(Continued from page 1)

and malaria runs rampant. Away from the banks are boundleass plains where rice is grown and shifting agriculture practiced. The river provides the main form of transport among the villages but it is also the source of gastro-eneteritis and cholera which are the main causes of mortality and morbidity. The river is where people piss, shit, dump their sewage, wash their clothes, have their bath and get their drinking water. Most if not of the villagers boil their water before drinking, but I would think there is much to be done to set up some form of sewage disposal. But it can be seen how difficult it is to convince people that the more convenient way used for ages is not the best way.

Communication among villages are mainly by boat, or by bicycle. Only larger villages are served by by unsurfaced roads wide enough for a jeep. This, together with the scarcity of motorised vehicles create great difficulty when a patient from outlying villages requires more intensive care in hospitals.

THE WORK

Using a large village as our base, we went out to surrounding smaller villages to set up temporary outpatient's clinics. Some villages are rather far away — the trip to the village of Bedjaja, for example, took us four hours by boat. Many of them had not seen a medical team for a long time, and everywhere we were making a scene. We used the local village office or the police quarter for our clinic for there were no permanent set-up for the purpose. Each medical student was expected to work on his own, examining patients, forming diagnosis, and giving prescriptions as well as injections. The supervision from the doctor was only minimal, first because of the large number of patients (over 150 in a morning), secondly because even the doctor cannot do much more with the limited drugs and diagnostic facilities. There was no point in taking a detailed history or doing a meticulous physical examination for the patients' sake, even if there was enough time. In the absence of radiologiacl, bacteriological and other laboratory ancillaries, with the lack of drugs and surgical facilities, the practical procedure of enforcing rigid therapeutic schemes and folow-ups — a more cursory procedure is just as adequate. In one occasion, I had to treat all kinds of patients that came along with either multivitamins, INH, sulphonamide, or erythromycin ointment. There were no PR gloves and the sterilizng apparatus has to be set up from make-shift gadgets. Language was a signicant problem, naturally for me, but also for the Indonesian students. The indigenous Bungaris people speak a dialect somewhat different from Javanese which my colleagues speak.

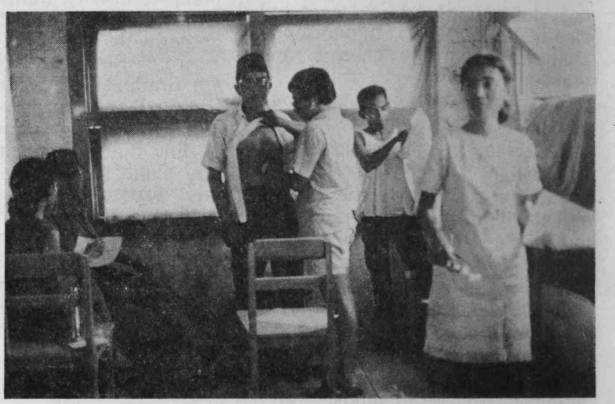
The patients' complaints were mainly chronic cough with chest pain suggestive of pulmonary tuberculosis, and non-specific complaints probably indicative of nutritional deficiencies though more sinister diseases could never be excluded. There were others with intermittent fever, and many cases of endemic goitre. Pallor was prevalent for the patients that we met. There are no filariasis in Hulu Sungai Selatan, but the disease is endemic in other regions (e.g. Hulu Sungai Utara) where some of my friends saw full-blown cases with elephantiasis.

MCH

We had also been meeting some young mothers in our Mother and Child Health Clinics, where we gave little talks concerning nutrition and psychological development of the infant as well as about family planning. These mothers were all the way rather passive and undemanding and one doubts if they were attracted by the vitamin pills that we gave away rather than the unfamiliar ideas that we tried to sell.

The marital age is very young and one of the mothers we met got married at 13. It is said that these girls never have to masturbate since they will get married when their first period came. It is average for a family to have 8 or 9 children, a large brood being

(Continued on page 3)



Make-shift OPD. Hope no heart attack in our staff (Tong)

The Editorial Board wishes to thank the special Support of glaxo (HK) Ltd.

LETTER TO THE EDITOR

Dear sir,

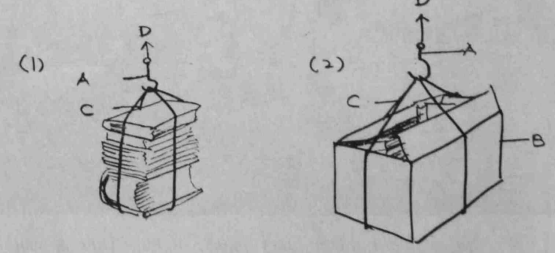
Recently the staff of the Medic Library have been busy over the incorporation of the extension and this involves the transport of many books from one part of the library to the other. I appreciate this means hard work and a lot of sweating but I am more dismayed by the way the books are handled. One does not have to be a booklover to object to this. A reasonable regard for the value of books should motivate one to think out more gentle and practicable ways of transport — than the crudest way of all, throwing the books about. How one's heart aches at the sight and sound of the books spanking on the floor.

Deducing from the friendly relationship between the staff and the user of the library, I have no doubt as to the willingness and sincerity of them. Hence it may be that the staff, owing to the pre-occupation with their work, have taken less than usual precautions. So I wish to venture two suggestions to the library staff.

Maybe this can make the task easier, faster and kinder to the books.

Thanks.

Yours sincerely,
Kib.



A hook
B box
C string
D hook connected to a rope so that the whole lot can be raised to or lowered from different levels

ARMSA VIth General Assembly

VIth GENERAL ASSEMBLY, A REPORT

1. General

a) Date: July 15th to 21st, 1972 inclusive.

b) Place: Wisma Depkes, Hang Djebat IV/10, Djakarta, Indonesia, & University of Indonesia, Salemba Raya 6, Djakarta.

c) Attendance:

Australia, Hong Kong, India, Indonesia, Israel, Malaysia, Singapore, Japan, IMSOP.

e) Chairman of the 6th G.A.: Mr. Raveendran (Malaysia); Vice-chairman: Mr. Judilherry (Indonesia).

2. Subcommittees and their reports

a) Credentials Committee

i) Chairman: Mr. Cheng Kam Wing (Hong Kong). Members: Mr. David Scrimgeour (Australia), Mr. Ajit Sachdeva (India).

ii) It granted appropriate status to the participants.

iii) It pointed out that only AMSA and HK submitted valid 'Official Documents' required by Bye-Laws XVI part 8, and recommended in future the Secretariat and Organising Committee should remind members to do so.

iv) Each delegation should have only one vote.

v) Recommended the credentials to take a more standardised form.

b) Steering Committee

i) Chairman: Mr. Foong King Sun (Singapore), Members: Mr. Azrul Azwar (Indonesia), Mr. Sartani Avi (Israel), Mr. Ridzwan (Malaysia).

ii) Proposed the agenda for the 6th G.A.

c) Finance Committee

i) Chairman: Mr. Lau Toh Nee (Malaysia), Members: Mr. Cheng Kee Hwa (Singapore), Mr. Mohamad Slamet (Indonesia), Mr. Wong Wai Kung (Hong Kong).

ii) Examined the statements of accounts for period 1st August, 71 to 10th July, 1972.

iii) Recommended to send a letter of regret to Dr. Subramanian (Director of SCOP 1970/71) of Singapore for submitting to the G.A. a report which cannot be audited.

iv) Recommended to settle all outstanding debts of members.

v) Considered the setting up of the Trust Fund impractical.

3. Miscellaneous resolutions at 6th G.A.

a) AMSA should submit the completed new bye-laws and standing orders of ARMSA within 2 months.

b) The National Vice-presidents of member countries should preferrably be appointed within one month after the G.A.

c) Publications of member countries should include adequate coverage on news about ARMSA.

d) The ARMSA account will be opened in Malaysian currency at Bank Bumiputra, Kuala Lumpur, Malaysia in the coming year.

e) ARMSA subscriptions for member countries can be reduced in special cases on application to the annual G.A.

India applied to have its annual subscription reduced to US$25.00. It was granted. To help Indonesia to clear its understanding debts to ARMSA it was passed that every member country donated US$1 per participant to Indonesia.

f) Travel grants to Executive Board members
i) Mr. Raveendran applied for M$150 in case his application for government grant was rejected. It was granted.

ii) Mr. Cheong Pak Yean (Singapore) requested for M$60. It was granted.

g) Singapore proposed to bid for the host country of IFMSA 22nd G.A. in 1973. The 6th G.A. passed a resolution to support Singapore's bid, and instruct every member conutry to write individually to the IFMSA Secretariat to indicate support for this proposal.

h) **ARMSA members' subscription to IFMSA.**

i) Since the Executive Board of IFMSA rejected the proposal of the 5th G.A. that every ARMSA member only pay US$10 to IFMSA through ARMSA Treasury, the 6th

(Continued on Page 2)

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(Continued from Page 1)

G.A. requested member countries to indicate the max. subscription they are prepared to pay to IFMSA, as a basis for negotiation in the coming 21st G.A. of IFMSA.

AMSA	US$25
Hong Kong	US$15
India	US$10
Indonesia	US$10
Israel	According to membership number,
Malaysia	US$15
Singapore	US$15

ii) While recognising the right of IFMSA G.A. to review the subscriptions of member countries, the 6th G.A. recommendes the subscriptions for ARMSA members to IFMSA as above.

iii) The importance of being a member of IFMSA is in the sense of international friendship and goodiwll, but not, at present, in the actual benefits derived from professional exchange.

4. ARMSA Projects in 1972/73.

a) Clerkship/internship in Community Health Centres in Israel Details will be forwarded by Israel to individual members.

b) Rural Health Project in Indonesia.

5. Discussions

a) Professional Exchange among ARMSA members (proposed by Malaysia).

i) The next director of SCOPE will publish the ARMSA handbook for professional exchange as soon as possible.

ii) When ready, application forms for clerkship exchange will be obtainable from the ARMSA Secretariat at US$1 each.

iii) The Secretariat and Director of SCOPE will contact airline companies for fare reduction for exchange students.

iv) Dr. John Mathew from Singapore of the International Medical Students' Organization on Population (IMSOP) was empowered to promote student exchange within Asia.

b) Exchange of Information on various aspects of medical Education. (proposed by Hong Kong).

Topics under discussion included:

i) Student Representative in University Administration.

ii) Examination Systems.

iii) Curricula and correlation between preclinical and clinical years.

iv) Inclusion of some non-medical subjects in the medical curriculum.

c) Community Medicine (proposed by Indonesia) a talk was given by Dr.Rahadi M Santo, followed by discussion.

6. Invitations

a) The 6th G.A. endorsed an Asian Regional Medical Students' Seminar on 'Family Welfare Planning' sponsored by IMSOP, to be held at Singapore, possibly in Dec., 1972. Invitations were extended to medical students in Asian countries.

b) Invitations were extended to all member countries of Armsa to attend the National Seminar on Medical Education sponsored by all India Medical Students Association, to be held in Trivandrum Medical College in Kerala, India from Aug. 28-31, 1972.

7. Venue for 7th G.A. of ARMSA

a) First choice is India (to be held after 1st Aug., 1972) Confirmation should be sent to the Secretariat by 31st Aug., 1972.

b) Second choice is Malaysia, on condition that participants from Israel will be able to obtain their visas.

c) Third choice is Hong Kong.

8. New ARMSA Executive Committee for 1972-1973.

a) President: Mr. Cheong Pak Yean (Singapore)
Secretary: Malaysia
Treasurer: Malaysia
SCOP: Australasia
SCOPE: Israel
National Vice-Presidents: Australasia, Hong Kong, India, Indonesia, Israel.

b) An interim meeting of the Ex-Co may be convened at Singapore in Dec., 1972.

Cipher for front page headline:

Kerdja	**:**	**work**
Sosial	**:**	**social**
Kesehatan	**:**	**health**
Ke	**:**	**to**

The Indonesians call it Kerdja sosial kesehatan. The ARMSA people call it Rural Health Project.

ACKNOWLEDGEMENT

The Medical Society wishes to thank the following for their support towards the Delegation:

ICI (CHINA) LTD.
DYECHEM TRADING CO. (HK) LTD.
CIBA-GEIGY (HK) LTD.
PFIZER CORPORATION
HANG SENG BANK LTD.
CHINA ENGINEERS, LTD.
JAPAN AIRLINES
MR HENRY FOK

Wisma Depkes, Venue of 6th GA.

exposure

I was so tired when the day was done
She still dragged me out to have some fun
She looked at me with shining eyes
I knew I've got to tell some lies.

I told her I have acquired a pain
Down in the brain called Migraine
And bedresting was all I needed
In a mournful tone where I pleaded.

With suspicious eye she seemed to be in doubt
But she still insisted to go out
Tears dripped down her rosy cheeks
She kept on yelling "It's a cheat."

She let me down and went away
On that gloomy rainy day.
Goodbye I said to that girl
Who once existed in my world

We associated like opposite poles of magnet
And we got along very well without any upset
Though now I'm like a convict rid of chain
I wonder if we can ever meet again.

Love is a real hard game to play
I learnt it on that very last day
It's a game where no place for me
An individual with absolute freedom I love to be.

Love involves receiving as well as givings
Where I'm tired of all these proceedings
I hated marriage because it's a bond
Once the oath said and your liberty gone.

Why can't people in love just associate
Living together without marriage
Till they find they are incompatible
Then divorce is the process they can avoid the trouble.

A.T.

(Continued from Page 2)

necessary to make allowance for infant deaths which form part of their daily life. With the propagation of knowledge and the improvement of sanitary and health services, an initial growth in population is forseen. But unless the parents can be assured of a lasting son, there is no way of improvising any effective family planning program to eventually curb the population growth.

Diseases related to childbirth is very prevalent, like puerperal sepsis, premature abortion, retention of placenta, rupture of uterus etc. This is the case not only in the villages we visited, but also in large cities like Djararta. The related mortality rate must be considerably high but actual figures are not available. The most pressing problem now is to have somebody with at least the basics of hygiene to assist in each delivery. Efforts are being made to trian local women to be midwives and to offer course for the dukun-kambung[2] (indigenous traditional midwives).

CHOLERA PROGRAM

There was also a cholera case-finding program, in which we went to alternate houses in a village to ask for histories of diarrhoea and/or vomiting in the past week and to see any active cases present. Exact figures are not on hand but about 30% of all families visited gave positive histories. Several active cases of gastroenteritis were found, one case presenting with severe dehydration. Though a definitive diagnosis of cholera could not be made without means for bacteriological investigation, the clinical pictures in some instances were typical. My Indonesian colleague advised the patients to drink only coconut water since this is the only sure source of clean water. There was no means for intravenous drip, no way of bringing the seriously ill patients to the nearest hospital 60 miles away, and all we could do was to give some antibiotics and left.

SOME AFTER THOUGHTS

There were only 4 to 5 days of active field-work. The shortage of time and the language barrier did not allow me to go deeper into what I fleetingly saw. I would like to have learnt more of the people, their ways of life, their dietary habits, their upbringing of children, their cultures, their taboos, and their reaction to western technology and medicine. On the whole, the villagers I met were frank and friendly and extremely receptive to western medicine. Many patients would not be happy to go without a shot in the hind. Whether more out-lying villages or other ethnic groups react the same, I have no means to know. The influence of religion is omnipresent. 100% of the population in this region are Muslims. They pray regularly five times a day. Mosques are seen everywhere. In the village of Tambangan, population 9150, there are 22 small and one large mosques. During a discussion with the villagers, I was asked about the harmful effects of "onani" (masturbation). Unaware of the Muslim taboo, I went about expounding the modern theory on the subject until I found the jovial gathering turning sullen and quiet.

There were shamans practising in the region, but I had not the opportunity of seeing one.

The basic problem of medical care in industrialising countries is that of finance. When money is lacking, so is all that goes along with it in the form of personnel, buildings, drugs, equipments and facilities of every kind. The meagre GNP has to be shared among health services, education, transport, housing, development of agriculture and industries, of these is adequate or dispensable. Added to the maldistribution of wealth between industrialiesd and industrialising countries is a concentration of funds and human resources in the cities to the neglect of the villages. The severity of this as a world wide problem can only be appreciated when one is reminded that 2/3 of the world's population is in the so-called developing countries, and 80% of these is rural. The concept of tropical disease is for a signicant part a myth. Thus cholera, smallpox, malaria, leprosy, plague, rabies and Kwashiorkor were once common in temperate countries. These countries have undergone industrial revolutions in the last century or so which enabled them to control the diseases. The diseases of poverty have thus retreated to the countries which remain poor, and which happen to be in the tropics.

Different patterns and priorities of medical care in developing countries must be worked out, to which exported notions from industrialized countries do not apply. The use of limited money and skill must be calculated to bring the maximum return in human welfare for the largest possible community. The glamours of comprehensive ultra-modern hospitals, intensive care units and high-power surgeries must be resisted to give way to the funcionalism of modestly staffed and simply equipped units that disperse among the mass.

For a medical doctor from an industrial society to work in a rural developing country area, he has to stand the absence of luxuries and common conveniences that he has taken for granted. He has to prepare to work alone without consultation from colleagues. He has to deal with everything from curing sore-throat to doing appendicectomy. He will find his preconceived ideas about medical care continuously challenged. He has to be satisfied with the better rather than the best. He has to be comforted by the thought that though he may not be expert, it is likely to be either him or nobody and most patients will still prefer him. He is freed from the fragmentary specialization and impersonalization that are characteristic of medicine in modern society. On the other hand, there is no prescribed role — the role of super-technicians — that he can fall back to. He has to understand and to compromise with the people, their environment and their culture and to treat these as a holism.

This area of medical work is fascinating. Also it is there that the demand is most acute. For anyone of us to take part, it requires great fortitude to withdraw even temporarily, from the rat race, the ladder of fierce competition for status and professional advancement.

PROPAGANDA ON HEALTH

At the evenings, we usually had discussion sessions with the villagers in the local assembly halls during which we explained the disease processes and methods of preventions of endemic diseases like malaria, filariasis, cholera, tuberculosis with hand-made posters. An hour before each meeting, traditional music was broadcast through the loudspeaker, which never failed to bring a large gathering. Anything that breaks the monotony of the dark rural night is most welcome. But almost without exception, the crowd gradually dwindled as student after student rose to talk about such things as bacteria, aedes and immunization. Considering the literacy rate in Indonesia of 43% (surely much less in villages), a less academic but a more animate form of propaganda seems to be more appropriate. Those people that persisted through were usually respected elders who held positions in the local community. They often asked very challenging questions pertaining to local conditions. From them we learnt a lot.

香港大學學生會
醫學會月刊
第四卷
第九期
一九七二年九月

啟思

工作營記趣

工作營之在醫學院，實屬創舉，此次一行四十餘家，在檳榔灣動土，胸懷壯志，誰知抵達目的地時，竟受到村民們的奚落。原來上次大專聯會工作營之團員會食不會做，村民以爲我們也是一樣，諸多責難，營友們吃了「死貓」，認眞「唔潤」，幸而戰友們表現超卓，村民大受感動，態度亦改變了，還給我們熱誠招待。

× × ×

工作營地處郊外，營友們難免要鷄鳴而起，可是亞婆隻公鷄，零晨三時就「鬼殺咁嘈」，眞是「冇覺好瞓」，加上營地蚊患甚烈，營友們一覺醒來，傷痕纍纍，正是：

春眠不覺曉，
處處聞啼鳥。
夜來轟炸機，
中彈知多少？

× × ×

集體創作

工作營期間，乍晴乍雨，各英妮公司皆關門大吉，停止出貨，而戰友們却人人奮勇，個個爭先，工作效率奇佳，使材料頓形短缺，累到理民府幾位官員四出撲疋，亦趣事也。

× × ×

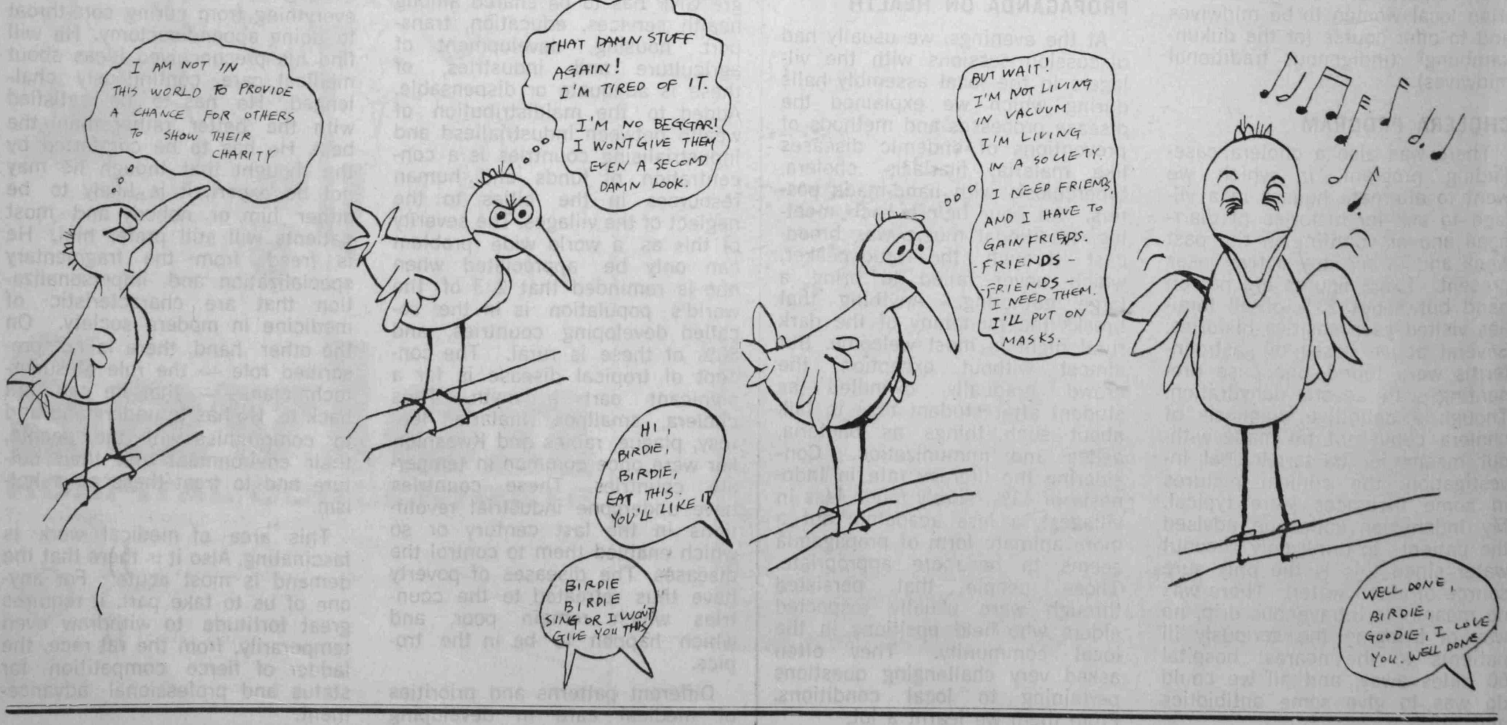
某營友深得黃教授訓誨，極知衛生之重要，對清潔運動之推行，不遺餘力，竟以漂白粉代替豆粉烫牛肉，幸而烹調之下，氣氣薰蒸，東窗事發，營友們才免於難。

× × ×

一個晚上，無甚消遣，有人提議玩撲克，某君則曰：「玩錢失感情，不如拿衫做賭本，每人限穿三件，穿在何處則無規定，一局無論輸多少均要脫衣一件。」大家同意，可是燈光火着，樓上各人隨時會走下來，不免有點難爲情？幸虧有位營友夠義氣，替我們「把風」，一切準備就緒，大家遂開始角逐，氣氛緊張，營友們狂笑不已，正在千鈞一髮之際，營長下樓要求我們靜些，免擾他人清夢，賽事被「腰斬」，大家不歡而散！

× × ×

鄉村地方，設備簡陋，由於辦公室的缺乏，我們這班「文明人」初到貴境，對出路問題頗感躊躇，大家第一件事，就是合力建築一個旱厠。因爲地方所限，旱厠之所在，離營地有一水（水田也）之隔，雖然路途遙遠，但我們有如厠指示器——白旗一面，使各人對厠所情況一目了然。這座建築物落成之日，大家還替它舉行了一個簡單而隆重的開幕儀式，節目包括剪綵，獻花和試用等，典禮完畢後，大家都爭着「解放」，一時白旗高懸，歷久不歇。



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