industrial medicine practises, and in so doing is laying the only foundation on which true economy can raise a lasting structure.

An industrial organization is made up of individuals and depends on their willing co-operation for its prosperity. Money is a direct and powerful incentive for drawing out such co-operation, but only upto the subsistence level. Beyond that non-materialistic incentives gain in importance. Man cannot live by bread alone and is always feeling the urge of self-expression through art, intelligence, religion; prestige, position, social compatibility and other similar motives have a higher value for him than money. That is why industrial physicians lay stress on reserve health as the soundest economy. Money economy when working all on its own is more destructive than creative, for it has a tendency to freeze its sources of wealth. It becomes truly productive only when it is linked up and is subservient to health economy. "Money makes money" is no more true; men make money. To-day the whole world is witness to the fact that money economy has brought in nothing better than an economy of tears, tantrums and want. Industrial medicine claims that health economy can convert it into one of cheer, peace and prosperity.

A PRACTICAL PHILOSOPHY OF REHABILITATION

Rehabilitation is the act of making a disabled person fit to engage in a full-time job comparable to his ability to perform the duties required. In the broader sense, it aims at the transformation of the individual to bring about an improvement in his physical, mental, and social well-being. The word "Rehabilitation" is a new expression with a modern and particular character. In other respects the spirit of rehabilitation is timeless and is behind the impulse which inspires every charitable act of one man towards another less fortunate than himself.

The scheme for the Rehabilitation of Physically Handicapped Persons is provided for in Part VII of the Social Services Consolidation Act which defines the limits of eligibility, the extent of benefits and outlines the objectives. It does not, however, specify how these objectives are to be achieved.

This is in turn dealt with in particular instructions issued to those concerned, but behind even the organization and procedure of the scheme there must exist the feeling and spirit of rehabilitation essential to its successful operation.

The spirit of rehabilitation is not a vague nebulous phrase but a predisposition of mind without which the best results will not be produced. Thus, although it is important to be practical and efficient in regard to routine matters, it is equally important to give each case the most conscientious consideration to ensure that the fullest possible benefits will accrue and to ensure that none is passed over that offers any reasonable hope of success.

Rehabilitation is the finest of all social services. Participation in its work calls for sympathy, enthusiasm, patience, tact, and complete willingness to subjugate one's own efforts to those of the rehabilitation team. In fact, those who do not possess these attributes are temperamentally unsuited to a place in the Rehabilitation Scheme.

Above all, the sincere co-operation of all those contributing their part towards the rehabilitation of the disabled is vital to the welfare and, indeed, to the existence of the scheme. Skill, brains, and experience must be pooled to achieve the best plan for each individual case.

It cannot be too strongly emphasized that the Rehabilitation Scheme belongs not to any particular group of specialists, be they doctors, administrators, social workers, therapists, training or employment officers, but to the combined efforts of them all.

The full gamut of rehabilitation includes acceptance, treatment, vocational training, and employment. Throughout this course, the accent will fall first on one phase and then another so that responsibility falls alternately on individual specialists or groups of officers for medical treatment, training, and placement. In between these stages, however, there must be intermingling of functions so that the threads are finally woven into a complete pattern for successful rehabilitation.

Rehabilitation differs from other social services in that each case is an individual problem, the solution of which very often depends on personal contact and right handling. Its methods cannot be reduced to a formula or a set of formulae. Another difference is that the monetary benefits are relatively unimportant and incidental to the main objective of the restoration of independence and the means of livelihood.

Those properly disposed towards the best aims of rehabilitation will approach their task with a mind free of suspicions, prejudices, and the consciousness of power delegated by constituted authority and backed

by law. The disabled need sympathy and delicate handling. Not only have their bodies suffered misfortune but their minds are often injured as well. In consequence their natures may be warped, introspective and sensitive. This may result in no happier response than rudeness, timidity, stubbornness, fear, and distrust. All this has to be met with patience and the fullest effort to devise means not only to overcome these obstacles but to see that no case where help is at all practicable is set aside.

Apart from the humanitarian side of rehabilitation there are the important economic considerations of increasing the number of employable persons and decreasing the number of recipients of cash benefits. Important as these considerations are it would be regrettable if they were allowed to overshadow the fact that in undertaking the task of rehabilitating the disabled we are dealing in human lives, happiness, and self-respect—commodities which cannot be assessed in terms of money.

The care and consideration which are extended to the physically handicapped in the early stages of rehabilitation should therefore continue until each case is satisfactorily terminated. Vocational training and employment should not be hastily undertaken in order that pensions may be discontinued or that employment figures may be enhanced.

At all stages from acceptance to employment it should be the joint task of all those who have an active part in the rehabilitation of the disabled to endeavour to inspire them with the courage, not only to go through with measures for their own reorientation, but also the courage to face a new life. The thought that society has no more use for a disabled person is a serious deterrent to recovery and this attitude of mind, if it exists, must be dissipated and replaced by faith in his own powers and in his ability to help himself to resume his status as a self-respecting, self-supporting member of the community.

ROLE OF VOLUNTARY SOCIAL SERVICE AGENCIES

Voluntary organizations and societies have been for many centuries an important feature of British life and wherever British communities have become established, in whatever parts of the world, there has been at work the same urge for individuals to come together and of their own free will and initiative bind themselves for mutual aid or for the common good. The love of freedom, which I believe is the deepest passion of the British race, has expressed itself in this way above all others; through our groups and societies, some simple and humble, others with lofty purposes and animated by deep religious aspirations, we have given content and meaning to our love of liberty and created the fabric of our British way of life. Think for a moment of your own community or neighbourhood—of the things which make life interesting for you, of the things you want to give to life, and you will inevitably think of small or larger groups of your fellow men, like-minded with you, who group themselves together in some society, whether for games, recreation, drama or music, for education or indeed, for worship. Your own full life finds its part in the life of others with which you co-operate, and in which you share. There is no people which has expressed its genius in the creation of a varied social life more fully than the British and it springs essentially from this love of freedom—to think and to do for oneself—in uncoerced fellowship with one's fellow men.

There is one important example **of this**

principle of free association which stretches like a silver thread through the whole of British history and it is of this I wish especially to talk. I refer to the voluntary organizations which exist to provide some service to society or to some section of the community which is in need, whether it be physical or mental, or for the young or for the old. It is no exaggeration to say there is hardly a social service administered and provided by the State which does not have its origin in private and voluntary action. In the old days, the State was little concerned directly with the poor, the sick or the aged, and it was left to voluntary group to care for those in need—often by religious agencies whose members were stirred to action by compassion for suffering and want in others and by groups founded on the principles of mutual aid, such as the Guilds, in the old towns and cities of England. These voluntary agencies were the cradles of our citizenship and the foundations of our community life. It was when the efforts of voluntary organizations became inadequate to the problems of society, particularly after the Industrial Revolution and the rapid growth of great urban populations, that the State began to take action, slowly at first, but then at an increasing pace which in our day almost assumes the proportions of a revolution. In Great Britain there is hardly an aspect of work undertaken and pioneered in the past by voluntary action which is not in some measure affected. The sweep of social change, initiated cautiously 40 years ago by the State, is now truly tremendous. Let me give you some examples:—

First, there is the Beveridge Plan which was adopted by the National Government during the time of war and has since been put into action by the Labour Government. This plan brings into one comprehensive scheme the many efforts made over the past 30 or 40 years by the State to provide financial security for its citizens against the risks and hazards of life, unemployment, sickness, old age, widowhood; for the crippled, the disabled and the orphans. It broadly provides a basic minimum payment against these hazards and secures for almost every section of the population a means of protection against poverty and sickness. The old Elizabethan Poor Law has been swept away and in its place Central Government has accepted the responsibility for providing in addition to whatever may be secured from the insurance scheme, further financial assistance wherever it is proved to be necessary in individual cases. The old problem of dire poverty which bedevilled the development of our great urban cities and towns in Britain, has now, as a result of these measures, undergone a transformation.

Turn to the realm of education. The minimum school leaving age has been raised to fifteen. Later it will be lifted to sixteen. The re-organization of the whole system provides for secondary education for all boys and girls. The child of under five is to be provided for through nursery schools. Boys and girls who have left full-time schooling will be required to attend what are called county colleges for approximately half their working time each week until they are eighteen. School meal services, which played such an important part in maintaining the physique and stamina of children during the war, have been made a normal feature of school life, while the medical and dental services have been retained and extended. Even adult education and recreation are brought within the scope of the authorities as a proper medium for their service. The work of youth organizations, boys' and girls' groups, the scouts, the guides and many others are also affected, because the same Act of 1944, passed as you see in wartime by the Churchill Government, lays it down as a duty of local authorities to see

that there is adequate provision for the leisure-time pursuits of boys and girls out of school hours.

In the field of health and welfare the changes have been just as far-reaching. The voluntary hospitals, perhaps the oldest form of organized voluntary effort, have, these two years, been taken over by the State and are now operated as part of a national system under the authority of the Minister of Health. By the same Act which made this profound change possible, the local authorities became responsible for certain other services which hitherto have been rendered by voluntary agencies.

The National Assistance Act, another piece of post-war legislation, requires local authorities to provide welfare services for all those individuals in their area who stand in special need of care and protection, for the crippled, the aged, the blind and the physically and mentally handicapped. This has for centuries been a field of work which the voluntary organizations have pioneered. Other Acts of Parliament have extended the State's interest in social service. The Tomlinson Act, passed during the war, was far-reaching measure for the rehabilitation of the physically disabled. Remarkable progress has been made in this field in the past few years and a new hope brought into the lives of many individuals who might otherwise have been condemned to a life of uselessness. More recently, the Children's Act brings under the protection of the State all those children who are denied the love and care of ordinary home life, and has resulted in the establishment of a new children's service headed by specially trained children's officers, whose duty is to seek out and care for, whether in institutions, hostels or foster homes, those children who stand in special need and whose parents are incapable of providing for them or unwilling to do so. There are many societies in Great Britain, some of them very old, which have laboured to serve just this cause.

In the face of all this manifestation of State power what is there left for voluntary agencies to do? Is their day over? Are they now inevitably consigned to the limbo of things past? I will answer very briefly. After close study of the working of the Acts, I am convinced that there is as great an opportunity for voluntary effort in the future, as there ever has been in the past. Almost every one of these British Acts of Parliament provides for a continuation of the work of the voluntary agencies. In youth work for example, the local authorities in Britain have the power, and they are expected by the Minister of Education to exercise it, to encourage voluntary youth clubs and activities and to provide leadership and finance. The same is true of work for old people, for the disabled, and for children requiring special care.

Then there are fields of effort, which are recognized to belong to voluntary effort rather than to State action. There are many examples of this—I will mention one. It is Marriage Guidance. The rapid increase in the number of divorces in recent years has led to the establishment by voluntary action of Marriage Guidance Centres. There are at present over 100 of these centres providing a kind of repair service for broken marriages and in this difficult form of work they are carrying out a most valued service. The Government, concerned, as it must be, for the stability of family life, has taken an interest in the work. They recently appointed a committee, of which I happened to be a member, to consider what action the Government might take. We were unanimous in our conclusions and the Government accepted our advice. We recommended that work of this character affecting the most private intimate affairs of personal life, should not become an area

for State activity, but should be left to voluntary effort. Nevertheless, in view of the importance of the work and the difficulty of finding from voluntary sources all the money necessary, we recommended that the State should give grants in aid of the work. The Government agreed and is now making grants.

A partnership of effort between the statutory and voluntary agencies is now growing up, which, although not new in Britain, is a most striking feature of the post-war situation. This does not mean that all is well or that the future of voluntary organizations is secure. It is quite easy for the intention of an Act of Parliament to be defeated by administrative action. The great service of Government and authority could easily swallow the smaller services of the voluntary bodies. Great pressure will be exerted on voluntary societies to lift their standards of work and to provide more reliable leadership. This means money, it also means skilled planning, and all round co-operation (an activity in which energetic and enthusiastic voluntary societies do not always excel). But given energy, courage, and vision, I believe the future is bright with promises for voluntary effort in Britain.

HUMAN TOUCH IN PERSONNEL MANAGEMENT

India as a whole is far behind Western Countries in the matter of handling the personnel in industries. A few of the largest organisations have personnel departments approaching modern lines but as far as is known none of the factories with less than a thousand employees ever thought of a personnel department as distinct from a labour office. So when the National-Ekco Radio & Engineering Company with a complement of about five hundred, established a personnel department in August 1949, it was certainly a bold step forward. The author who has specialised in Industrial Medicine in England and has experience in modern personnel management as practised in that country, was put in charge of this department to act both as the Medical Officer and Personnel Manager. The idea of combining the medical and personnel departments is undoubtedly novel in this country and if it proves successful, it will certainly encourage many smaller factories to start their personnel departments.

The National-Ekco was. in the process of reorganisation at the time. So one of the first duties this department had to undertake was the recruitment of one hundred and fifty girls for the purpose of assembly work. It was not possible to get many girls with previous experience in radio assembly, and it was therefore, decided to do away with the old fashioned system of selection and to introduce modern methods. Industrial psychology was applied to select girls who had innate aptitude and qualities suitable for training into efficient assembly workers.

The assembly work is of a repetitive type and needs suitable temperament for resistance against monotony as well as manual dexterity. Manual dexterity really means innate power to control and co-ordinate a number of different muscular movements of the hand. Differences in this innate control makes one person "all thumbs" and another "neat fingered". Both these qualities—suitable temperament and manual dexterity—can be assessed by means of special mechanical appliances. But the use of mechanical appliances was restricted to dexterity tests only for the purpose of this

selection. The temperament assessment was done during interview with the help of specially prepared interrogation.

Two dexterity tests were devised, in each case using appliances to which all girls are normally familiar. One consisted simply of a piece of paper on which two zigzag lines were drawn side by side leaving a very narrow space in between. The candidate was required to cut through this narrow space by means of a pair of scissors without touching either of the lines. The time taken and the nature of movements of the hands and fingers were considered for assessment of dexterity. The second test correlated the actual job more closely. It consisted of a wooden tray on which two radio valve holders were fixed. On the base of each of these holders several small metal eyelets were attached. The test consisted in taking pieces of fine wires from an adjoining tray and passing them through and twisting them round the eyelets. The assessment was done in the same way as in the first test.

All interviews are conducted by fixed appointment thus eliminating long waiting which often spoils the success of many psychological tests. A most informal chat by the personnel manager soon overcomes the initial nervousness of the candidate and sets her at ease. She is then encouraged to talk and the interviewer only puts in a word or two here and there just to conduct the talk in a specific direction. This planned and conducted talk completely reveals the temperament and intelligence of the applicant. The information thus obtained is recorded on a special rating form. Then the candidate is put through the tests described above and is only selected if she comes upto the standard in these tests. It might be interesting to note how far these tests have been found useful. One hundred and seventeen girls have been selected after tests and as an experiment a batch of thirty have been engaged without tests. In the tested group the percentage of failure is nine per cent. whereas in the other group it is thirty per cent. This is only the percentage of failures; if to this is added the better efficiency of the tested group, the benefit derived by systematic selection is certainly considerable.

The other most important duty a personnel department has to undertake is the creation of good human relationship between management and workers and between workers and workers. Deficiency in this is manifested in extreme cases by strikes and hold ups and more often by the increase in the rate of absenteeism. The study of absenteeism is therefore the index of human relations in a factory. The rate of absenteeism in the National-Ekco has shown a steady decline in the last seven months. In August last, man-hours lost due to absenteeism was ninteen per cent of the total man-hours worked. Today it is four per cent only.

How has this been achieved? Initial correct placement in jobs, improvement in the working conditions and good efficient medical facilities are, of course, pre-requisites. But unless the workers are given full opportunity to develop team spirit, job-interest and dignity in their work and unless they can give vent to their creative imagination—good human relationship will not exist. There is only one way of achieving this; through joint consultation. This has been provided by present day Joint Consultative Committee such as Works Committee, Production Committee, Safety Committee and Suggestion Committee.

The National-Ekco started these Committees as soon as the Personnel Department was set up. Works Committee was set up in August. It is composed of an equal number of representatives from the management and workers; workers representatives

being elected by the workers themselves. The Works Committee has an unlimited scope and can discuss anything affecting the factory and personnel with only one exception. No question relating to pay or increment is allowed for discussion in this Committee. How well the Committee is functioning in the National-Ekco can be seen from the quotation given below from the minutes of one of the Works Committee meetings—"Mr. Martin Fernandes, thereupon, exhibited sample components and narrated the difficulties which had been experienced in making and or assembling them, which is the direct cause of inadequate production. He made a number of practical suggestions for improvement and requested the management to take necessary action." This paragraph is only one instance of many such where workers have shown interest in their work.

Space will not permit me to discuss the functions of all the Committees and also other work of the Personnel Department. Each one of these committees has its merit and plays an important role towards betterment of industrial relationship which is so necessary for efficient control of industry.

After reading upto this point one might be tempted to say, "Yes, it all sounds good, but how much is the gain, in rupees, annas and pies. After all saving in rupees, annas and pies all that matters in industry." The answer to this question is that the saving is substantial.

The difference in the failure between two groups of selection is twenty-one per cent. which in a group of 117 is a saving of thirty failures. Now supposing each of these thirty girls had worked for a month before they were detected as unfit, the total financial loss would have been Rs. 85 X 30 = Rs. 2,550 (Rs. 85 being the average earning of an assembly girl). This total takes into account only the loss due to direct pay and not the loss due to lowered efficiency which surely would have been several times this sum. Saving on absenteeism is still more striking. The fifteen per cent improvement in absenteeism in a factory of 500 strength gives equal man-power saving of 15 X 5= 75 everyday. Taking the average daily wage figure as Rs. 4/- per man (and each man produces twice his wage in production value which is a very conservative estimate) the total saving in production would not be less than Rs. 8 X Rs. 75=Rs. 600 per day.

Most important of all however is the question of operation efficiency. It is generally admitted that, the present efficiency of the average Indian factory worker is less than half that of Western standards. In cases where time study is used a direct assessment of operator efficiency is possible and in the National-Ekco Factories this has shown a marked improvement within the last six months. Even if an improvement of only ten per cent. in this factor is obtained, the actual saving in cost per cent. of production is several times the total cost of operating **a** Personnel Department.

From this cursory survey of the seven months working of the Personnel Department of the National-Ekco Radio & Engineering Company, it will not be wrong to assume that the novel project undertaken by this small Tata concern is bearing fruit. The Department has fully justified the hopes cherished by the Company's Director and General Manager, Mr. Howie at the time of its inception. We may conclude by saying that it is not impracticable to combine beneficially in small factories the medical department and a personnel department for the sake of economy.

. (By Dr. H. Mukerji, Reprinted from **Tata** Monthly Bulletin).

MODERN DEVELOPMENTS IN LEPROSY

LEPROSY ! A word which, despite the almost continuous propaganda of the past fifteen or more years, strike fear into the heart of man. So hysterical is the general public's attitude towards leprosy—and this applies to all countries—that it only needs the announcement of a new cure to set the press tapes ticking all over the world. I welcome the privilege and honour of speaking at the Bombay Presidency Women's Council, for I firmly believe that it is the women of this land who can do more than any other single group to help us dispel the ignorance of leprosy—an ignorance which breeds fear, for what is not understood is feared, and fear results in a cruel and inhuman attitude towards the thing that is feared.

Leprosy, unfortunately, has social implications which are very far reaching. One only needs to remind oneself of the word "LEPER" to realise what social ostracism surrounds the disease, and in many ways the more enlightened the community the greater the social penalties placed on the person with leprosy. So great are they that they lead to the hiding of the disease until infection of others has taken place and gross deformity "set in", rendering the patient a still greater drag on society. One only needs to experience the methods an educated family adopts to hide the knowledge that they have a case of leprosy in their midst to be aware of the social implications. The fear of others knowing is so great that younger members of the household are exposed to infection lest the very precautions, simple though they are, reveal the fact of the disease. Modern developments in many ways have increased this tendency to hide the disease and all kinds of devices are resorted to in order that the fact of treatment may be kept secret.

Before, therefore, an account of modern developments in treatment and in research leading to alleviation of deformity can be given, it would be well to remind ourselves of a few fundamental observations concerning this disease. The basic cause of fear of leprosy is that leprosy in the days of long ago was confused with many other diseases. Religion decreed, and for excellent reasons, that if a person had a deforming, infective or disfiguring disease he should be separated from the rest of his fellowmen. The best illustration of this is seen in the attitude of the Jews. All persons were ceremonially and permanently unclean if a blemish which proved to be permanent was found on their skin. Such people were put without the camp of Israel and condemned to isolation. In the early days when diseases had not been differentiated, persons with infective, mutilating or disfiguring diseases came under the same sentence—"Unclean, unclean, without the camp shall be their habitation." These diseases which resulted in separation from the community were all grouped under the one name, which in the Hebrew was called "Zarath". When the Old Testament scriptures were translated this word unfortunately was rendered "Leprosy". Consequently there arose a fear and horror of the disease which was almost entirely unjustified and led to social implications which resulted in untold suffering in the name of hygiene. This attitude was not confined to the Jewish race, for there is hardly a people which have had leprosy in their midst for centuries that do not practise, wittingly or unwittingly, mental and, at times, physical cruelty on the unfortunate sufferer from leprosy. One only needs to refer to that detested word by which the sufferer is known—"LEPER"—to realise the full force of this statement. Some of us

for many years have avoided the use of that word, for it implies an insult to those whom we consider our friends and whom to serve is a rare privilege granted only to a few. Recently, however, this word has been banned by international consent and I trust that the word "LEPER" will speedily disappear, not only from our lay vocabulary but also from medical parlance, as surely as the words "consumptive" and "lunatic" have fallen into disuse in connection with tuberculosis and mental ill health. Leprosy being one of the earliest diseases known to man has come under condemnation in many faiths, not only because of its antiquity but because its insidious onset, its progressiveness and its final mutilation, combined with the fact that the patient seldom dies of the disease, has struck fear into the heart of man.

This, then, is the background against which we have to consider our subject of to-day. As a result of the researches and pioneer work of many in the past, certain fundamental facts have been elucidated and the knowledge of these should help to dispel fear and engender a more reasonable attitude towards the disease and towards those who suffer from leprosy. I will enumerate the main facts which are now known:—

1. All leprosy is not infective—probably only about 20% of all the cases in India are capable of transmitting the infection to healthy persons, particularly children. If a person is not infective, be he ever so mutilated, he cannot pass the disease on to another.

2. Leprosy is not a hereditary disease. There is no such thing as a leprosy taint.

3. Leprosy is acquired most frequently in childhood by constant contact with an infective or open case. Adults are, generally speaking, non-susceptible to the disease. Even in the closest relationship of life, that of marriage, only in about *5%* of instances will the healthy partner acquire the disease.

4. Many children recover spontaneously from leprosy before adult life is reached—i.e. in only a proportion of cases does the disease progress. It is the doctor's task not only to diagnose leprosy but to give some estimate as to whether the person—be he child or adult—is likely to progress to the more advanced stages of the disease.

5. The mutilations and deformities which are frequently seen are signs that the body is overcoming the disease and in its grim fight with the invader has caused damage to vital structures such as nerves and, through nerves, to muscles. I would remind you that the tissues of the body are no strangers to a "scorched earth policy".

In the light, therefore, of the above facts, let us consider the modern developments of leprosy from the following points of view and relate our discussion to the social implications of the problems which arise:—

A. Advances in our knowledge of prevention.
B. Advances in our knowledge of physiotherapy and orthopaedic surgery in relation to leprosy.
C. Advances in our knowledge of therapy.
D. Social implications and duties in relation to the above advances.

A. Advances in our knowledge of prevention.

I place this in the forefront because the fact remains that even with the advances in therapy, our treatment is not so sure of effecting a "cure" within so short a time that precautions as to infecting others can be given up in their entirety. There is much speculation as to the method by which leprosy is conveyed from the infected person to the healthy, but all our investigations indicate that normally the only factors that really matter in the spread of the disease are (i) age, (ii) infective case and (iii) con-

tact with healthy persons. There are other factors of subsidiary significance, but to mention them only detracts from the immeasurably more important part the above factors play in the acquirement of leprosy and unnecessarily complicates the preventive picture.

If, then, the aim is to prevent infected people from coming into contact with healthy persons, particularly children, why not forcibly isolate every infective case? Compulsory isolation is impossible of enforcing in India—(i) Because early infective leprosy is easy to hide and by the time a case is discovered infection has already taken place. (ii) It is inhuman to isolate a person for life and make no provision for his family. It is a policy impossible of adoption and unreasonable in execution to separate a person for years from contact with the outside world, and it is an inhumanity which is self-condemnatory. The only justification for such a policy is when there are so few known infective cases of leprosy that it would be possible to isolate every case—then there would be some reason for compulsorily isolating such persons, provided the families are cared for by a State subsidy and the patients are discharged as soon as possible after they are declared non-infective. (iii) Compulsory segregation is costly and results in expenditure of money on a disease which is out of all proportion to its importance as a public health problem. Nevertheless, because leprosy is a communicable disease under certain conditions, it is necessary for some measure of isolation to be adopted if there is to be any hope of controlling leprosy within a measurable period of time. Segregation must, however, be only partial. Evidence of a fairly conclusive nature is forthcoming to show that by preventing night contact of infective cases with healthy people, particularly children, there is a reasonable hope of controlling leprosy in a village community. Details from the Leprosy Preventive Unit some 20 miles from Chingleput support this. The social implication of this discovery is obvious. If, in addition to spending effort and time on trying to persuade Government to take the beggar case of leprosy off the streets of Bombay, energy was directed towards the education of the public in the modern preventive approach to the problem of leprosy, we should be nearer the solution of this problem. If the Bombay Presidency Women's Council persuaded women to preach—in season and out of season—the following simple principles, a great advance towards the control of leprosy would be made in the State:—

(i) If a person has leprosy it is essential to find out whether he is infective or not.

(ii) If he is shown to be infective, the patient should strictly observe the following precautions:—

(a) Keep apart from children—this is a self-discipline that every infective case must learn.

(b) Keep all personal utensils apart—sleeping, washing, eating.

(c) Sleep apart from the family and in a separate room.

In villages in India these conditions can be achieved by erecting separate huts outside the village linked up with a treatment centre where there is a resident doctor to care for the cases. Propaganda is then undertaken to persuade the infective case to sleep apart from his family. As has been stated, this method is already proving successful, for in the villages in the Chingleput district where there is a night segregation unit the incidence of leprosy has very markedly diminished over the past ten years; whereas in another village, where nothing has been done and the popultation is relatively static, the increase in the disease is now $2^1/_2$ times that of ten years ago! In towns, night segregation is much more difficult, but if friend-

ship leagues were formed and the problem of leprosy brought out into the healthy light of day, the social welfare and voluntary worker, by befriending the household in which there is leprosy, could do an inestimable service in hastening the day when leprosy was controlled. It would then only be a matter of time before it was finally eliminated.

B. Advances in our knowledge of Physiotherapy and Orthopaedic Surgery in relation to leprosy.

To-day, when there is so much written about the "cure" of leprosy and so much expectation abroad concerning the new Sulphone therapy, I must remind my audience that to raise hopes with Sulphone therapy when there is irretrievable nerve damage is a refinement of mental torture which a physician can unconsciously inflict on his patient in his over-anxiety to give him the latest remedy. Let me also remind you that only a comparatively small proportion, taking the whole leprosy population, can benefit by Sulphone therapy. In the first place, sulphones are the drug of choice in the lepromatous (infective) cases of leprosy and over 80% of all cases in this country have that type of leprosy which tends to deform and multilate and may not be infectious. Further, of the infectious cases a large proportion show nerve damage which will ultimately result in gross deformity. This does not respond to specific therapy and will only yield to intelligent physiotherapeutic and orthopaedic measures.

During the last two years intensive study of the orthopaedic aspects of leprosy has been undertaken both at the Government Lady Willingdon Leprosy Sanatorium, Chingleput and at the Christian Medical College, Vellore. These studies are opening up an entirely new approach to the leprosy problem and give hope that those who show early deformity can be relieved and those who have advanced deformity can be so treated that they can regain function of their limbs to a large extent. I believe that through the excellent work of the ladies of Bombay much attention is now being given to physiotherapy and occupational therapy. If there is available a trained physiotherapist who could be spared to work in the field of leprosy, I am certain that she would find a sphere of interest which would not only lead to original discoveries but would bring as great, if not greater relief from suffering than that brought about by the Sulphone drugs. I myself would be happy to give such a person facilities to do her work so that after working under the visiting Orthopaedic Surgeon at Chingleput she could return and bring relief, healing and peace of mind to the many sufferers in this State who have lost all hope—for they have found that the new drugs can benefit the active and infective cases very greatly, but make not one iota of difference to those who have deformities or who are threatened with paralysis. Here lies a challenge to all those of goodwill, for to relieve this suffering is to take a mighty burden off a group of persons who are indeed in the valley of despair.

C. Advances in our knowledge of therapy.

All who are familiar with the history of leprosy are aware that almost every year some outstanding claim is made for this or that drug in the treatment of leprosy. Unfortunately, if enough publicity is given to such claims the news travels round the world and great hopes are raised, all too frequently to be shattered in a few years in the light of further experience. The Chaulmoogra, or more correctly Hydnocarpus treatment of leprosy was rediscovered and popularised some thirty years ago and still remains, if applied adequately and effectively, despite adverse criticism, the treatment of choice in a large number of cases. It is true, however, to state that the proper administration of the

hydnocarpus preparations involves **painful** injections. The results frequently are uncertain and the relapse rate too high to give the physician any real peace of mind. In view of this fact and because of recent statements of the astounding efficacy of **a** drug named Diamino-diphenylsulphone, it might be well to attempt to evaluate the claims of this new treatment, for to those who long for relief from the bondage of this disease a new cure comes as a ray of hope into the darkness of their night.

I cannot at the time at my disposal include a critical appraisement of the Hydnocarpus (Chaulmoogra) therapy, but it should be emphasised that until more knowledge of the new Sulphone drug—using that name to cover the parent substance Diamino-diphenylsulphone as well as derivatives such as Promin, Diasone, Sulphetrone etc.—is acquired and until these drugs are cheaper hydnocarpus therapy, adequately applied and intensively given, cannot be discarded for many types of leprosy.

The history of the new drug for leprosy goes back some forty or more years. In the year 1908 a new substance was discovered by the Germans which was a bi-product of the dye industry and was named Diamino-diphenylsulphone. This substance caused no interest until about thirty years later when chemists and bacteriologists renewed their search for drugs which would kill bacilli in the system and the science of chemo-therapy began to pass from its infancy to **full** adult life. British workers discovered in 1937 that Diamino-diphenylsulphone had the power of killing septic organisms. This discovery was made before the Sulphonamides had been isolated. Unfortunately, when **this** drug was used, the earlier workers found that it caused such serious toxic effects that it had to be discarded. Because of the extraordinary power Diamino-diphenylsulphone (DDS for short) had to kill disease-producing bacilli, it was natural that the attention of research workers should turn to tuberculosis—that other great scourge of mankind. An American pharmaceutical firm manufactured the first derivative of DDS which was capable of injection without serious toxic effects and reports were soon published of the efficacy of this substance in arresting the progress of tuberculosis in animals. Because of the similarity of the two diseases—leprosy and tuberculosis—it was not long before this new drug was tried out in leprosy. It was found that the drug, had a very marked effect on advanced leprosy, especially in the nodular variety. As a result of dramatic improvement, articles began to appear in the medical press and the news was taken up by the lay press. These reports speedily gave rise to the conviction that at long last leprosy could be certainly cured by these new and powerful remedies.

In evaluating the results of treatment it is necessary to define the basis upon which a cure is judged. In this connection it must be pointed out that certain types of leprosy, as already indicated, show a great tendency to spontaneous healing and therefore in judging the value of a cure, these cases, and cases in which it is difficult or impossible to assess results, must be rigidly excluded from any reports of "cure" in leprosy. The criteria for deciding that a drug, is effective in leprosy should be as follows:—

(i) The drug must render the patient non-infective within **a** reasonable period of time (2-5 years) **and** the patient should be free from relapse over at least a five-year period.

(it) The drug must be (a) relatively cheap, (b) non-toxic and (c) easy of administration.

In the light of the above tests, **Sulphone** therapy can be reviewed.

(i) **It is true that the Sulphone preparations—be they Promin, Sulphetrone, Diasone**

or the parent substance DDS—will render a considerable proportion of cases negative within a 2-5 year period. The exact percentage is still unknown, but it is very much higher than with the older Hydnocarpus preparations. It should be mentioned that when the "Sulphones" are administered, a significant number of cases pass through bouts of reaction, sometimes severe, before improvement definitely sets in. The remarkable fact appears that in comparison with the standard Hydnocarpus treatment, the later stages of the disease (in the infective form) may respond to Sulphone drugs better than the earlier cases. Evidence at the Government Lady Willingdon Leprosy Sanatorium, Chingleput, shows that in the early stages Hydnocarpus therapy, properly applied, is as effective as Sulphone therapy. Hydnocarpus therapy, however, is more painful and more tedious to administer. In the later stages of the disease the "Sulphones" have a remarkable effect in clearing up signs of leprosy, but unfortunately, while a patient may look very much better, the bacilli in the skin take a long time to disappear—so long in some cases that one speculates as to whether this will ever take place. While, therefore, the Sulphones may be curative in a considerable proportion of cases, in others they may be suppressive and never render the patient free from infection. Whether relapses occur on any large scale is yet unknown, but so far no cases of relapse have yet been reported in patient rendered negative by Sulphon therapy.

(ii) If a drug is to be universally used in the treatment of leprosy it must be:—

(a) Relatively cheap. Apart from oral administration of the parent substance DSS, all Sulphone drugs given by mouth are excessively expensive, costing from Rs. 200 to Rs. 500 to treat one patient for one year. The most convenient form, from the point of view of expense, is an aqueous solution of one of the Sulphone derivatives. The work in Madras has demonstrated that the cost in this way has been reduced to Rs. 30/- per annum per case. The only reason why this drug is not used more extensively is because the present policy of restriction of imports make it impossible to import sufficient quantities into the country.

(b) Non-toxic. Judged by this criteria, DDS cannot be considered at present as the most suitable Sulphone to administer. It is true that there is a much smaller tendency to produce serious toxic results if dosages of less than 1.5 grammes a week are given. Injections of DDS suspended in an oily medium are being given in Chingleput, but the preparation of this is tedious and steps must be taken to ensure that the right dosage is administered. Recent reports have indicated that DDS given by mouth in relatively small dosages is largely free from toxicity, but to organise treatment on a large scale, based on tablets given daily, is an obvious difficulty because if patients do not follow instructions implicitly dangerous complications may arise. Experiments are being undertaken to see whether some of these defects can be remedied, but until this obvious drawback is overcome DDS is considered unsafe except when given under strictly controlled conditions.

(c) Ease of administration. While oily emulsions or suspensions of the Sulphone preparations are in many ways to be preferred, until the mechanical difficulty of injecting the relatively large quantities needed for effective therapeutic action is overcome, these also are not possible to use on a large scale.

It will be seen, therefore, that while considerable advance has been made in Sulphone therapy, the time has not yet come to state that this or that Sulphone prepara-

tion is the drug of choice. It may be said that therapeutic research is being done in India under strictly controlled conditions and is not behind that of other countries. If import restrictions were eased it would be possible to recommend a safe and reasonably effective Sulphone preparation for general use, but so long as supplies are limited as a result of currency difficulties, widespread publicity will only raise hopes which are not possible of fulfilment.

Research workers in India are constantly working at the therapeutic problem of leprosy, and all drugs—be they Western or Eastern in origin—which give the slightest hope of success are tried. It is therefore encouraging to know that workers in India are in no way behind their colleagues in research in the modern therapy of leprosy and it is sincerely hoped that ere long the therapeutic battle against this age-long disease will have been won,

DR. GARDNER MURPHY AT THE INSTITUTE

Dr. Gardner Murphy,* UNESCO Consultant on the study of Group Tensions, undertaken by the Government of India, was on a visit to Bombay in September 1950. As the Tata Institute of Social Sciences is actively co-operating in the project, he was invited to address its students and staff on "The Problem of Social Integration". Dr. Murphy readily agreed and visited the Institute on Monday, September 11, 1950.

In the course of his address, Dr. Murphy observed that, in the beginning, all life was undifferentiated and formless. It was in a diffused or global state. This was followed by friction or collision, causing differentiation. In this stage started the discrimination of sex, age, skills. When these differentiated parts became interrelated, there emerged the third stage of integration in the human body, in the society and in the nation. Therefore, integration without differentiation was bound to fail. Hence no attempt should be made at integration in the global or undifferentiated state.

Continuing his main thesis, Dr. Murphy said that all integration was not necessarily good, just as all differentiation was not necessarily bad. Respect for and treatment of men must be personalistic. Each individual has a definite personality and that has to be respected. In the United States, there is integration going on of different industrial units. But this is being achieved for purposes of efficient economic exploitation, which is not a healthy feature or development. Dr. Murphy felt that, if this integration had instead been directed towards the goal of achieving co-operation, it would be accomplishing more healthy social results.

If there is to be integration of human family, it will not come by saying that there should be inter-racial or international mix-up. This should be attained by a gradual *democratising* process. Frank recognition of differences and welcoming contribution by different or dissentient elements without enforced leadership from above is likely to bring about better results for humanity.

*Dr. Gardner Murphy, an internationally reputed psychologist, is Professor and Chairman of the Department of Psychology in the City College, New York (where nearly 35,000 students receive their education). In 1938, he was elected President of the Society for the Psychological Study of Social Issues, and in 1943, of the American Psychological Association. Among the books he has written, the most well-known are: *A Historical introduction to Modern Psychology, Experimental Social Psychology* (with T. M. Newcomb), *General Psychology, Public Opinion and the Individual* (with R. Likart), *Personality* and *Human Nature and Enduring Peace*,

Before joining the City College, Dr. Murphy taught in the Harvard, Vale and Columbia Universities. He was a recipient of the Butler Medal of Columbia University.

In the West, education is being used for promoting competitive spirit in the mind of man. This is very undesirable as it has been the root cause of so much social destruction in the recent past. Education should, on the other hand; become a medium for fostering a co-operative spirit in man. Dr. Murphy, in conclusion, expressed the hope that India would so model her educational system as not to promote the destructive spirit of competition but to create and encourage a co-operative sense among her citizens.

At the end, there was a discussion in which both students and staff took part.

Dr. J. M. Kumarappa, Director of the Institute, was in the Chair.

On Wednesday, 13th September 1950 at 6 p.m., the Trustees, Members of the Governing Board and Faculty of the Institute gave a reception at the Taj Mahal Hotel, in honour of Dr. Murphy, when there was an informal discussion among those present on various problems.

DR. P. H. PRABHU

Dr. Pandharinath Prabhu who was Honorary Reader with us since February last has now joined the Faculty as Reader in Industrial Psychology and Research Methods as from June 1950. Dr. Prabhu took his B. A. Hons. with Mental and Moral Philosophy from the University of Bombay in 1930, LL.B. in 1933, and Ph. D. in 1937 with a thesis on the Psychology of Hindu Social Institutions from the same University. He was a Research Scholar and later Research Fellow in the University. Dr. Prabhu's book on the Psychology of Hindu Social Institutions is very highly spoken of by the press and scholars in India and abroad. It is considered as a standard work on the subject and is used as a text book for M. A. in many Indian Universities. He has also published over twelve monographs and papers on socio- psychological subjects.

Since 1938, Dr. Prabhu has been teaching Psychology and Sociology in the University of Bombay. In 1939 he was selected by the Syndicate of the University of Bombay to officiate as University Lecturer in Sociology during the absence of the University Professor. He was also the Maharaja Sayaji Rao Lecturer for 1942, at the invitation of Baroda Government.

Three years ago, Dr. Prabhu was selected by the Overseas Scholarship Committee of the Government (Public Service Commission jointly with a Committee of Experts) to hold their Foreign scholarship for two years for advanced studies in Applied Psychology and Research Techniques, and was sent to U.S.A., and to Cambridge (England) and France. While in the U.S.A., he was, in recognition of his scholastic achievement, awarded the status of an Honorary Visiting Scholar in Columbia University and in the University of Pennsylvania (by invitation) in their Departments of Psychology, and of an Honorary Fellow in the University of Minnesota. He worked under Professors Gardner Murphy, T. M. Nevicomb, Rensis Likert, D. Katz, M. S. Viteles, and Sir Frederick Bartlett. He was elected an Associate of the American Psychological Association, an "Active" Member (i.e. Class I) of the American Sociological Society, and an "Active" member of the International Congress of Psychotechnology.

FAMILY WELFARE AGENCY, BOMBAY

Some time ago, a few enthusiastic professional social workers met to discuss the feasibility of starting a Family Welfare Agency in Bombay. It was felt that in a big city like Bombay, family problems were acute and complicated due to various reasons. It was thought that social scientists should tackle the problem of family living, considering family life as the cornerstone of a good society. Steps were taken in this direction and a preliminary Committee was formed to do the spade work.

With the financial help of the N.M. Wadia Charities and the American Woman's Club, the Agency was brought into being on 1st May 1950, and Miss Usha Rani Kanal, a graduate of the Tata Institute of Social Sciences, was appointed Family Case Worker. Lady Jehangir and Dr. K. S. Mhaskar of the Bombay Mothers and Children's Welfare Society, kindly agreed to allow the Agency to have its office at their Society's premises at Delisle Road, Bombay. Recently the Sir Dorabji Tata Trust sanctioned a munificent donation of Rs. 3,000/- towards the Agency which has greatly facilitated its work.

The Agency acts as a counselling body to the public. In most cases an individual in a family or the family as the unit is able to handle adequately certain problems. But there are those which cannot be dealt with satisfactorily without some assistance. They may be so overwhelmed by special problems that they cannot think through and arrive at an adequate solution. It is in such cases that the need for a Family Welfare Agency is felt. Sometimes financial and material assistance is also needed along with the skilled counsel. The Agency will, we hope, be in coming years of immense help in counselling on problems of family relationships, marital adjustments, financial and vocational planning, or for working out parent-child or employer-employee relationship and so forth.

Though it is true that, in a city like Bombay, there are scores of urgent and pressing social problems, yet the importance of the need for a Family Welfare Agency cannot be minimised. The problem of family welfare is very vital to our society. When problems are treated at the family level, many of their offshoots like juvenile delinquency, adult crime, alcoholism, unmarried motherhood, are tackled indirectly.

The Tata Institute of Social Sciences has a specialisation course in Family and Child Welfare and the Family Welfare Agency which is worked on moderen lines will provide a good field work centre for practical training in this branch of social work.

ALUMNI NEWS.

New Executive Committee:—At this year's Annual General Meeting of the Alumni Association, Dr. Miss Perin Vakharia was elected President. Subseqently, the following persons were elected as office-bearers:—

T. L. Kochavara	*Vice President*
K. A. Zackariah	*Treasurer*
Miss Freny Gandhi Miss S. Bhatia	*Joint Secretaries*

Other members of the Executive Committee are Miss S. F. Dastur, Mrs. R. Shroff, Miss Sheroo Mehta, N. F. Kaikobad and S. D. Gokhale. Mrs. Indira Renu was co-opted on the Committee for the purpose of conducting the study circle on child welfare.

The first task of the Committee is to keep an up-to-date list of names and addresses of all the alumni. It is found that some of them are forgotten and a few prefer to

remain unknown. So, the alumni are requested to assist the Committee in this matter. A campaign for collecting membership fees has already been undertaken by Miss Dastur and others.

As it is felt there is a need for helping some of the alumni in securing suitable jobs, the Executive Committee is exploring the possibility of starting an employment bureau in collaboration with the Institute. Some preliminary work has already been done in this connection.

Resignation of the President:—The President tendered her resignation within a few months after her election to this high office, as she was required to leave Bombay to take up the post of the Head of the Baroda School of Social Work, M. S. University, Baroda. However, Miss Vakharia is keeping in touch with the activities of the Association. The Vice-President, Mr. Kochavara, is now carrying on the duties of the President.

United Nations Fellows:—John Barnabas, Assistant Secretary, Prohibition Board, Bombay, is observing Public Recreational Systems and Welfare Administration in the U. S. A.

2. P. R. Rao, Governor, Borstal School, Dharwar, (Bombay), left for the U. S. A. for observation study in the field of rehabilitation of offenders.

3. K. Paul, Field Work Supervisor, Delhi School of Social Work, is observing field work arrangements and supervision in the American Schools of Social Work.

4. Mr. T. Edward has left for Europe for observation study of labour conditions on the continent.

5. Miss Kokila Doraswamy has left for Europe to observe Child Welfare arrangements on the continent.

Picnic:—In the month of April, a picnic was arranged at Mamori Island, when several alumni and some of the staff members of the Institute participated. Swimming was one of the most important items on the programme.

Farewell Party:—B. Chatterji, Executive Secretary, Indian Conference of Social Work, was given a send-off by the Alumni Association in the month of June, prior to his departure for Paris to represent the Conference at the International Conference of Social Work.

Social:—In the month of August, we had arranged a social to welcome the new batch of students of the Institute. The other students and the staff also were invited. It was a gay function enjoyed by one and all. Sorry for those who missed it.

Rest of the News:—Our Treasurer has been elected as one of the members of the Board of Directors of the Y. M. C. A.

Miss Batliwala has received her Master's degree in Social Work from Smith College in the U. S. A.

Miss S. F. Dastur and Mr. V. R. Baktavatsalam left for England in September for higher studies in Social Work.

Late Miss P. F. Ginwala:—A condolence meeting in memory of late Miss Ginwala was held in the first week of September at the Y. M. C. A. Some of the alumni who had gathered on the occasion paid tribute to the selfless and outstanding work done by Miss Ginwala in her home town of Broach.

ANNOUNCEMENT

The Tenth Convocation of the Tata Institute of Social Sciences, Andheri, Bombay, will be held on 3rd December, 1950 at 5.30 p.m. at the Institute's premises. The Hon'ble Rajkumari Amrit Kaur, Minister for Health, Government of India, has kindly consented to deliver the address. Dr. John Matthal a Trustee of the Institute, will preside on the occasion,

TATA INSTITUTE NOTES

Class of 1950-52

1. el Arculli (Mrs.) V. L.,
   B. A., Bombay University, 1942
   Poona, Bombay State.
2. Birjay, R. M.
   B. A., Mysore University, 1949
   Bangalore, Mysore State.
3. Calla, V. K.
   B. A., Agra University, 1946
   LL. B., Nagpur University, 1948
   Jodhpur, Rajasthan State.
4. Deshpande, S. P.,
   B. Sc, Nagpur University, 1942
   M. Sc, „ „ 1944
   Buldana, Madhya Pradesh.
5. Dube, D.,
   B. Com., Rajputana University 1948
   M. A., Agra University, 1950
   Harsud, Madhya Pradesh.
6. Gangrade, K. D.,
   B. Com., Agra University, 1948
   M. A. „ „ 1950
   Indore, Madhyabharat.
7. Govind (Miss) C,
   B. A., Allahabad University, 1948
   M. A., „ „ 1950
   Gorakhpur, Uttar Pradesh.
8. Hathi (Miss) A. R.,
   B. A., Bombay University, 1950
   Bombay City.
9. Iraqi, F. R.,
   B. A., Agra University, 1950
   Azamgarh, Uttar Pradesh.
10. Iyer (Miss) N. K. M.,
    B. A., Bombay University, 1950
    Bombay City.
11. Jalnawalla (Miss) R. J.,
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