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BEING HEALTHY
(or)
HEALTH FOR ALL - NOW

INTRODUCTION :

The single most important need for all of us is good health. It is more important to us than all the wealth in the world. It is true that all of us living must eventually die-but while we live if we must be in a position to enjoy our lives and live to the fullest extent, we must be healthy. Ill health and disease also leads to premature dealth for drores of our people. While in many countries of the world a child born can expect to live on an average for 75 years or more an Indian child can expect to live for only 57 years. While in many countries of the world for every 1000 children born less than 10 will die in the first year of life, in our country almost 100 will die within one year- more than one in every ten.

Even this figure does not tell the truth for it as an average of the rich few and the many who are poor. The poor have a for worse situation and die far more easily than the rich. And more important such figures hide the fact that while they live, the poor suffer from repeated attacks of disease and their grouwth and development is so stunded both physically and mentally that they can never live fully.

WHAT IS HEALTH ?

"Health is not the mere absence of disease. Health is a state of complete physical, mental and social well-being" (Definition of Health by World Health Organisation). What is it that our being healthy depends on?

Being Healthy depends essentially on our having adequate food to eat, safe water to drink, a clean environment to live in, proper employment and proper leisure. It is these five components that are essential to health.

HUNGER :

It is meaningless to talk of good health when most of

people who die of hunger are seen as dying of some disease or the other. A body weakened by hunger is a prey to every passing illness. A mild diarrhoea, an attack of measles, a chest infection, a fever - which in a normal healthy person would be only a few days' inconvenience that would go away by itself, is enough to kill a malnourished person especially children. Thus it is that the commonest cause of death of children are conditions like respiratory (chest) infection, diarrhoeas, measles, all of which need never have caused death at all but for the malnourishment.

Malnourishment also leads to a stunting of the physical growth of the child, so that it can never realize its potential. (The average weight of the Indian rural male is as low as 44 Kg. while of the female is only 40 Kg.).

The root causes of malnutrition lie in poverty - in the inability of our people to purchase the food they need. There is, except on occasions, no true scarcity of food. Indeed our country grows enough food - even to export if necessary. And if needed we have the capacity and the knowledge to produce much, much more.

A BALANCED DIET:

Is malnutrition caused by lack of knowledge about the type of food to be eaten? Scientists say that a proper diet - a balanced diet for an average Indian must include adequate staple grain like rice or wheat or jowar, and adequate pulses. It must include about 170 gms. of vegetables, about 65 ml. of fats and oil, 55 gms. of sugar and at least 250 ml. of milk or equivalent value of meat, fish or eggs. If a person has all this he needs no special health foods, no tonics to maintain his health. Food is the best tonic.

Grains like rice or jowar or wheat is the main food. It is the chief supplier of energy for the body. The fats and oils are also a rich source of energy and especially in children they are important, as the stomachs of childern are small and they cannot eat too much of just rice or wheat. Fish, meat, eggs and milk

Other than these the body also need small amounts of substances called vitamins. Carrots, mangoes, leafy vegetables, and fish, meat especially the liver are good sources of Vitamix-A a substance essential for our eyes & skins. Lack of this is a major cause of blindness in India. Fish, fruits & vegetables are a good source of Vitamin-C, especially lemons, guavas, amla. Even green chilles & other fresh vegetables & fruits contain this. A lack of this leeds to painfull bleeding into the skin and joints.

Milk, eggs & meat provide Vitamin-D. However a good exposure to sunlight is by itself enough to provide enough Vitamin-D & deficiency of this substance which is essential for strong bones and teeth is thus commoner in women who stay indoors all the time.

Then there are minerals, like iron which is needed for the blood clacium that is needed for bones and iodine. These too are obtained from good, and the balanced diet suggested would provide all of it.

However the average Indian finds such food far out of his reach. His money is just enough to buy the staple grains that he needs and some salt and perhaps a few chilles, and if money permits a bit of dal. An average Indian family of about 5 or 6 people would require almost 3.5 Kg. of rice or lowar or wheat and about a quarter kilo of pulse per day. This itself would cost at least rupees twenty per day and even this is a great struggle to obtain. And one has to remember that on many days there is no work to be had, or there is sickness that prevents him from earning a wage. It is for these reasons basically that the poor do not have a balanced diet. They krow that milk is good for children, that eggs are good for health, that green vegetables are good, that meat and fish make you strong - but they cannot but it.

There is nothing much that a doctor can do, as a doctor to remove this single most important cause of ill-health. Were he to prescribe a tonic or a milk powder or health food he is actually depriving the family of much needed food. Such health foods and tonics are frauds promoted by drugs companies to make

vegetables, bananas, guavas, oranges and lemons are all healthier and more nutritious that any tonic and far cheaper too.

COMBATTING HUNGER:

Then what indeed can be done to tackle hunger and ensure our health. The single most important measure is to ensure employment that provides the minimum income necessary for a person to live as a human being. This would mean effective formulation and implementation of laws regarding land reform and of ensuring a minimum wage for agricultural workers and indeed all other categories of workers. Whatever the circumstances the minimum wage cannot be less that the amount needed to provide the minimum food, clothing and shelter needed to sustain life and this can be determined by scientific calculations.

Ensuring employment must also in the present context mean rural development programmes and technologies and industrial development stratergies that are able to absorb the entire labour force and provide gainful employment to all.

NUTRITION EDUCATION:

However a proper programme of nutritional education may be needed in addition to ensuring a minimum income, especially to help parents make optimum use of the scarce resources available to provide proper nutrition to children. Malnutrition in children is often compounded by wrong feeding practices and ineffieicnt use of available resources.

Breast feeding during the first 9 months of life is one effective guarantee of good health. The change to bottled milk powders and infant formula is a major cause of preventable infant deaths and in most cases should never be done. Even where bottles are to be used close attention need to be given to washing the bottle and plastic nipple in boiling water for at least 5 minutes or better still feed the infant with a clean spoon and avoid the bottle altogether.

Young children also need for their body weight a higher amount of energy and proteins. Too often the food given them is

cheap fruits like banana etc. should be given them as also a greater content of fats and oils.

FOOD SUPPLEMENTATION SCHEMES:

Food subsidies are no long term solution as they are difficult to sustain due to high costs and more important as they create a culture of dependency. However given the abyssmal poverty of some sections of the population and the impact that it has on the food intake of the sections within these sections which are most vulnerable to the ill effects of malnutrition namely children and preganant women, food supplementation or subsidy schemes remain an essential component of primary health care. It is therefore essential that the special nutrition programmes, the ICDS 'Anganwadi' based programme and mid-day school meals programme be strengthened and expanded along with schemes like the 'food for work' programme. Efforts need also be made to administer them effieiently, and in a corruption free manner and to ensure that these subsidies reach the sections that need them frost.

SAFE DRINKING WATER:

After food, the single most important determinant of health is the availability of safe, potable drinking water. Water is an essential component of all life. Today the efforts to secure adequate water for one's essential needs occupies the energies and time of most households, especially of the women. There are many districts especially in Punjab, Haryana, Andhra and Tamil Nadu where the water so obtained had deleterious levels of fluorides - a substance that leads to crippling of a considerable section of the population. At other places high levels of iron or salt makes the water difficult to drink. Indiscriminate dumping of factory effluents especially from chemical companies and tanneries have also rendered water hazardous for drinking in many areas all over the country, as for example in and around Madras, North-Arcot etc.

More commonly, water is a carrier of dangerous germs of diseases like diarrhoea, cholera, typhoid, poliomyelitis,

drinking water are therefore the two sides of the same coin. Scientists estimate that almost 80% percent of all preventable incidence of sickness can be eliminated by provision of safe drinking water alone. 'The status of health in the country should be measured' not by the number of doctors it has but by the number of water taps' - a very true quote indeed to which are may add the number of water taps with water in them!

Provision of safe drinking water and proper sanitary facilities is not an insurmountable problem even with already available technology. What would concretely need to be done for this in your area? One may for example need a) proper construction of wells taking all the necessary safety precautions to prevent contamination b) chlorination of wells c) filtration plants in urban areas and larger rural habitats with a regular piped water supply d) prevention of defecation near tanks and streams from which water is used for drinking purposes e) construction of locally appropriate, cheap and culturally acceptable latrines along with a proper sweage disposal system in urban and larger rural habitats f) defluoridation techniques or identification of safe drinking water sources in fluoride and iron affected areas g) preventing factories and sweage disposal systems from dumping untreated or hazardoues waste into river and other water sources including the sea. If indeed this is such an important, yet in most places an easy measure, why has it not been done?. There are many reasons for it but one major reason we should note is because we the people have not demanded it - despite the fact that diarrhoea has killed and polio has crippled more of our children than any other single disease! Eventually one we can ensure our own health and it is high time we organized and ensured safe drinking water in our own area.

There are however many areas in the country where availability of any water is a great problem. In such areas engineering works- minor or major will have to be taken up or new technologies like desalination of salt water adopted.

ENVIRONMENT :

The third important determinant of our health is the

to both industries and to the inefficient smoky chulhas are a major cause of chronic cough and other respiratory problems. Indiscriminate use of pesticides and unsafe unscientific disposal of industrial wastes, poisons the land and water in many areas.

BIOLOGICAL ENVIRONMENT :

Man as part of the living world, and related by evolution to all living things, is also affected by any serious affection of the living world. Cutting down of trees and green plants deprive the air of oxygen so essential for life. The indiscriminate killing off of so many plants and animals has altered the delicate balance in nature on which all life depends. This as well as the unplanned urban and rural development that leads to dirty cesspols water in all our cities and towns have become ideal breeding grounds for mosquitoes and flies and other carriers of disease. The mosquitoe alone is known to be a vector of 5 diseases in India. Malaria, filaria, brainfever (viral encephalitis), viral fevers (dengue), haemorrhagic fevers (fever with bleeding) the first three of which are major causes of death and disease. Flies are the carriers of disease like typhoid, cholera, worms and dysentery and many other diseases. The sand-fly causes Kala-azar in many parts of Bengal, Assam, Bihar and Orissa. Similarly pests on crops are also rapidly multiplying. Control of such pests whether affecting man or crops is possible in the long run only by ensuring a proper ecological balance and a healthy environment. Measures like pesticides may be needed in a limited and controlled manner but seldom will it by itself offer a solution. (The failure & programmes like the National Malaria Control Programmes are related to this).

SHELTER :

However by environment we need also include the social environment. The provision of good shelter and clothing is one major aspect of this. A person with adequate clothing living in a well ventilated house which is not over crowded within the house or located in an over crowded area is far less likely to be affected by disease then the millions of homeless scantily-clad people or those who live in crowded dark hovels. The

Of the various respiratory infections, by far the most serious is tuberculosis. Despite various programmes the incidence of tuberculosis continues to rice and is more than million today. Of there despite the fact that good drugs are available 5,00,000 die every year. On the other hand, tuberculosis which was a common disease in the West once is now almost eradicated there. This is not prirarily due to drugs but to less overcrowding, better shelter and nutrition, Even in India, tuberculosis is primarily a diseas of the poor and a reflection of their standard of living.

EMPLOYMENT :

Another aspect of social environment and a essential pre-requisite for health is proper employment and leisure. Proper employment is not only essential because an income purchases food & clothing and shelter but it is essential as an end in itself for mental and social well being. Indeed man's prime want is to play a productive and useful role in society and his satisfaction is most when his employment ensure this. And his leisure he can use for rest and for developing all the various aspects of his self that all contribute to being a complete human. Indeed a social environment free of conflicts and tensions, meaningful employment and adequate leisure are the basis for mental and social well-being for a truly healthy citizen. (The basis of many a social disease like suicides, alcoholism, drug addictions, crime are to be found in the lack of satisfactry work and related social tensions). Just as only healthy individuals can make a healthy society, it is also true that a healthy society is needed for healthy individuals.

HEALTH EDUCATION :

To nearly all people much of this is common knowledge. Medical science has only helped establish that most disease result from a lack of these essential requirements. Medical science has helped us understand also how for example diarrhoea results from contaminated water so that not only can be prevent

This knowledge about how our body works and about how diseases are caused is another essential pre-requisite of being healthy. It is necessary that not only doctors and nurses or health workers know about this but that every person has a minimum idea of it, so that they can understand their own bodies and keep it healthy.

Health education should also include a minimum knowledge of diagnosis and treatment of simple diseases. Take for example diarrhoea. If diarrhoea is watery and not associated with blood or mucus the best and only correct treatment is to give the patient plenty of fluids. The fluid adviced can be prepared at the home by mixing a scoop of sugar and a pinch of salt in a glass of boiled water. Alternatively rice water with some salt added is also good treatment. The majority of deaths due to diarrhoea, especially in children can be prevented by this one measure alone. Indeed more deaths have been prevented due to this one advance than any other single advance in medical science in these last few decades.

Similarly colds, simple cuts & bruises, an occasional body ache or headache can all be treated with proper knowledge.

Health education should also be adequate for people to identify certain serious diseases like polio, measles, chickenpox, tetanus etc. so that they seek medical help early.

Measures to prevent diseases like tetanus & rabies, knowledge about immunization, knowledge about occupational health hazards- all are essential aspects of being health.

EDUCATION :

Obviously a literate person has far greater access to such knowledge than an illiterate person. Literary is an essential component of health. But mere literacy is not enough. The level of general education is important. General education increases the 'health' literacy' of the people. It enables them to understand their health problems and how to identify, prevent and control them. It helps them make maximum are of what is provide to them including nutritional supplements, vaccinations, medical

disseminate a lot of knowledge about health, and the access to thisinformation is directly related to literacy.

Women's literacy and schooling of girls needs special emphasis for the impact of this on society & the family is much more.

Indeed just like food, water, shelter and work, education must be also considered an essential component of being healthy.

MATERNAL HEALTH CARE :

One area where medical science has led to a great benefit is about pregnancy and childbirth. There was a time when many women and even more children died due to pregnancy and at childbirth. Now we can in most cases detect problems of pregnancy well in advance and take proper steps to save the lives of the children, and mother. We know that a pregnant women needs extra nourishment and should have more rest and should be spared heavy work. We also know that if they have many children too soon and too frequantly it endangers the lives of the child a nd the mother. It is recommended that the first child should be after the age of 21, the second child should be after a gap of 4 years at least and there should be no third child. This is essential to safeguard her health.

Suitably trained persons - both doctors and health workers can datect the pregnancy cases where natural delivery is not possible or dangerous and in such cases the child can be safely delivered by an operation or forceps. When natural delivery takes place we can ensure by simple hygienic measures that any trained nurse knows that the delivery is safe and that there are no complications for the mother.

CHILD ¾ CARE :

The newborn child fed on breast milk from a healthy mother is likely to be healthy. Immunication pretects us against a few major killers like tetanus, diphtheria, whooping cough measels and polio. Proper nutrition and feeding practies are also

birth, and many more (about 40/1000) die in this age group due to ca uses related to childbirth indirectly.

The reason for this lies in the poor health of our mothers and the difficulty in getting or total lack of maternal and child care in most of our villages. Even if they are available women are not adequately aware of why they need such help and the vast difference such help will make to their lives and that of their children's. The children of illiterate women die far more often, than those of literate mothers. Studies have even estabilished relationships between numbers of years of schooling of the mother, and infant mortality.

This is not only related to the proper socio-economic background of the illiterate and the knowledge about health that literacy contributes but also to a critical awareness of their own reality and their attitude towards it.

The inability of the illiterate woman to make the correct choice - to ensure the health of their children, their own health and of their children, their inability to plan for the future security for the family leads her to reject the temendous pressures that the government exerts today for the family welfare programme and thereby she seriously endangers her own health.

THE FAMILY PLANNING PROGRAMME :

India is one of first countries in the world to have a major national family planning programme. Enormous resources have been spent on it - in the last five years plan period alone - more than 3000 crores have been spent on it. Nearly half the budgetary allocation for health care goes to family planning - yet the programme has not succesded. The crude birth rate over the last 10 years has remained static at about 31/1000 as against a 22/1000 that it was supposed to reach. Or in simpler words despite 3000 crores spent there has been almost no change at all in birth rate. The measage of family planning has been literarlly taken to every corner of the country, roughly to every village & every home - to meet with only a poor response.

The reasons for this need to be understood. The

is the only long term investment or savings they can make. When they are old or sick it is only their children that they can fall back upon. (In a better income group in our country or in more developed countries savings is in the form of a home, in a bank, pension, provident fund etc). Now when 10 out of 100 children die the need to ensure a living child and that too a male child becomes a matter of para mount importance. The loss of a child for a mother is a matter of great agony and guilt, for the being she brought into the world and loved so intensely is lost as the was unable to protect it. But the millions of mothers are voiceless and we do not hear them cry. And even as they cry they need to go through it again - to bear more children.

Only in a society where there is social security and low infant mortality will the birth rate come down. And only in a society where the woman is literate and liberated enough to make her own choices will family welfare be realized. There are countries like Cuba where there is no Family Planning Programme at all yet the birth rate is low. There is no population problem in any of the developed countries of the world. Indeed all of them want more people. The day our women are educated, they day they are able to ensure the survival of their children and become active participants of social development, that day family planning will become universal. Till then all we can do is to ensure easy access for every mother to health services which include family planning and to information about family planning. The money being wasted on many of the schemes be better spent in educating women, providing basic health care and on development programmes.

PREVENTION OF ENDEMIC DISEASES :

Good knowledge of the way diseases spread consequent to the advancements of medical science have also helped us completely eradicate some diseases like small pox which once killed millions of people every year. It has made it also possible for us to eradicate or control may of others. Take guinea women for example with existing knowledge and technology resources it is possible

Or take endemic goitre which is limited to the foothills of the Himalayas, the Terai area, and to north east. This is a disease that causes children to be born mentally related due to lakk of ex iodine in the diet. Provision of iodized salt alone. (The details of prevention of a few endemic diseases specific to that area must be undertaken at this point).

FUNCTIONS OF HEALTH SERVICES :

When one of us as an individual suffer from many of these diseases there is little to be done but to see a 'doctor'. But let us never forget that is most instances, had we acted together earlier we could have taken measures or forced the government to take measures that would have ensured that none of us ever undergo that disease at all. However when we do fall sick we do need a trained person to examine us and tell us what our ailment is? Is it just a common cold that will pass off by itself?

Is it jaundice? If it is jaundice is it the type which we must commonly see, which is most cases becomes alright by itself provided we take rest and proper diet or is it a different variety which we need to take treatment or very rarely even undergo an operation? We all need to know something about the common diseases but knowledge about diseases is now so much that some people - be it a community health worker, a nurse or a doctor, are needed whose profession is to provide health care.

There are many diseases that we get due to out body's own mechanisms being inddequate - either due to defects inherent in our cells or due to the body being unable to cope with an overwhelming an external factor. Good medical care help our body be restored to its normal function or at least ameliorate the symptoms thereby lessening the suffering caused by diseases. Often medical science is inadequate to do either and we need to accept the limitations of this science and adjust our lives accordingly.

Death is inevitable. Medical science can prevent a number of preventable deaths, postpone it and make it less agnozing. The function of health services - the para medical workers, the doctors & nurses, the primary health centres and hospitals, the drugs and diagnosis equipment like X-rays is to find the causes

EQUITABLE DISTRIBUTION :

Unfortunately though there are tens of thousand-s of doctors, and even some of them are unemployed, the vast majority of our people have no access to health care. These who are rich enough to pay and live in cities have access to the best equipment and drugs and doctors and they consume the major part of what is spent for health. The poor especially those living in our villages have no access to any medical care. Even if there is a primary health centre nereby it is understaffed poorly equipped and usually lack the basic drugs needed to provide primary health services. The general hospitals are overburdened and themselves terribly unsanitary places, the medical staff there overworked and the health care provided mostly **inefficient.**

COMMUNITY HEALTH WORKER :

It has been repeatedly been stressed that proper access to medical care must be based upon deploying adequate numbers of suitability trained and motivated community health workers. A community health workers is a person of your own village, who has studied at least upto 6th standard in school, who is trained to recognise common illness and treat them. He can also recognize more serious illness for which he will advice you to see a doctor. He will also be abbe to assist at delivery, give immunization to children and advice regarding prevention of other diseases. He may be a peasant who works his land who only spends a few hours per day on such work or a local traditional healer or dai trained for this purpose.

The precense of such a person or person in your village means that you need not run to a doctor or to a far off centre, but can have basic health services at your doorstep from a person you trust. Does you village have one such worker, who is easily accessible to you when you or your child has a health problem? If not you must ensure that one of in the village be trained, for it.

DRUGS :

Drugs too are essential - especially for diseases like

the district or taluk hospital. Even here no more than some 150 drugs are needed to take care of all the possible medical treatment you may ever need.

Unfortunately in most places including these 25 primary health centres these 25 drugs are not available. Even at taluk and district level hospitals often there 25 drugs are not available - not to speak of the 150. But at the same timeevery local drug shop and even at villages there are freely available hundreds of other tonics and injections and tablets which are of no use at all. Because people do not know the causes of their diseases they often take tonics and other tablets 'for feeling better or stronger'. But these medicines waste our money. Then why are they there at all? Why do doctors prescribe them? Why do governments allow them? Why do companies make them?

Of all these questions only the last has an easy answer. The companies make them because they get a lot of money by selling them. We need to ensure that our governments and doctors do not encourage such useless drugs that waste our money. We also need to insist that the drugs essential in that area are cheap and easily accessible.

OF DOCTORS:-

Last of all, we need doctors, too, at least in every primary health centre there must be two doctors - doctors who are interested in serving the people. They can help when our own knowledge and training and that of the community health workers is inadequate. Doctors are also needed as scientists to find out more about the causes of diseases so as to discover ways to prevent the diseases and to treat them. In every district there should be at least one hospital where modern scientific instruments are available and specialists in various fields are available to treat serious conditions or rare diseases. They also need to provide training to newer health personnel and educate people about the causes of ill, health and the way to be healthy.

HEALTH POLICIES :-

If many doctors today to not do this it is also because amongst other factors the people do not know enough to ensure it. We need to know what we need for being healthy and what we need to

have proper, equitable access to health or the other benefits that advancements in medical science have made possible.

Good health needs far more than doctors and drugs. The struggle for being healthy is part of the struggle against conditions that make ill health possible. It is a struggle for good food, good water, a clean environment, for good employment & for leisure. It is a struggle for a better quality of life. Science gives us the knowledge and the possibility of making good health care available today but to make this a reality, society must be willing to redistribute available resources so that these basic needs for all are met. This then is the true meaning of Health for all by 2000 Ad.

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A P&M APPROACH TO PRIMARY HEALTH CARE

The Declaration of Alma Ata marked a historics step in the history of health. It was the first clear international declaration that health which is a state of complete physical, mental and social-wellbeing, and not merely the absence of disease or infirmity, is a fundamental human right and that the attainment of the highest possible level of health is a most important world-wide social goal whose realization requires the action of many other social and economic sectors in addition to the health sector'[1].

The Alma-Ata declaration was a major step forward for it was beased on an understanding and implied that

(a) 'the main roots of poor health lie in the living conditions and the environment in general, and more specifically in poverty, inequity and the unfair redistribution of resources in relation to needs, both inside individual countries and internationally.

(b) That the people have the right and duty to participate individually and collectively in the planning and implementation of their health care.[3]

(c) Primary health care, defined as "essential health care, based on practical, scientifically sound and socially acceptable method and technology... at a cost that the community and country can affort to maintain atevery stage of their development in the spirit of, self-reliances & self determination.. is the key to attain the target of health for all by 2000 AD'[4].

Unfortunately despite the brilliant polemic and sweep of this declaration, its implementation lags far behind, and now 22 years since its adoption in practical terms, at least in India, this great slogan has had little impact. Unfortunately the World Health Organization who gave this call, has its contacts limited to the health ministries and to medical and allied professionals, and it is to these sections that the task of implementing this programme went. One critic ruefully comments 'Handing over the implementation of PHC to the medical establishment was similar to handing over the implementation of land reforms to landlords.'[5]. One outcome was to attach 'health for all by 2000 AD' as a slogan to already existing or on-going programmes or to set new series

The other major thrust of the present primary health cave programme, as it is in India, is the establishment of primary health centres and the deployment of community health workers-both at subcentres and at village level. This too has run into serious problems. Not only is the number of health workers that have been trained and deployed far short of what is needed, but even those who are deployed yield only a limited quality of health service. The selection, training, monitoring and motivation of the community health workers is so poor that most tend tend to drop out & some even migrate and set up as quack medical practioneers themselves. 'Community participation', one important planned feature, is in most places completely absent. Almost no research, planning or training goes into identifying the problems and working out the tactics of health care delivery.

For the medical establishment, it is business as usual. The last 10 years have seen the mushrooming of corporate private hospitals and a number of private capitation-fee based medical colleges. A top few eminently 'successful' doctors preside over medical association, act on medical councils, advise governments on health policy, serve on its commitees and working groups, influence governmental decisions by virtue of their physician-level personal contacts with decision makers and in many a case even dominate research and private practice. The entire primary health care campaign and the Health for all by 2000 AD slogans are seen as empty politician's slogans or at best as the department of P & SM's responsibility. Clearly no major change is likely to be contributed by these **sections.**

It must be recognised that members of the medical profession can do little in their professional capacities to achieve this goal. Medical & paramedical professionals are well positioned to investigate the causes and consequences of ill health. However they can rarely tackle the root cause of ill-health-hunger, poverty, shelter, water, sanitation, employment, leisure etc., Without tackling these basic questions-primary healthcare as spelt out by the Alma-Ata declaration is not realizable.

This differentation between the wider concept of primary health care and the narrower concept of primary health services or basic medical services was not made in the original declaration.

It is possible with adequate political backing and administrative will to immediately achieve, such medical care at least in large areas of the country. It is possible for socially minded doctors, helpted by donations or grants to provide such basic medical services in remote rural areas or even in urban areas where the poor have limited access to such health services. There is a record of numerous doctrs from a wide variety of backgrounds the catholic hospitals associations, the people's polyclinics of Andhra Predesh, the work at Nagapur, at Chikmagalur etc., who have undertaken such work. Such work is a valuable contribution but in terms of the actual contribution to the health of the community as measurable by indices the impact has only been marginal. Impact on health itself can only take place by the implementation of primary health care in its broader concept. Though provision of health services and essential drugs are a part of the concept of primary health care, they are not the major part or the focus of primary health **care.**

This should not however be interpreted to mean that health professionals have no role in the implementation of primary health care. The word 'doctor' is itself the derrivative of the word 'to teach' The doctor and other health professionals are looked upon as a source of knowledge about health and disease. Today many of the ideas prevalent about disease, both right and wrong and most of the health policies have been contributed by the medical professional. To view disease as an affliction of an individual by a germ and lose its social dimensions is the result of a curative bias, that the PHC approach sets itself against. The result of such a bias in the sphere of health policy is to search fortechnological or managerial solutions to what are essentially social issues. The doctor has contributed to such a bias and the doctor can contribute to its unmaking also.

The people's Science Movement and indeed all other individual group's & organisations desirous of realizing the goals enchrived in the Alma Ata declaration need to plan for intervention to prevent the demise of a powerful concept "Health for All, by 2000 A.D." A great concept should not be allowed to dissolve into platitudes.

One of the primary areas that people's science movements can address themselves to is to create an awareness of what health

Health education has many limitations and pitfalls. Much of the health education current today is technical, fragmented and culturally in-appropriate, other than being for that situation irrelvant. Thus a health worker may deliver a one hour lecture on diarrhoea, without ever mentioning that the water source in that village should be safe. Instead she would probably preach a sermon on cleanliness, suggest using boiled for water all drinking purposes and finish with suggesting oral vehydration therapy. By the time she reaches the most useful part, both sympathy and inevest would have been lost. Or a class on nutrition may tell all mothers assembled that they must give milk, eggs, fish, fresh fruits & vegetables to their children - when most of them are going hungry for want of ability to purchase rise. Even in many a people's Science movement lecture we tend to leave out social causes and possibilities of remedial collective action and instead stress on technical causes and individual solutions.

It would of course be of little use if health education lectures were only polemical or philosophical in nature and discussed and curative knowledge will need to be imparted. But where collective action is the only real solution and the basic problem is a health determinant like water or nutrition or sanitation, health education should be aimed at exposing such causes and appropriate remedical collective action. The health professional should provide the technical information, if such is needed, to justify, a PSM effort to organising such action.

Could health by itself serve as an entry point for collective action? The health worker-can she become the agent of social change? Can oppressed people be organized around and for health issues. Though this debate is far from over some Indian experiences have replied in the negative. 'Health work they feel has only weak political implementation and without a proper political context not much of genuine people's participation can be achieved in community health work done.

However most are agreed that 'health should be one of the activities of a group trying to organise the rural poor

The reception and popular response to proper health education is also limited by the dominent culture of seeking a pill or an injection as an instant remedy instead of trying for a more scientific understanding of the cause of disease. They come to the health professional for a 'cure' and not for knowledge. Many health education strategies therefore choose to combine therapeutic services with oral education-both within the governmental and in the non-governmental sections. Thus the women waiting to see a doctor in the queue before a primary health centre are given an half-hour lecture before he arrives, or while they are waiting for their turn. Or else after seeking the doctor they have to see a social worker who spends a few minutes talking to her about her disease. Both these of course are rare events, and only in an occassional centre, usually run by a socially concious doctor do they really occur.

Experiences in the people's science movement, though undoubtedly limited, have found greatest success where the health education has been done in the form of a mass campaign. The media used has been popular lectures, slide shows, street-theatre (the Kalajatha), posters and to a limited extent video. The popular response from the audience has been very positive but it is difficult to evaluate the gains of such general health campaigns.

Campaigns focussed on specific issues especially on provision of essential drugs and the drug policy have had a much greater impact. The KSSP in particular by its wide dissemination of books on essential drugs and on hazardous or irrational drugs, have been able to make a mark on drug consumption and prescription patterns. To this end they have held seminars and guest lectures for doctors, campaigned in the local press, used posters and news papers and kalajathas to disseminate their views on drug policy. Their successful efforts to expose multinationals selling anabolic steroids by intervening in the usual 5 star hotel drug promotional campaign also won them popular support and media coverage. Such a wide variety of activities and on such a scale needs a major organisational network and this the KSSP had. The KSSP organisational growth is a result of the wide varieties of activities the KSSP takes up-covering issues like environment, science, education, health, rural technologies

a broad-based organisation has helped all PSMs in carrying out effective health campaigns. The K.R.V.P. the Lok Vigyan Sangatana are some of theother PSMs who have held such campaigns on health.

Another factor in the success of many KSSP programme is their educational campaigns not only on health but also on environment, do not stop at awareness generation but go on to mobilizing people for collective action. The scope for such health education campaigns which lead on to direct collective interventions by the people have not been adequately explored by other PSM groups & health activists mainly due to their organisational weaknessess.

But as the PSMs continue to expand the scope for such action increases exponentially. It is possible non to plan for campaigns for total immunization or control of diabotical diseases. It is also possible and needed to campaign for implementing iodized salt distribution in the Terai & other iodine deficient areas of the north while at the same time opposing the ill advised move to ban common salt, commercialize salt production-handing it over to large monopoly houses all in the name of preventing a wide incidence of goitre that is far from established.

It is possible today to campaign extensively for ensuring provision of the 25 essential drugs within 1 km of any habitation and for banning hazardous drugs. In select areas it may be even possible to launch health education combined with collective action against diseases like guineaworm infestations which are potentially easy to eradicate and even against diseases like leprosy, measles which are potentially eradicable even within the present system with existing medical knowledge.

Successful health education work however needs a lot of careful planning and knowledge of local conditions and culture. It also needs an analysis and understanding of the health problems involved. Given the bias of the medical establishment and official structures today, one is seldom able to rely of official documents and pronouncements alone to evolve a people's understanding of the issue. As a result one major area of people's intervention has been to study health issues critically, subject

There are many groups notably the groups associated with Medicos friends circule, A.I.D.A.N. Helhi Science Forum, Karala Shastra Sahitya Parishat, F.M.R.A.I. who have made major contributions in this regard. Though due to their organisational structure most such groups have limited themselves to presenting critiques, such critiques are essential for future action. These critiques could have formed the basis for collective action by other groups like youth movements, women's organizations etc. but in practice such a cross-fertization has not occurred to any significant degree.

Most such analytical, theoretical contributions are desk work relying largely on secondary date or compilations from various published sources. There are however a number of significant health surveys and field studies by health activists which was formed the basis for critiques. Health problems comsequent to the Bhopal gas tragedy, occupational disease in selective areas & industries, the general health survey and the study of primery health centre facilities in Kerala are some examples of such intervention. It needs be pointed out that the major medical research institutes with elaborate research facilities seldom study such topics. The marked reluctance of such institutes to undertake study on areas of immediate relevance to people, especially if the topic is likely to be controversial and go against local vested interests in well known. Unless health activists intervere actively in such areas of research work, the PSM's and democratic groups will be unable to intervene in both the for mulation of health policy or even identify the deleterious effects of ill concieved health or developmental strategies.

Even theoretical work, based on analysis of published data has a significant role to play. The drug policy is one area where health activists in India can take pride as being the sole force to have opposed the government's consistent pro-industry and anti-health policies. And most of this intervention is based on study done by various health activists themselves. Similarly on patent law and on iodisation of salt, official policies have been subjected to critical analysis and have become or are becoming the basis for collective action to

critiques or evolve alternative strategies. There is an urgent necessity for health activists to widen its contacts among trained and sincere health professionals who can help. A large number of doctors, especially junior doctors and medical students and many with good academic backgrounds are interested in a social activity of the medical system and willing to contribute to it. Their participation in the work of PSM should be ensured.

Can PSM s go beyond health education campaigns (both general health awareness and on specific issues) and beyond presenting critiques and critical reviwcs of health policy? Can it attempt to tackle the concept of primary health care in its entirety? Can it by its work raise the level of health in a measurable fashion or contribute to such a rise in health status?

One approach to these questions is to work on a model- to take up an area varying in size from a village to a taluk or district and in this area attempt to render primary health care. Too often what is rendered is only basic medical services and then in the long run the results are not adequately rewarding. However there are attempts to integrate in such a model, basic medical services with major health educational campaigns, introduction of scientific imputs to upgrade existing rural technologies and launching rural development schemes that generate employment, provision of better nutrition not only through income generation but by a more optimal use of available resources especially for children, provision of safe drinking water and elementary sanitation and above all literacy education and scientific awareness. The people's science movement is better equipped than most groups to implement such an approach. It has within it folds considerable experience in rural technologies in literacy. and non formal education, in running campaigns on issues espeically using local art-forms as a vehicle for new ideas, in drinking-water and sanitation work - and in running basic health services. It should be thus possible for such a model to the built up with the available experience in the PSM s.

When building such models one needs remember the past PSM experience, that successful campaigns need a critical size for raising enthusiasm & for success. If work is too microscopic in diversions, success is less and the project merely peters off.

What would be the socio-political implication of such a

automatically replicable all over the country, by virtue of its being successful in one place. Even for the model area to succeed social inequalities will pose a problem but we need not assume they are insurmountable ones. (Such a model cannot therefore be posed as the road to success of primary health care).

Then what would such a model contribute? It could by its very presence and success help to pose the issue of an alternative strategy to health care and development. It could demonstrate that health for all is possible - now, given the administrative and political will. It would help bring, by virtue of its experience, the issue of health on to the agenda of national priorities - where it is there notionally but not in practical terms. In organizational terms it would mean mobilizing new sections into PSM activities and adding a newer dimension to activities aimed at social change.

What we should not do when the PSMs take up primary health care work is to confine it to health services, and to health professionals. Thereby we would be going back to locating health issues as separate from other social problems and nurture the belief that good health can be won by technological or managerial inputs alone. PSMs can organize people around health issues only - if they link it up. With other issues of development - especially literacy, education and employment.

One area of expanding PSM activity that offers immediate scope for linking with the health issue is literacy. The concept of functional literacy as understood by us, includes an understanding of health. Literacy, and education by themselves, independent of all otherfactors have been shown to be major determinant of health status. Women's literacy in particular has been shown to affect, independent of other parameters, women's health, attitudes to family planning, number of children born and infant mortality. The process of imparting literacy is a useful vehicle for the generation of scientific awareness of which health awareness is an important aspect.

One major new area of contribution of PSMs is in adult literacy. With the landmark success of the Ernakulam campaign and the subsequent initial experience of the on-going total literacy campaign in Pondicherry, Goa and Kerala it is likely that

by operation smiles - a project for 100% immunization in Ernakulam district. Diaorrheal deaths & mortality have come down significantly. In Pondicherry too a health phase is likely to follow the total literacy campaign.

The coming Bharat Gyan Vidyan Jatha, being organized by the people's science movements of India is one major avenue for health activists to enlarge the scope of their work. The B.G.V.J. aims to organize one cultural groups of volunteers from all walks of life in each of the 500 odd districts of India. In each of these districts the jatha will give performances at 120 to 150 centres. Their performance is aimed at creating an awareness of literacy and science. The basic organizational task of the BGVJ is to organize 60,000 centres all over India to receive these troupes. Each centre will also identify a resource persons to give 10 lectures each on topic. One of these topics is 'Being Healthy' - a basic talk expalining the causes of diseases and the need and nature of primary health care.

The generation of such wide and diverse voluntary network of activists by the people's science movement opens up vast potentials for future action by the people's science movement. Literacy is definitely the major follow-up action envisaged - and definitely the issue we need to address ourselves to most urgently. But it is not possible to open up actual teaching work in all these 60,000 centres as follow up, nor will we be able to sustain even the active centres with a single point programme of literacy alone. Health is definitely one major thrust area for follow up work in these centres. The follow-up work may take the form of health education campaigns or even of intervention in areas like immunization, guinea worm eradication etc.

Or there may be areas where we could attempt comprehensive primary health care. It is premature at this stage when the 60,000 centres exist only on paper to plan for a detailed follow-up but we need to start thinking about it. We can however state confidently that the very attempt to train 60,000 voluntures to give a talk on primary health care in every village of India, is an unique attempt that is bound to throw up a major manpower resource for futurehealth activities.

The People's Science Movement

THIRD ALL INDIA PEOPLE'S SCIENCE CONGRESS

8-11, March 1990

Shri K. H. RANGANATH

Hon'ble Minister for Education, Agriculture and Forests

Govt. of Karnataka

has kindly consented to inaugurate the Congress on

8th March at 10 - 00 a. m.

Prof. C. N. R. RAO

Director, Indian Institute of Science

will preside

You are cordially invited.

nue : J. P. Youth Centre, Vidyanagar

Bangalore District

Karnataka Rajya Vijnana Parishat

Local Organising Committee

Programme of Inaugural Function

8-3-1990 10 a. m.

Welcome	:	**Prof. J. R. Lakshmana Rao** President, KRVP
About AIPSN	:	**Prof. B. M. Udgaonkar** President, AIPSN
Inaugural Address	:	**Shri K. H. Ranganath** Hon'ble Minister for Education, Agriculture and Forests Govt. of Karnataka
President's remarks	:	**Prof. C. N. R. Rao** Director, I.I.Sc. Bangalore
Role of NCSTC	:	**Dr. Narender K. Sehgal** Director, NCSTC, New Delhi
Role of Dept. of Science and Technology	:	Dept. of Science and Technology, Govt. of Karnataka
Vote of Thanks	:	**Shri M. A. Sethu Rao** Secretary, KRVP

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National Council for Science & Technology Communication
and
Dept. of Science and Technology, Govt. of Karnataka

BACKGROUND PAPER ON HEALTH AND PSM'S

Presented at 2nd All India People's Science Congress, Calcutta.

BY DELHI SCIENCE FORUM.

India was s signatory to the "Alma Ata Declaration" a adopted by the World Health Assembly in 1978, which gave the call "Health for all by 2000 AD". Today, 10 years after the Alma Ata declaration, the state of health in India makes the country one of the most backward in this respect. The facilities in some of our hospitals may be among the best in the world and the same can be said about our doctors. This, however, does not determine the health ofnation. The only true index of a nation's health is the state of health of the vast majority of people, andnot that of a privileged few. In this regard the Government's own "Statement on National Health Policy" (1982) states "The hospital based disease, and cure-oriented approach towards the establishment of medical services has prodived benefits to the upper crusts of societ specially those residing in the urban areas. The proliferation of this approach has been at the cost of providing comprehensive primary health care services to the entire population, whether residing in the urban or the rural areas".

POST-INDEPENDENCE EXPANSION IN HEALTH SERVICES

However this should not detract from the fact that since independence there has been improvement in many areas, both in terms of growth in in rastructure andinterms of their actual impact on the health status of our people. The following table gives an account of the progress made.

Table - 1

IMPROVEMENT IN HEALTH FACILITIES/CONDITIONS SINCE INDEPENDENCE

Year	Life expe tancy at	Infantmort ality rate	No. of hosptials	Population per bed	No. of PHCs	Doctors per lakh popln.
1951	32.1	180	2694	3199	725	16.5
1961	41.2	165	3094	1930	2800	17.6
1971	45.5	137	3976	1672	5112	25.0

It is however important to understand both the content and the process involved into this progress made in the health sector. There is a tendency to cite the above figures to make out a case for positing that this progress has been adequate, and hence no major policy interventions arenecessary. The health services at the time of Independence were a function of the socio-economic and political interests of the colonial rulers. Consequently they were highly centralised, urban-oriented and catered to a small fraction of the population. Public health services were provided only in times of outbreaks of epidemic diseases like small pox, plague, cholera etc. The post-independence era witnessed a real effort at providing comprehensive health care, and in extending the infrastructure of health service.

Even the West wemt through this rapid phase of improvement of health services, after a period of stagnation, at the turn of the century. In the early days of the Industrial Revolution the bulk of workers who came to work in factories from the countryside suffered from malnutrition, communicalble diseases and high rates of infant and maternal mortality. When it was realised that the very suffering of the people was endangering industrial production (and thereby profits), active steps were taken to dramatically imrpve publicchealth services. Economists who had considered medical expenditure as a mere consumption item, realised that allocation on health care was actually an investment on increasing productivity of labour. Another major thrust was provided in the aftermath of the Second World War, when with the rise of organised workingclass movements and the consequent development of democratic consciousness in many European countries the concept of "Welfare States" was mooted, For example the National Health Scheme in Britain, which is highly regarded even today, took shape under the Labour Government just after World War II. A rough analogy can be drawn with this and the Indian situation after Independence. Consequent to the transfer of power in 1947, the character, and as a result the long term interests, of the ruling sections changed and consequently their intereest and motivations were qualitatively different from that of the British. Their own interests required a major thrust towards building of an infrastructure to provide some basic facilities to the people. This thr

At the same time major scientific discoveries revolutionised the treatment and prevention of many diseases. These have contributed greatly to the increase in life expectancy and in reduction of mortality. The antibiotic era has made it possible to control a larger number of infectious diseases, for which no cure was earlier possible. Rapid strides have been made in the field of immunisation, diagnostics, anaesthesia, surgical techniques and pharmaceuticals. This has had a dramatic impact on mortality and morbidity rates all over the world. There are pitfalls of an absolute dependence on technological solutions to health problems, but it is definitely true that in many instances newtechnologies have had a major impact. However the imporvements in ourhealth delivery system have not kept pace with the needs of a vast majority of our people. So much so that the Government's "Statement on National Health Policy" (1982) is forced to state "Inspite of such impressive progress, the demogfaphic and health picture of the country still constitutues a cause for serious and urgent concern".

BALANCE SHEET OF HEALTH

The following statistics give a picture of the state of health of our people:

__ Only 20% of our people have access to modern medicine.

-- 84% of health care costs is paid for privately.

-- 40% of our child suffer from malnutrition. Even when the foodgrain oroduction in India increased from 82 million tonnes in 1961 to 124 million tonnes in 1983, the per capita intake decreased from 400gms. of cereals and 69 gms. of pulses to 392gms. and 38 gms. respectively. Due to increasing economic burden on a majority of the people, they just cannot buy the food that is theoretically "available".

-- Of the 23 million children born every year, 2.5 million die within the first year. Of the rest, one out of nine dies before the age of five and four out of ten suffer from malnutrition.

-- 75% of all the diseases in India are due to malnutrition,

-- 50% of children and 65% women suffer from iron deficiency, anaemia.
-- Only 25% of children are covered by the immunization programme. 1,3 million children die of diseases which could have been prevented by immunization.
-- 1/3 of the total population of India is exposed to Malaria, Filaria and Kalazar every year.
-- 550,000 people die of TB every year. About 900,000 people get infected by Tuberculosis every year.
--nAbout half a million people are affected with lepsory, which is 1/3 of the total number of leprosy patients in the world.
-- 70% of children are affected by some intestinal worm infestation.
-- 1.5 million children die due to diarrhoea every year.

A comparison of Infant Mortality Rates (i.e. number of deaths under the age of one month per thousand live births) of some countries in 1960 and 1985 shows that many countries with a poorer or comparable record 20 years back are today much ahead of India.

TABLE - 2

Country	IMR in 1960	IMR in 1985
Turkey	190	84
Egypt	179	93
Algeria	168	81
India	165	105
Vietnam	160	72
China	150	36
UAE	145	35
El Salvador	142	65
Jordan	135	49

Sources: *State of the World's Children' 1987 - UNICEF.

INADEQUATE RESOURCE ALLOCATION

One of the principal reasons for the state of health of

TABLE - 3

Plan Period	% share of Health Budget
1951-56	3.32
1956-61	3.01
1961-66	2.63
1966-69	2.11
1969-74	2.12
1974-79	1.92
1980-85	1.86
1985-90	1.88 (esstimated)

Source: GOI, Health Statistics of India, 1984.

The government spends just Rs.3/- per capita every month on Health. (This may be contrasted with the estimated average expenditure, incurred privately, of Rs.15/- per capita every month) The following table gives a comparison of the percentage of govt. allocation on health.

TABLE - 4

Country	% of central govt. expenditure allocated to health (1983)
India	2.4
Egypt	2.8
Bolivia	3.1
Zaire	3.2
Iran	5.7
Zimbabwe	6.1
Kenya	7.0
Brazil	7.3
Switzerland	13.4
FRG	18.6

Source: The state of the World's Children-1987.

Moreover, even these meager resources are not equitably distributed, 80% of the resources is spent on big hospitals and research institutions which are situated in metropolitan cities and large urban centres. They cater to less than 20% of the people. On the other hand just 20% of the resourcesis spent on primary

TABLE - 5

COMPARISION OF NO. OF HOSPITAL BEDS IN RURAL AND URBAN AREAS (As on 1.1.1984)

	No. of Hospitals	% of total	No.of Beds	%of total
Rural	1894	26.37%	68233	13.63%
Urban	5287	73.63%	432395	86.37%
Total	7181	100.00%	500628	100.00%

Source: Health Status of The Indian People, FRCH, 1987.

Of the total number (just over 2 lakhs) of allopathic physicians in the country, 72% are in urban areas. Further, only 15.25% of all health personnel work in the rural primary health sector of the government. As a result of the highly inadequate Govt. intervention in the health sector people are forced to take recourse to the private sector in health care. By this kind of an approach, health has been converted to a commodity to be purchased in the market. Only those who can afford it can avail of the existing health facilities. It is thus clear that health is perceived by the Govt. as a low priority area with grossly inadequate resource allocation, and a skewed pattern of utilisation of these meager resources. This is afundamental problem in the health sector which calls for rethinking refarding the whole developmental process in this country.

Here another disturbing trend needs to be mentioned. In the last few years there has been large scale investment by theprimate sector on curative services. With encouragement from the government for the first time in India big businesshouses are entering thefield of health care. In addition to the fact that they areexclusively meant for the elite, the trend is also an indicator of a certain kind of Philosophy within Goct. circles regafding health care. It is the kind of thinking which draws inspiration from a World Bank report which says "present health financing policies in most developing countries need to be substantially reoriented. Strategies favouring public provision of services at little or no fee to users and with little encouragement of risk-sharing have been widely unsuccessful". (de Ferranti, 1985). This, in other words, is a prescription for increased privatisation. The National Health Policy Statement says "With a view to reducing governmental expenditure and fully utilising

in providing health care to all. Increased privatisation in health can only serve to exclude the most impoverished sections, pricisely the section who need health services the most!. The answer to theGovt's inability to find sufficient resources for health programmes certainly cannot lie in taxing the community fof provision of health care.

LACK OF HOLISTIC APPROACH

Health services, in the traditional sense, are one of the main but by no means the only factor which influence the health status of the people. Today the concept of social medicine recognished the role ofsuch social economic factors on health as nutrition, employment, income distribution, environmental sanitation, water supply, housing etc. The Alma Ata declaration states "health, which is a state of complete physical, mental and social well bring, and not merely the absence of disease or informity, is a fundamental human right and that the attainment of the highest possible by level ofhealth is a most important world-wide social goal whose realisation requires the action of many other social and econokic sectors in addition to the health sector". Flowing from this understa ding, health is not considered any more a mere function of disease, doctor and drugs. Yet even today the existing public health infrastructure in India is loaded in favour of the curative aspects of health.

For a country like India, it is possible to significantly alter the health status of our people unless preventive and promotive aspects are giben due importance. An overwhelming majority of diseases can be prevented by the supply of clean drinking water by providing adequte nutrition to all, by immunizing children against prevalent diseases, by educating people about common ailments and by providing a clean andhygienic environment. It has been estimated that water-borne diesases like diarrhoea, poliomyeilitis and typoid account for the loss of 73 million work days every year. The cost in terms of medical treatment and lost production, as consequence, is estimated to be Rs.900 crores-which is about 50% of the total plan allocation on health!

Yet accordi ng to the Govt's health policy statement (1982)

50% of the total rural population. Where these centres have been set up, they are under staffed and suffer from lack of medicines and equipment.

Another major drawback has been the difficulty in attracting doctors to serve in the rural health scheme. By and large doctors opt to work in rural centres only as a last resort. This refelcts on both the quaity and motivation of medical personnel manning primary health centres. Unwillingness of doctors to serve in the rural sector is also an indictment of our medical education system. The curriculum is heavily loaded in favour of curative medicine and within this in favour of diseases conforming to themortality and morbidity profile in the West. During their period of training medical students are taught to rely on sophisticated disgnostic aids. Such training ensures that medical graduates are ill-equipped to work in conditions prevailing in the rural areas. Moreover the medical profession isinvested with an aura of glamour, which unfortunately is seen to be lacking in service in the rural sectors.

It needs also to understood that entry into medical colleges is by and large limited to those coming from a higher socio-economic stratea, predominantly from urban areas, who consequently find it difficult to conceive of working in rural areas. Even when uneploument among doctors is not uncommonm doctors are unwilling to take up jobs in PHCs. A two pronged strategy is required to tackle the situation. Medical curriculum has to be reoriented and entry into medical colleges needs to be regulated in a manner which ensures amorebalanced "mix" of students. Side by side incentives have to beworked out to attract doctors to the rural health schemes. After all its is impractical to believe that doctors ~~xexkhexxuxalxhexxkhxxekhxmes~~, are natutally fired by altruistic motives and with feeling of "service to the poor".

At the same time, within the medical fraternity, there is a strong resitance in changingehthe age old concept of health as function of doctors and drugs. Implementation of recent concept of primary health care requi es a certain degree of demystification of Medical Science. But within the established medical bureaucracy and in the entrenched sectionsof the medical fraternity there is a vested interest in maintaining the

However all theseprogrammes need tooperate through the rural health scheme, but as they have separate administrative controls, they are not accountable to the rural health scheme. As a result there is needless duplication of administrative manpower, costs and often confusion regarding aims. While the basic aim behind the vertical programmes of giving emphsis to problem areas is laudable. they need to be administratively integrated with the rural health scheme. Otherwise they will continue to work at cross purposes with the rural health scheme, often at great cost to the available material and human resources.

COMMUNITY PARTICIPATION

The slogan "Peoples" health in people "hands has today received universal support. Diverse agencies cutting across all kinds of ideological positions accept that community participation is vital to the sustenance of any comprehensive health programme. The Govt's Statement on Health Policy also recognises this position while stating "Also, over the years, the planning process hasbecome largely oblivious of the fact that the ultimate gola of achieving a satisfactory health status for all our people cannot be secured without involving the community int the identification of their health needs andpriorities as well as in the impelementation and management of the various health and related programmes". Unfortunately there is a basic lack of clarity on the ceoncept of community participation. Often, especially in official circles, it is taken to imply that the community participates in collectively receiving health services! A strategy developed by the Govt. to bring about community participation is the Community Health Worker (CHW) scheme. The scheme involves recruitment and traing of a Community Health Workers from every village community. The CHW is required to interact with the PHC system on behalf of the village community he repr sents. The scheme was introduced in 1977, as part of the Govt.'s Rural Health Scheme, nased on the recommendations of the Srivastava Committee (1975). The guidelines for the selection of dandidates for the CHW schemes are:

1) They should be permanent residents of the local community, perferably women. (in 1981 it was recommended that all

leaps and bounds. From a meager 0.14 Crores in the First Plan it went up to 409 Crores in the Fifth Plan, 1426 Crores in the Sixth Plan and finally to a proposed 3256 Crores in the Seventh Plan. Yet the birth rate has remained static at around 33 per 1000, for the last decade. How then is the continued increase in expenditure on family planning to be justified?

Actually the basic problem lies in the inverted logic that a falling birth rate precedes socio-economic development. The experience in countries all over the world has shown that exactly the reverse is true. The family planning programme as it stands today, is another example of attempting to find technological solutions to social problems which require societal measures. Moreover, the family planning programme with its fetish for targets, places an added burden on the health care delivery network, which it is ill equipped to carry. As a result there is a further whittling down of the already meager relief that the primary health care system provides. As noted in the case of other vertical programmes, the family planning programme too needs to function in an integrated manner with the rural health scheme.

CRISIS IN PHARMACEUTICAL INDUSTRY:

Though there continues to be a greater emphasis on the curative aspect of health even this area is plauged by a variety of problems. This is examplified by the total anarchy which prevails into the production and supply of medicines. Only 20% of the people have access to modern medicines. There are perennial shortages of essential drugs, while useless and hazardous drugs flourish in the market. There are 60,000 drug, formulations in the country, though it is widely accepted that about 250 drugs can take care of 95% of our needs. The market is flooded with useless formulations like tonics, caugh syrups and vitamins while anti-TB drug production is just 35% of the need. While 40,000 children go blind every year due to Vitamin-A Deficiency, Vitamin-A production was just 50% of the target in 1986-87. The production of Chloroquine has shown a decline in recent years, at a time when 20% of the people are exposed to Malaria every year.

Globally the Pharmaceutical Industry is today a live topic

turnover of the Pharmaceutical Industry has increased by leaps and bounds and today, globally, it stands next only to the Armaments Industry. The growth of the Industry has been phenomenal in India too. From a turnover of Rs.10 crores in 1947, it rose to Rs.1050 crores in 1975-76 and today stands at Rs.2350 crores.

In spite of the growth in Pharmaceutical production in the country, however, morbidity and morality profiles for a large number of diseases continue to be distressingly high. It is thus clear that there is a dichotomy between the actual Health "needs" of the country and drug production. It is also obvious that a mere arithmetic increase in Drug production cannot ensure any significant shift in disease patterns. Hence, if this dichotomy between drug production and disease patterns is to be resolved, some drastic measures are called for to change the pattern.

The Pharmaceutical Industry in India has developed along the lines followed in developed countries. The reasons for this are twofold. First, the Industry in India being in the grip of MNCs, drug production has naturally followed the pattern of production in the parent countries of these MNCs. No attempt has been made to assess to actual needs of the country. Secondly, the India/Drug Industry caters principally to the top 20% of our population, who have the purchasing power to buy medicines. This is also the section which is amenable to manipulationsby the high power marketing strategies of the drug companies. Moreover, in this section, disease patterns do roughtly correpondent to that in developed countries. The industry is thus able to neglect the needs of 80% of the population andyet make substantial profits. It sees no ned to change its pattern of drug production and thrust of its marketing strategu. One is unlikely to see any change in these areas unless the industry is compleeled to change by stringent regulatory measures, by the ov Government.

Further, drugs differe from other consumer goods, in that while the consumers have a direct say in the purchase of consumer goofd, such is not case for drugs. Drugs are purchased on the advice of doctors. Even in the caseof over the counter sales of drugs, doctors and chemists have role in determining themarket

large the curriculam has very limited relevance to the existing situation in the country. On this the report of the Medical Education Committee, Ministry of Health and Family Welfare says, "The present system of medical education has had no real impact on the medical care of the vast majority of the population of India". It is thus the not suprrising that what doctors prescribe have little relevance to the disease patterns in the country.

What is probably even worse is the fact that doctrs, after passing out of teachinginstitutions, have almost no access to unbiased drug information. As a result their prescribing habits are moulded by information regularly supplied by drug companies. This information for obvious reasons, is manipulated to support the production pattersn of the drug industry. So ulti tely what medicines the patients gets is determined not by his actual needs but by what the drug companies feel are necessary to maximise their profits.

INCORRECT PRIORITIES OF GOVERNMENT

The problem is compounded by themanner in which the government makes estimates for drug requirements. The most important criterion used for this purpose is based on 'market needs'. Given the scenario related above, this can never reflected the actual drug needs of the country. Today, a need is created forvarious inessential durgs, by salves prmotion campaigns conducted by drug companies. Thus for ecample Vitamins and tonics in large doses are prescribed lon with antibiotics. This is a 'created need', though Vitamins and tonics are sameof thehighest selling products in themarket.

India accounts for about 18% of the world's population, manufactures andmarkets only 2% of the total global drug production, out of which barely 30% are essential, to meet the drug needs to drug to treat 24% of the total global morbidity. Thefollowing table gives us some idea of the shortfall in essential drug production. (Though the gravity of the situation ismore than waht the table indicates, as the demand estimategiven for 1982-83-based on government figures are a gross under estimation. Moreover for 1986-87 the Chemicals Ministry has even stopped giving gurues for demand estimates, and supplies only figures fortarget of production!)

TABLE - 6

Chloramphenicol	T	300	111.46	300	71.60
Ampicillin	T	200	142.27	380	158.45
Vitamin-A	MMU	77	52.00	140	69.34
INH (anti Tubercular)	T	250	288.40	325	188.59
Chloroquine	T	200	194.57	410	177.61
Dapsone (Anti Leprosy)	T	200	86.90	60	25.51
Diptheria Anti Toxin	MU	800	653.57	800	691.05

Source: Indian Drug Statistics, 1984-85 Ministry of Chemicals and Fertilizers, GOI. & Annual Report Department of Chemicals and Petrochemicals, GOI, 1987-88.

The Indian sector in the Pharmaceutical Industry(including both private and public) has the capability to produce all essential drugs. Yet the multinational sector continues to play a dominant role. The mercenary attitude of drug multinationals is responsible for holding the health of the country to ransom. They market drugs in this country which arebanned in their parent countries. They use the country to test new drugs with dangerious side effects and in a variety of ways flout the law of the land with inpunity. Health related industry has the second largest turnover, owlr over, after the armaments industry. Today the predatory nature of thepharmaceuticals industry appears ready to outstrip even the arnaments industry. The conctol of drug multinational companies on the the Indian market is alsmot complete. There are more than 50 MNCs in the drug market in India. Fifteen such companies control as much as 31.8% if the total Indian market. MNCs in theprocess have earned huge profits while charging exorbitant prices for their products.

There have been persistant demands that the Multinational companies should be nationalised. In fact this was one of the recommendations of the Hathi Committee set up in 1974 to go into the problems of the Pharmaceutical Industry. MNCs are still being allowed to operate in this country on the plea that they bring in new technology. Yettheir record in the last decade shows that their contribution in this field has been less than the Small Scale Sector. Today the MNCs reap super-profits by mainly producing inessential drugs. The following table gives an account of the contribution of MNCs in drug production

TABLE-7

COMPARATIVE CONTRIBUTION OF MNCs AND NATIONAL Cos

(Top 85 Cos.)

(Rs.in Crores)

Class of Drug	Total prod.	MNCs(40)	National(45)
ESSENTIAL			
Antibiotics	256.5	82.9	173.6
		(32.3%)	(67.7%)
Anti-T.B.	29.2	4.0	25.2
Anti-T.B.	29.2		
Sera-Vaccines	1.5	0.5	1.0
		(33.3%)	(66.7%)
INESSENTIAL			
SIMPLE REMEDIES			
Tronics	32.0	20.1	11.9
		(62.8%)	(37.2%)
Cough&Cold	55.7	41.4	14.3
		(74.3%)	(25.7%)
Preparations			
Rubs &Balms	12.5	12.3	0.2
		(98.4%)	(1.6%)
Vitamin	98.0	78.8	19.2
		(80.4%)	(18.6%)

Source: ORG Retail Survey, April 85 to March 86.

The new drug policy announced in December 1986, instead of spelling out measures for control of MNCs has granted them even more concessions. It has allowed increased profitability on drugs and has reduced production controls. The recent trends of import liberalisation and peoduction and price decontrols are in line with the present over ments attitude to industry as a whole. However the drug industry is probably unique in that it has adirect bearing on the lives of almost everyone. The Government has never, while formulating its drug policy, takenitto account this uniquences. As a result "market"forces" are being allowed to determine the availabilty andprices of drugs. In a situation w ere only one out of following a policy which is detrimental to the interests of an overwhelming majority of people.

ROLE OF VOLUNTARY AGENCIES

Probably the single largest contingent of Voluntary agencies are involved in work in thehealth sector. Unfortunately thenet output of their work has not been commensurate with theextent of their presence. One of the major problems has been themultiplicity of

are depedent on the quality of those heading such projects, which ultimately works as a constraint in replication of pioneering efforts in different conditions. Moreoverthe need to develope models for replication are not recognised as a priority by most. These problems are often compounded by the multiplicity of dunding agencies, each with differing perspectives. This results, at times, in agencies having to modify their outputs to suit the needs of funding agencies.

Compared to Government services the coverage by the Voluntary sector in providing primary health care is negligible and will remain so indeed, the basic responsibility forhealth care must rest only with the state. Hence the contribution of the Voluntary section in India needs to be assessed in terms of the kindof innovative ideas andprogrammes it has been able to throw up in thelight of its experiences, With the voluntary sector three broad trends can be identified. Some agencies are engared primarily in providing curative services. There are others who have attempted to impelmented the concept of Primary Health Care by also incldуing programmes aimed at community participation and preventive care. A third set has taken up broader issues like land relations, agr cultural wagesm power structures in villate communities etc. in addition to health issues.

The latter two trends have come up with alternate models for primary health care. Unfortunately very f of them aresuch as can be replicated under different conditions all overthecountry. The reasons for this are many, but some may be highlighted. Most a gencies depend heavily on the drive and initiative of 2-3 individuals. As replicability is not seen as a priority little thinking has gone into formulating strate ies that do not depend on the quality of a 2-3 project leaders. The costs involved, sources of funding and their impact on replicability have also not been worked out. Another notable trend is that, in looking for alternate modesl, emphsis has been on "parallel" structures andmechanisms outside the state run PHC structures-i.e the outlook is to build new structures to by passor even run counter to the existing health delivery network. For nationwide impact, such an enterprise would neither be successful nor desirable. further, such fundamentally differently structures may in fact be envisaged only under alternative socio-economic structures and this, of course, is why the need is felt by somehealth groups to engage themselves in taking

in the purely socio-economic political dokain, PSMorganisations work both to promote greater consciousness about the issue and to creat working "models" -i.e. viable and replicable structures with the potential for becoming nationwide alternative policies and impkementation mechanisms. In the health sector, as perhaps in education too, this would necessarily involve working, in a broad sesnes, within existing institutional&other structures and looking for alternative models&mechanisms for the State Health Delivery System, with well-defined roles for PSM and other peoles' organisations.

ROLE OF AIPSN

The AIPSM has the potential forintervening in a meanginful way in the health sector. It has thetwin advantage of having an All India reach and a relative homogeneity of purpose and approach. There is also the in-built scope for exchange of views among constitutent organisations. Moreover already existing linkages with organisations of medical and para-medical personnal can be strengthened. Such advantages confer on the AIPSN the necessary impetus to overcome many of the shortcomings of voluntary agencies cited above. The broad direction of AIPSN's involvement in health should be along the following lines:

__ Policy issues: Work out its perspective on Health Policy, Drug Policy etc. A campaign aimed at the policy makers can be planned based on this perspective.

--Mass campaigns: Based on the AIPSN's basic understanding regarding health some fundamental demands need to be formulated. These can be taken up as campaign issues among the general public. Given the nascent stage of develppment of the Peoples Science Movement in most stages, the campaign should be focussed on a few key demands.

-- Linkages with health delivery personnel: Lingages need to be built with organisation of doctors, para-medical personnel, medical representatives etv. Such linkages can work also to attract these sections, involved in health care delivery, to the Peoples Science Movement.

-- Models ofor Primary Health Care: Initially in a few selected areas the AIPSN should develop models for Primary Health Care. Based on the experience gained strategies for replication can be

The most probelematic area in the Health Care Delivery system in the country is the interface between the PHC system and the users of this system i.e. village communities. The AIPSN can have a major role to play in this area. It can play the catalysing role in making the PHC system more answerable to the community. It can also work towards sensitising communities to issues to issues related to health, so that instead of being passive recepients of Government servces they can involve themselves in the decision making process. Such interventions also require demooratisation of the political and administrative set up, with much greater powers being reserved for local b odies right down to the panchayat samities. Here again the AIPSN can play a major role in association with local democratic organisations of thepeople. Given such a perspecpective the AIPSN with its All India reach, is in a position to work out models for primary Health Care which can be replicated all over the country.

--- Referemce

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BUILDING THE NEW PARADIGM

- A Study-Reflection-Action experiment on Community Health In India

Community Health Cell
47/1 St Mark's Road
Bangalore 560 001

The Community Health Cell (CHC) is a Study-Reflection-Action experiment drawing upon the rich and varied experience in Community Health Care from all over our country. In the initial phase, two members of the existing team travelled all over the country interacting with Health and Development projects. The team now continues interactions from its base at Bangalore, Karnataka.

The Study-Reflection-Action experiment has been based on interactions which are open-ended, non-formal, non-threatening and a reflective exploration of past experiences and future plans.

The purpose of the CHC experiment has been to build a framework for an alternative approach to health care, based on a diversity of micro-level experiences. The attempt has been to look at philosophical assumptions, goals, methodologies, successes and failures, strengths and weaknesses, opportunities and threats in order to build the components of a new paradigm.

A necessary first step of this approach has been the experimentation within the team with a non-hierarchical, participatory, mutually supportive effort in its working. This has led to democratic decision making which has a team-sustaining effect and smoother function. The team has a few full timers, while the part-timers contribute at

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their convenience, such that their participation has a flexibility ranging from half-a-day contribution, through alternate day work, to even alternate week contributions to the team. In addition, there are a number of associates on the CHC network, coming together off and on.

The catalyst process has generated activity for the CHC team, ranging from participatory reflections, perspective planning, exploration, issue-raising, networking, documentation, inputs into training programmes, workshops, seminars and Action research on Community Health related issues.

The CHC team participates with individuals, whether health professionals or otherwise, field based project groups, Resource and Co-ordinating groups and Government agencies interested in exploring Community Health Action in its various dimension.

The topic range spans Rational Drug Therapy, Alternative medical education, community health training, Environmental health issues, Health Policy matters, Medical Pluralism and Integration of Traditional Systems of Medicine in Health Care and so on. In short, anything of relevance to Community Health.

The definition that is emerging from our interactions over six years is that

> "Community Health is a process of enabling people to exercise collectively their responsibility to their own health and to demand health as their right. It involves the increasing of the individual, family and community autonomy over health and over organisations, means, opportunities, knowledge, skills and supportive structure that make health possible"

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To make Community Health a reality, the present health superstructure has to be:

* more 'people oriented'
* more 'community' oriented
* more socio-epidemiologically oriented
* more democratic and participatory, and
* more accountable.

The paradigm shift is to be in our thinking of health and health care from the orthodox medical model of health to understanding, appreciating and practicing a social model that will tackle health problems at its deeper roots. This shift of emphasis should take place at all levels and at all dimensions of existing health care planning and management.

The Technological/Managerial components of the new Paradigm include:

* Appropriate Technology for Health
* Community organisation and participation in Health
* Community/Village Health Workers
* Involvement of Traditional Healers, Dais and indigenous system
* Education for Health
* Health with Integrated Development
* Community support to Health Care -- financial/ resources.

....4

The critical Social values/issues of the new Paradigm include:

* Social Analysis, conflict management
* Individual/Community autonomy
* Medical Pluralism
* Accountability and socio-medical audit of health services
* Demystification and skill transfer
* Community building efforts
* Participatory Team decision making.

Despite some negative trends like Commercialisation of medicine, mushrooming of medicalised health projects, verticalisation of health efforts and cooption of Health by status-quo forces, it is heartening to note an emerging growth of people/project/group aware of the deeper dimensions of Community Health symbolised by:

a. new approaches in Government policy reflections,

b. a growing base of village health workers,

c. involvement of non-medical health activists in health care issues,

d. health issues becoming part of the education process, and

e. health issues emerging in other movements, like the Science, Environment and Women's movements and so on.

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A time has come to take critical stock of the Community Health Action reflection and experimentation in India and identifying the enabling/empowering dimensions so that groups like the People Science Network can build their health action efforts within this emerging paradigm. Ultimately all Community Health action initiators have to ask themselves the following three questions:

1. Will we work together to put pressure on the established medical system to commit itself to this new vision of Health Care?

2. Will we work together to put pressure on 'Health Policy and decision makers' to move beyond policy statements and get community health oriented programmes and actions off the ground?

3. Will we work with the people and their organisations to enable and empower them to get the means, structures, opportunities, skills, knowledge and organisations that make health possible?

All these are unanswered questions. Micro level experiments have shown that a lot is possible, but macro level change requires a collective understanding and a collective vision.

WE EARNESTLY HOPE THAT THIS PEOPLES' HEALTH SCIENCE CONGRESS WILL BEGIN THIS PROCESS.

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This working paper is based on five key papers of Community Health Cell which are available on request for all those who wish to explore these ideas further.

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Please write to author

C/o:Community Health Cell
No 47/1 St Mark's Road
Bangalore 560 001.

PEOPLE'S PARTICIPATION IN HEALTH: THE CATALYTIC ROLE OF THE KERALA SASTRA SAHITYA PARISHAT (K S S P)

V. Raman Kutty

INTRODUCTION: Community participation has been accepted as a major factor in health development strategies in the context of health for all by 2000 A.D.[1] This marks a departure from earlier paradigms where health was seen as a purely 'techno-economic' problem: technology being inappropriate and/or unavailable, and if available, resources being constrained so as to make access impossible for most of the population. This rethinking has come in the wake of the WHO's adoption of the policy of primary health care as the appropriate one for reaching health for all, when it was realised that health development in most of the third world followed inappropriate models.

But community participation cannot be understood in isolation from the realities of the social situation. If the power structure of the society and the resource misallocation that it has given rise to is ignored in promoting community participation, then it is likely to degenerate into a passive participation as 'beneficiaries', and not participation in decision making[2]. This would only serve, in the name of community participation, to legitimise exploitation in the health field.

Non governmental organisations (NGO's) are seen as nodal agencies to promote participation by people in health activities. This is because in most developing countries, government institutions are apathetic to the real needs of development in the rural sector. Moreover, NGO's also seem to inspire more confidence in the people than government organisations which are often viewed with suspicion due to various reasons. (Here NGO is used in the sense of any organisation other than profit making commercial concerns, not connected with the government).

these organisations, one can recognize 2 types: research and analysis oriented, and action oriented.

But it also true that many NGO's do not offer a viable alternative in development. 'Lip service is often paid to such phrases as 'community based' and 'community participation'. Many projects are seen as offering neither responsibility nor opportunity for decision making locally. In many instances, decisions are made nationally by the elite. Often foreign managers and their salaries absorb a large percentage of the available funds[3]. At best these types of NGOs offer a bland volutarism which smacks of charity; at worst they degenerate into agencies subtly serving the interests of foreign organisations or governments in the country.

It is in this context that we propose the unique role and experience of the Kerala Sastra Sahitya Parishat (KSSP) as a model for development effort from the people in the area of health.

HISTORICAL: The KSSP was formed in 1962 as an organisation of science writeres in Malayalam. It evolved from earlier societies in the fifties primarily concerned with the problems of those who were trying to popularise science topics in the local language. Very soon it grew into an association which welcomed anyone interested in science and prepared to accept the scientific method as a guideline to analyse problems of man, life and society. This growth also meant that the organization changed its style from detached deliberations of intellectuals to active action oriented programmes and involvement at grassroots level. It was sustained by a very democratic style of functioning and grew to have numerous branches throughout the state.

The Parishat has a guiding philosophy which can be summed up as 'science for social revolution'[4]. In other words, the scientific method forces us to see (a) all processes as constantly subject to flux or change, and (b) the potential of science as an agent to bring about change in a desired

Thus the KSSP has been in the forefront of all major movements in the state towards a more people-oriented policy in areas such as energy, health, environment, and planning. Notable among these are its involvement in studies on the ecosystem of Kuttanad, on the pollution caused by various industrial units in the state, and its championing of the cause of preserving the silent valley, a veritable gene pool, against submersion by a proposed hydroelectric project. This latter struggle earned the KSSP many epithets, from friends and enemies alike, notably that of being 'anti-development'. But in the decade since the project was abandoned, most people have accepted the wisdom of the KSSP in opposing the silent valley project.

The KSSP sees its involvement in health as part of this overall scheme. Its major thrust area in health has been, for a long time, the need for a rational drug policy. Kerala is a state where the demand for health care is being exploited to the fullest extent by national and international lobbies alike. It offers one of the major markets in India where considerable amounts of irrational and even dangerous drugs are being sold. This is the result of an unholy alliance between profiteering firms and some not very discerning doctors. The Parishat launched its campaign for a rational drug policy with seminars, discussions and meetings all over the state, taking the drug issue right to the people. A major initiative was the seminar 'A decade after Hathi committee' in 1985 in Trivandrum. It can be said that the KSSP was responsible for the revival of the Hathi committee report from the quiet oblivion to which it seemed to be delegated by the authorities.

Health activities initiated by the KSSP took many forms. Some of these, over the years, have been:

1. organising of thousands of health classes for the people in 1985,

4. drug information packet for the doctors,

5. the health survey in 1987, which was an occasion for educating Parishat activists on the public health issues in the state,

6. the call for boycott of Union Carbide products following the Bhopal industrial disorder, and the campaign against the callousness of MNC's operating in underdeveloped countries,

7. most recently, the initiative to utilize the 100% literacy drive in Ernakulam district to make a campaign for 100% immunisation in the district.

The Parishat shares with other health movements in India a strong critique of the existing health system, which is characterised by hospital and curative orientation, urban bias, and elitism. But it does not subscribe to the view that it is futile to attempt to reform it. The KSSP has stated its desire to see a dialogue between scientific practitioners of different systems so that points of convergence may emerge. But the KSSP does not support the view that modern medicine is an alien science and should be rejected in toto.

The theoretical framework for the KSSP's health activities can be summed up as follows:

1. Health of the people cannot be seen in isolation from the socio-economic processes around us. It cannot be reduced to an equation of doctors, drugs, and technology.

2. The increasing technological complexity of modern medicine has led to an alienation of health care from the people for whom it is intended. This is turn results in exploitation of the people by unscrupulous professionals, companies, and others in the health field. Knowledge is the best guard against such exploitation. So the KSSP aims to arm the people with information.

3. Ultimately, 'health for all' cannot be achieved without active support from the people not only as beneficiaries, but also in the decision making process. So the KSSP tries to act as a catalyst in inducing people's participation in health.

The greatest advantage of the organisation over its fellow groups active in the health field is that it is not confined to health activities alone. Thus KSSP worker is aware of the links between the campaigns for cleaner water, better stoves, and the drive for promotion of oral rehydration. He sees the organisation push the campaign for 100% literacy to one for 100% immunisation, and how literacy helps create the demand for immunisation. This is a unique role which very few other organisations are fortunate to emulate.

Moreover, health activism in KSSP is not confined to doctors or health professionals. The 'demystification' of health is an important part of our strategy to take health to the people. The grassroots level acceptance and democratic functioning of the organization provide a better environment for promoting health action.

SOME CONSTRAINTS: But being a mass organisation has its own problems. Most voluntary organisations in India play a complementary or substitute role. Because government organisations are inadequate to perform their own tasks in health, voluntary agencies try to replace them or substitute their work in some areas. They do most of the jobs which ought to have been undertaken by the government agencies themselves. The Parishat does not believe in this philosophy. We think that in a democratic polity, polular pressure can and should result in a more responsive role by government institutions. This often means that some avenues of activity are resorted to only as a last measure. The KSSP is also particular not to be involved in major projects involving donor funding.

The KSSP, eventhough an organisation committed to the ethos of science, has had very little opportunity so far to initiate original research. This has been compensated to a large extent by the involvement in action research as in the development of smokeless chulhas or the health survey. The Integrated Rural Technology Centre is a specific step in this direction to initiate research appropriate to the needs of the people.

In conclusion, the KSSP in health strives to act as a catalyst for people's participation. Without this, we believe, no programme in primary health care shall ever be successful.

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A "PEOPLES' CLINIC" - EXPERIENCES

"RAMACHANDRA REDDY PEOPLES POLYCLINIC" as it is now called is an institution which is serving people of Nellore District and its adjacent districts in its own humble way. It is managed by a trust. It may be interesting for an activist in the health movement, to know the experiences of a hospital whose basic concern is common man and his ailment.

BACKGROUND & DEVELOPMENT OF THE PEOPLES CLINIC

Dr.Ramachandra Reddy's activities and the evolution of the Peoples Clinic cannot be seen or understood separately. They are so closely interrelated that a brief account of his activities is necessary to understand the guiding philosophy behind the peoples clinic.

Inspired by the National movement in the thirties when the country was politically electrified, Dr. Ram, as he is fondly called, was drawn into the struggle against British. Coming from a very remote village of Nellore District , he was able to see, experience, appreciate and understand the suffering of the vast masses of the rural side. These people got very little food to eat, practically no clothing on them. Emaciated to the bones. No worthwhile shelter. Literacy unknown. Children utterly malnourished. Production primitive. Superstitions rampant, almost bordering on Tribal culture. Added to this is the attrocities of the landed gentry, the religious clergies and the harassment of the police. He wanted to

With this background, he having become a doctor, wanted to utilise his knowledge and technical skills in the service of the downtrodden not only in the field of medicine but in social, economic, educational, cultural and political fields. His area of work also extended to organise intellectuals. He established Science Clubs, drawn intellectuals(College teachers, doctors, lawyers etc), into it and was able to inculcate scientific attitudes through its activity.

He has grown to a stature that he played key role to avert communal clashes in Nellore Town. He became a legend in his own lifetime.

The influence of his activities moulded the thinking and working pattern of the doctors and staff of the hospital. He caught the imagination of the youth and mobilised them in the service of the down-trodden. The Peoples Clinic slowly emerged and evolved into an institution and with a philosophy of its own.

BEGINNING:

The Hospital was started with the team of three doctors. Ofcourse, Dr. Ram's name is synonimous with the clinic. He brought modern medicine in a revolutionary way within the reach of the poor people. He and his team of doctors did a lot of promotive, preventive and curative work, on a very large scale. He himself being an eminent, skilled and exceptionally genious doctor he was able to train many doctors to become proficient in their skills.

Taking note of the strong family traditions in rural India, he used to utilise the services of the family members in attending the sick, instead of the hospital-aides. He evolved a new concept of a family member attend a patient, more or less as medical-aids, with good results. In the course of treatment, he was able to communicate with the family members of the sick people about health, hygenic and pestelence etc. During this process he was able to convince the people and dispel many a superstition in them. At the same time, he would demistify the therapeutic wonders achieved by Modern medicine. At times when communicable diseases (cholera, maleria, filaria, small pox, meseals, chicken pox etc.) become epidemics he used to go to the villages and take the people into confidence and saw to it to prevent in first place and to treat those who are affected. In a very short time he was able to achieve spectacular results in all these epidemical forms of diseases.

Another important area of his mass education is nutrition. When people had mythical understanding about food ("bread, apple, barly etc. are better food for sick people"), he used to give proper perspectives in a relevant situation.

Eventhough other doctors and staff members of the hospital worked in the same direction as that of Dr. Ram's, the hospital got personified in him. We are zealously guarding the traditions set by Dr. Ram till now.

As the Hospital grow into an institution, more and more joined and to day it is a fully grown polyclinic

The doctors, 120 of them, trained in the above said traditions, spread all over Andhra State. They have been able to reach out the most needy and neglected sections of the Society.

CURRENT ACTIVITIES:--

Apart from the curative area of health, the institution is engaged in many other activities, in the path shown by Dr. Ram.

In the recent past, youth drawn from rural Nellore was trained both in health education and limited first-aid. These paramedics guide the people in their respective Villages to take necessary preventive steps amongst the community and guide those who need curative treatment appropriately and in time. They also give relevant information to the Health authorities and get various preventive measures implemented in their Villages. These health workers have got many achievements to their credit in the fight against diseases like cholera, malaria etc. and to get immunization done on a large scale in rural Nellore.

In the field of health education our doctors used to educate patients and their families about misconceptions and misunderstandings (tonics, injections, health drinks, food habits etc.) in the day to day life. Most of times own prescriptions are bounded by W.H.O. list of essential drugs. We scrupulously avoid unnecessary drugs, hazardous drugs and irrational drugs. This method is evolved through persistent discussion and education of

they can manage medical, surgical and obstritic problems. It is such type of basic doctor, we feel, needed in the present indian situation , where the specialities are mushrooming up, mostly taking Care of the rich, leaving the majority of the poor to either lack of medical facilities or to the Fresh medical graduates, who were given little training in Medical Colleges in dealing with the rural medical problems. The paramedics are also trained in such a way that most of them cannot only attend to the needs of the ward, O.P. , Operation Theatre but acquire basic skills in the techniques of X-Ray, E.C.G. and Laboratory.

Through this institution of Health, we have immense opportunities to penetrate into the closed groups of the Society, (who have been shielded by various vested interests) and give them some out look of health education and scientific attitudes.

Through exhibitions, cultural programmes, book publications and public meetings, our doctors are inculcating scientific attitudes in common people. We are getting good results in these fields. We found that people will readily accept most of the scientific thinking in field of health (breast feeding, ORT etc.) provided they are properly communicated and convinced.

At times of natural calamities, our institution teams rushed to those areas and helped the affected in its own way (Great Bengal Famine of 1943, Rayalaseema Famine of 1952. Tragedy of Tidal wave of Coastal Andhra of 1977

We have to go a long way in the aspects of preventive health and the institution is gearing up for this task. On curative side our work worth mentioning. Daily on an average 350-400 out-patients will get consultation and treatment from the doctors. The in-patient turnover is 6,000 in a year, with its 175 bed capacity. The Major surgical procedures done per year more than 1,200 and the Minor surgeries will be to the tune of 5,000 per year. This large turnover of patients on the curative sector is one of the factors which makes the doctors panetrate into the Society and reach the remote villages. One of the main reasons for this large turnover is the cost effectiveness. The modern medical facilities are catered to the needy at a low cost because of the sacrifice and industry of the doctors and staff and also because of the ethical methods that are adopted.

In the conclusion, the institution is being recognised as the one for people, and they own it and protect it. But all this is not achieved smoothly. It has to fight against many odds, against conservative outlook, against many attitudes. In one sentence it is a swim against current and it continues to be so. It is not possible without the services of many and dedicated youth, who has come to work here as doctors and paramedics. With their dedication, determination and steadfastness, they worked in whatever form demanded of them.

The tremondous mass support this activity received from the people, sacrifices by various individuals and

COMMUNITY HEALTH CELL
47/1, (First Floor) St. Marks Road
BANGALORE - 560 001

SCIENTIFIC AWARENESS FOR PEOPLES BENEFIT - CHAI'S CONTRIBUTION

Catholic Hospital Association of India is a national organization of 2,222 member hospitals, dispensaries, health centres and social service societies spread throughout the Country. Our member hospitals are noted for quality and efficiency of services and utilization of latest technologies and advancement in medical science.

Very often, missionary sisters and priests had started these institutions in needy areas where suffering humanity had no other option for health care. Some of them started in a very humble way and grew into impressive institutions. It was the compassion and healing spirit of Jesus Christ that motivated them to go to the extreme rural areas and to the peripheries. But as the years passed, critical evaluation makes us realise that some of us have lost the original vision and commitment to the people. Survival and maintenance of the institution became the focus of attention. Sophistication and incorporation of advanced medical technology turned out to be the answer to survival. Some of these modern changes are not affordable by the poor majority and the fact remains that we fail to realise the additional burden we place on the poor due to this.

CHAI, holding on to its original vision, endeavours a critical analysis of the health situation in the country in relation to the socio-economic and political situation. Very often many of the health problems, in a detailed analysis, ultimately are due to an unjust distribution of land, unequal sharing of profits, exploitatory marketing systems and unfair wages. This leads to poverty of many and surplus for a minority. It is this poverty-stricken majority that have malnutrition, recurrent illnesses and chronic diseases unattended adequately. It is the weak women of this majority who will be doing hard labour inspite of carrying a baby in an anaemic body. They will deliver a low birth-weight infant which will continue to have a poor weight gain and succumb to many infantile disease.

They are unimmunized as their parents do not know its

mosquitoes in plenty. They are fondled and cared for by elders who cough out tuberculous bacilli. Their weaning foods are mixed with water drawn from the village pond which carry any number of Rota Virus, Amoebic Cysts, Round Worm Ova, Hepatitits Virus, Typhoid and even Cholera Bacilli.

Out of whatever little money their parents earn toiling many hours in the hot sun, a good share is spent in the local arrack shop which is run quite profitably by the rich business class. This business class will see to it that no saving schemes survive in the village as it will make the poor villagers stronger in facing any financial crisis. Only when such saving schemes collapse, the poorest of poor will fall at the feet of the money lender and become more and more chained to him.

Health can never be a reality in such a vicious circle. No amount of medicines or efficient medical staff can ensure the total well-being of that community.

In the light of the above analysis we realise that unless people are made to take care of their own health, HEALTH FOR ALL BY 2000 AD will be a myth. It is this "enabling" process that CHAI has been facilitating through many of its programmes. Ultimately we want "empowered" communities who can understand their health problems and take appropriate remedial measures. We believe that the poor can do "something" for themselves and they are "somebody" in society. The poor man with a number of miseries, a great deal of incapacities and innumerable needs, poses before us as a man who has lost his dignity. We want people to rediscover their dignity and self esteem. They should also rediscover their potential in achieving remedial changes.

Our awareness building programmes are aimed at raising a critical consciousness level of the community so that they will be analysing, questioning and challenging people on various relevant issues. Based on the community's

insisted upon, based on a prioritization. Those health activities which will bring about maximum desirable changes in society and those activities which require minimum resources input, deserve a high priority. If people are involved in health activities it becomes a people's movement. It is this movement we are facilitating through our orientation sessions, training programmes, follow up and evaluation and replanning of various projects. Many of our hospitals are getting reoriented in undertaking community based health care programmes. Many institutions have taken up training of local community health volunteers to increase the army of community health movement. At a national level we organise programmes for leaders of community health projects. We also identify appropriate resource persons in various parts of the country and strengthen regional resource team for training more workers.

CHAI has taken leadership in coordinating many of the isolated health activists groups and promoting linkages among them. We also facilitate exchange programmes between people based health movements of other countries such as Philippines, SAARC Countries, Latin America etc.

Another attempt of ours is to influence the donor agencies in America, West Germany, Holland, Switzerland, etc to direct more funds to 'people based' health programmes rather than sophistication of big institutions.

RATIONAL DRUG THERAPY: Drugs being one consumer item in which the consumer has no say in the selection and use, was our major concern for many years. This consumer item was misused widely knowingly or unknowingly. The prescriber has to apply maximum ethical principles considering financial status of the patient, cost benefit ratio, actual indication, side effects, availability of alternative drugs etc. Through various conventions, training programmes, our publication Health Action , we have promoted the concept of essential drug and rational drug therapy. Many of our member hospitals have made a conscious attempt to remove all banned drugs from their pharmacies. Some institutions have a "Therapeutics Committee" which

hospital formulary. Still the pressurising marketing technics of many drug companies are influencing our institutions. In the field of quality control of available drugs we do not have enough facilities to monitor and report promptly to member institutions. Even at Government level only four states in India have adequately equipped drug testing labs and partial facilities in ten states. 10 states do not have any quality control test labs. To meet this lacunae in service, and ensure the quality of the drugs, CHAI is planning to start a central quality control lab of its own.

The necessity of public opinion andconsumer pressure on the prescribing doctor, for the effective implementation of rational drug therapy is quite significant. Our publications including Health Action magazine continuously try to educate the masses in this regard.

CHAI had initiated to bring together the producers of essential drugs who also believe in Rational Drug Therapy. The plan is to form a cooperate body of these producers for pooled procurement of bulk drugs and ensuring steady production of good quality essential drugs at reasonable prices.

MISUSE OF MEDICAL TECHNOLOGY : We are protesting against misuse of any medical technology. The Amniocentesis for sex determination and descrimination to girls are strongly condemned. When Ultra Sound Scanning and CAT scanning became the fashion of the day an unhealthy trend to overuse them was noticed. The Doctor-Medical Technology Axis was unfavourable to the poor man. We also expressed our distress in the growing commercial cooperate sector hospitals, especially by the business groups and non-resident Indians. The value system cultivated in these institutions is damaging to the medical profession.

There are attempts to study and campaign against unnecessary surgical procedures such as Caesarean, Appendicectomy and unnecessary lab investigations.

which if explained to mothers can save millions of dying children. We had organized 9 regional workshops for Paediatricians and Paediatric nurses in reorienting them in diarrhoea management. Each hospital is supposed to start an Oral Rehydration Corner in their out-patient departments and in the paediatric wards. An innovative attempt to expose ORT to the general public was done in the twin cities of Secunderabad and Hyderabad by starting demostration counters at Railway Stations, Bus Stands, Post offices, Museums etc. during last summer.

Immunization is another scientific technology that has to reach every common man for a safer future generation. Social mobilization for immunization is one area to which CHAI had given emphasis last year. There was overwhelming response from our member institutions for taking this up seriously.

We believe many of the herbal and home remedies practiced through generations in various parts of the country are effective. It is cheap and affordable to the people. Scientific bases of its action is yet to be discovered. A lot of research if undertaken in due course might generate many effective indegenous drugs eg. Reserpine, Vincristine etc. We encourage the practice of herbal medicine.

CONCLUSION : CHAI believes in peoples' welfare through peoples' power. This power of the people generates from awareness building and peoples' organization. Science movements contribute enormously to peoples' awareness.

The Declaration of Alma - Ata

Primary Health Care is the key to health for all

In a world in which four - fifths of the population has no access to any permanent form of health care, and in which millions more are disenchanted with the service provided by conventional health systems, primary health care is the key to achieving an acceptable level of health for all. The International Conference on Primary Health Care, held at Alma - Ata in the USSR from 6 to 12 September 1978, drew up the fundamental principles of this far - seeing concept and embodied them in The Declaration of Alma - Ata. Urgent national and international action is needed now to translate these principles into dynamic, practical programmes.

WORLD HEALTH ORGANIZATION * UNITED NATIONS CHILDREN'S FUND

Declaration of Alma-Ata

The International Conference on Primary Health Care meeting in Alma-Ata this twelfth day of September in the year Nineteen hundred and seventy-eight. expressing the need for urgent action by all governments. all health and development workers and the world community to protect and promote the health of all the people of the world, hereby makes the following Declaration :

I

The conference strongly reaffirms that health, which is a state of complete physical, mental and social well being and not merely the absence of disease or infirmity, is a fundamental human right and that the attainment of the highest possible level of health is a most important world-wide social goal whose realization requires the action of many other social and economic sectors in addition to the health sector.

II

The existing gross inequality in the health status of the people, particularly between developed and developing countries as well as within countries, is politically, socially and economically unacceptable and is, therefore, of common concern to all countries.

III

Economic and social development, based on a New International Economic Order, is of basic importance to the fullest attainment of health for all and to the reduction of the gap between the health status of the developing and developed countries. The promotion and protection of the health of the people is essential to sustained economic and social development and contributes to a better quality of life and to world peace.

IV

The people have the right and duty to participate individually and collectively in the planning and implementation of their health care.

V

Governments have a responsibility for the health of their people which can be fulfilled only by the provision of adequate health and social measures. A main social target of governments, international organizations and the whole world community in the coming decades should be the attainment by all peoples of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life. Primary health care is the key to attai-

ning this target as part of development in the spirit of social justice.

VI

Primary health care is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participataion and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self reliance and self-determination. It forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process.

VII

Primary health care :

1. reflects and evolves from the economic conditions and socio-cultural and political characteristics of the country and its communities, and is based on the application of the relevant results of social, biomedical and health services research and public health experience ;

2. addresses the main health problems in the community, providing promotive, preventive, curative and rehabilitative services accordingly ;

3. includes at least : education concerning prevailing health problems and the methods of preventing and controlling them, promotion of food supply and proper nutrition, an adequate supply of safe water and basic sanitation, material and child health care, including family planning, immunization against the major infectious diseases, prevention and control of locally endemic diseases, appropriate treatment of common diseases and injuries and provision of essential drugs:

4. involves, in addition to the health sector, all related sectors and aspects of national and community development, in particular agriculture, animal husbandry, food, industry, education, housing, public works, communications and other sectors and demands the coordinated efforts of all those sectors:

5. requires and promotes maximum community and individual self-reliance and participation in the planning, organization, operation and control of primary health care, making fullest use of local, national and other available resources and to this end develops through appropriate education the ability of communities to participate:

6. should be sustained by integrated, functional and mutually - supportive referral systems, leading to the progressive improvement of comprehensive health care for all and giving priority to those most in need;

7. relies, at local and referral levels, on health workers, including physicians, nurses, midwives, auxiliaries

and community workers as applicable as well as traditional practitioners as needed, suitably trained socially and technically to work as a health team and to respond to the expressed health needs of the community.

VIII

All governments should formulate national policies, strategies and plans of action to launch and sustain pri mary health care as part of a compre hensive national health system and in coordination with other sectors. To this end, it will be necessary to exer cise political will, to mobilize the countr's resources and to use availa ble external resources rationally.

IX

All countries should cooperate in a spirit of partnership and service to ensure primary health care for all peo ple since the attainment of health by people in any one country directly concerns and benefits every other country. In this context the joint WHO / UNICEF report on primary health care constitutes a solid basis for the further development and operation of primary health care throughout the world.

X

An acceptable level of health for all the people of the world by the year 2000 can be attained through a fuller and better use of the world's resour ces, a considerable part of which is now spent on armaments and military conflicts. A genuine policy of inde pendence, peaces, and disar mament could and should release ad ditional resources that could well be devoted to peaceful aims and in parti cular to the accelaration of social and economic develpment of which pri mary health care, as an essential part should be allotted its proper share.

* *

The Inernational Conference on Primary Heallh Care calls for urgent and international action to develop and implement primary health care throughout the world and particularly in developing countries in a spirit of technical cooperation and in keeping with a New International Economic Order. It urges governments, WHO and UNICEF, and other international organizations as well as multilateral and bilateral agencies, non-govern mental organizations, funding agen cies, all health workers and the whole world community to support national and international commitment to pri mary health care and to channel inc reased technical and financial support to it, particularly in developing cour tries. The conference calls on all the aforementioned to colloborate in int roducing, developing and maintaining primary health care in accordance with the spirit and content of this Declaration.

3rd All India People's Science Congress
Sub - Congress on Health Bangalore
8th to 11th March

Contemporary Developments in Drug Industry

- Amitava Guha.

Situations in drug industry in recent times have undergone rapid changes. There has been high profile activities from the Transnational(TNC) drug companies to affect the policies involved in drug industry. Vigorous criticism from the people have influenced the making of policies in many countries. Even WHO had formulated guidelines for drug policy. The greatest concern of the world drug situation had been rational use of drugs, availability of essential drugs, pricing and quality of drugs. It is evidently clear that drug policy involves number of policies. In recent past there has been deterioration in all spheres of policies and it was found that of all the things interest of the country was sacrificed first. It will be not only time taking but most shocking task to unvail the anti-people and pro TNC steps taken in the field of drug industry in recent past. It is therefore attempted here to reflect some of the important areas where immediate attention is needed to improve the damages done in the areas related to drug policy.

Licensing Policy

On 8th May,1952 Drugs and Pharmaceuticals were put under the first schedule of the Industries (Development & Regulation) Act. According to this Act all manufacturers excepting the Small Scale manufacturers would require to appeal for Registration Certificate and Industrial Approval.

1st instance :

The licensing Committee in 1953 decided the term "New Article" of IDR Act and parameters of exemption from Registration Certificate was also decided. Between 1953 and 1966 only 17 TNCs applied for such exemption which proved that all others violated the decision. Therefore, to enforce I(D&R) Act, the Govt. had to revise the exemption limit for fixed assets of the companies in the following manner.

January, 1964	: Rs.25 lakhs	February, 1970	: Rs.1 crores
April, 1978	: Rs. 3 crores	August,1983	: Rs.5 crores

2nd instance :

It was again violated. The Govt. had to undergo a make shift arrangement to glorify the laws and exemption was provided under carry on Business licence - The objective was -

"In the case of an industrial undertaking required to be registered under Section 10 of the I(D&R) Act which has not been registered within the time fixed for the purpose of carrying on business of the undertaking after the expiry of such period".

3rd instance :

In 1980 the Department Industrial Development appointed a special Task force for studying the rampant violation of licensing system. In 17th October, 1981 New Industrial Policy was announced. The policy provided. Recognition of excess Industrial capacity or Recognition of Excess Production (RIP) over the licenced capacity. This was made even violating the Drug Policy of 1978 where it was stipulated that all foreign drug companies will have to produce bulk drugs at least 20% of their total sales turnover.

This liberalisation of the Govt. was also violated. A

produced 211 items without any valid licence. Therefore, the ultimate was delicensing.

Delicensing :

Industrial policy declaration of 1980 stated that the principal aim of licensing is

a) Utilisation of indigenous capital and materials for increased production.
b) To meet the requirement of national priority
c) To ensure uniform development of the industry
d) Import Substitution.

1978 Drug Policy imposed sectoral reservation system for production of Drugs. 108 bulk drugs were declared as reserved in the following manner.

Only for Public Sectors - 17 bulk Drugs
Only for Indian Sectors - 27 bulk Drugs
Open for all Sectors - 64 bulk Drugs

This provided tremendous incentive for the developmentof technology and production of essential drugs by the Public Sectors and Indian Sectors, which was correctly observed by National Drugs and Pharmaceutical Development Council. Against such observation, the Govt. declared that "keeping in view of the need to stimulate industrial growth and simplifying the industrial licensing policy and procedures". On March 16, 1985 the Govt. declared a scheme of another delicensing. At that stage 12 drugs and in June '85/82 drugs were delicenced. The position became as

Life saving category - 13 drugs delicensed
Essential category - 10 drugs delicenced
Marginally Essential Category - 52 drugs delicensed.

Reseveration for both Indian & Public sector was confined to only 18 drugs !

In the meantime, the Indian sector had developed technology for at least 66 bulk drugs out of which 22 were delicensed.

Consequence of delicensing was such -
The TNCs jumped to procure licences for those reserved bulk drugs and prempted the production capacity of many. This has not helped the improvement of production. It was found that out of 90 monitored bulk drug slight improvement was found in the production of 13 drugs and only seven bulk drugs were produced more than the target but all others were under produced till 1986-87.* Therefore the shortfall of production has to be made up by import while TNCs under utilised their capacity. Govt.'s favour of TNCs interest were further accentuated by decision of broad banding, which was for the first time made applicable to drug industry. This allowed the TNCs to manufacture at least 100 more drugs without obtaining any licence. Despite all liberalisation production of essential drugs showed a very little improvement. *Table-1

FERA Liberalisation :

Pointing the inadequacy of Foreign Exchange Regulation Act, 1947 the 47th report of the Law Commission on "Control and Punishment of Social and Economic Offences" mentioned -

by shrewed and dexterous persons or sophisticated means greately affecting public welfare but detection is unusually difficult.

Based on these findings of Law Commission, Public Accounts Committee in 1968 recommended that the Govt. must take measures in repairing the leakage of foreign exchange occuring in the cource of imports and exports of goods through invoice manipulation by appropriate legal measures. Accordingly a Foreign Exchange Regulation Bill was introduced in 1972. The objective of the bill was to consolidate and amend the laws regulating certain payments, dealings in foreign exchange securities, transactions indirectly affecting foreign exchange and import and export of currency bullion and its proper utilisation in the interest of economic development of the country. It was further assured that the effect of the Act would be reviewed and ammendments would be made if the measures are proved to be inadequate. But always reviews were made and changes were enforced contrary to the interest of the country.

According to Sec. 29(2) of Foreign Exchange Regulation Act 1973 all companies (other than banking) incorporated abroad or where non-resident involvement was more than 40% as well as branches of such companies were asked to obtain Reserve Bank's permission to carry on their activities. But the Appendix-I of the Act enlisted 'Drugs and Pharmaceuticals Industry in a totally unrestricted manner". Hathi Committee criticised this position and recommended that -

a) The multinationals should be directed to bring down their equity to 40% and further progressively reduce it to 26% and that too should be done in such a manner that majority of the shares are diluted to the Government financial institutions to avoid dispersed holding of the shares.

b) To nationalise the multinational corporations.

The drug policy of 1978 could not do much in this aspect but declared that 'multinationals who were engaged in production of formulations only are required to bring down foreign equity to 40% forthwith'. This was also violated by the multinationals at ease. Thereafter, the Govt. decided that no pressure would be given to those multinationals who involve high technology in production. In reality large number of the Indian drug companies employ high technology in the manufacturing process. The OPPI then appealed to the Govt. for extention of Article 14 of the Constitution of India to multinationals. The Govt. assured that "Equality of law" would be provided although this evoked strong protest from Indian drug companies. But the multinationals started diluting shares little below 40% and thus became Indian Companies. Thus in 1988, excepting six all TNCs operating in India became Indian companies and freely started grabbing the facilities enjoyed by purely Indian companies.

This is ridiculous in the sence that even in most of the developed countries the definition of foreign companies are very strict. In Japan, France, Australia, companies have more than 10% to 20% of non-resident equity capital is considered foreign companies.

The pattern of equity dilution of TNCs are also dear that they retain absolute decisive power. For example, May and Baker retained 40% of Rs.45 lakhs shares and remaining 27 lakhs share are distributed among 61,314 share holders. The other way of retaining power by

The fdlowing articles which will be found in almost all companies's memorandum provides the absolute power to the parents which are

- Power to appoint one third of non-reliving Director
- Power to appoint and remove Managing Director
- Power to appoint and remove Chairman of the Board of Directors
- Power to appoint and remove the Vice Chairman
- Power to veto any resolutions by one of the ex-officio Directors

On the top, the Chairman is usually given a second or casting vote. These apart; the memoranda are usually found to have such clause as - that no resolution shall be deemed to be passed by the Board or Committee, unless a Director designated for this purpose from the parent company cast an affirmative vote in favour of resolution. It is evidently clear that no Board can function in detriment to the interest of the parents who are the none but the supreme policy maker. TNCs yet these companies are considred as 'Indian Companies' by our Govt.

As a result, the principle observation of 47th Law Commission of foreign currency manipulation remains unaltered. Following illustrations will establish it

1. The out go of foreign currency by way of repatriation has increased (See Table)
2. Balance of export and import is not only negative but outgo of hard currency has increased (See Table)
3. Import of raw materials to produce inessential and was OTC drugs have increased.

Other danger the TNCs posses is that the potentially large capital base of them along with the liberal licensing policy have put the Indian companies to face most unequal compitition. The TNCs in India have generated a large equity base and a very large reserve capital which had increased delet/equity ratio.to such extent that the borrowing capacity of the TNCs have reached to an enormous extent(See Table -). No Indian Company can stand against such powerful capital base.

Company	Original equity	Shareholders' Fund	Borrowing	Equity Debt ratio	Borrowing power
GLAXO	0.02	47.36	7.90	1:0.18	79.62
Warner	0.70	5.31	1.32	1:0.25	9.30
B urroughs	0.50	15.27	3.17	1:0.21	27.37
BOOTS	0.10	8.88	2.96	1:0.33	18.80
RICHARDSON	0.002	6.53	2.50	1:0.38	10.56
RECKIT	0.30	10.97	--	1:0.00	21.94
CIBA	0.03	10.64	8.64	1:0.20	73.21

Pricing Policy:- Pricing plays a major role in determining profit in pharmaceutical industry. Increase in price effects much more in profit generation than the decrease in manufacturing and marketing expenses. Therefore drug companies always try to incfease the prices of drugs even through they had faced a bitter criticism all over the world for over pricing. In 1970 Heffman-La-Roche preferred to pay £ 1.6 million to British Govt. than to reduce the excessive selling price of Vallium and Librium. But it was estimated by the Monopoly Commission that Roche made a profit of £ 4\ / million from the sale of £ 6.8 million of these two drug in that period.

Prices of drugs generally falls due to the expiary of patent and increase of economy of scale so long as its consumption keeps expanding. We have seen the prices of Choloramphenicol came down to 50 paisa from Rs. 12/- in 1950 for each capsules. In recent past same happened with Rifampicin within the span of five years prices came down from Rs. 5000/- to Rs. 2500/- per Kg. of the bulk drug. Yet the Govt. was convinced of the industry's argument that prices of drugs has not raisen in comparison to that for other commodities. It is also falsely claimed by OPPI that the prices of drugs are cheapest in India. We find that landed cost of finished formulation of essential drugs are higher those of the indigenous products. It is more applicable in the case of bulk drugs. Imported bulk drugs are mostly cheaper than the indigenously produced ones. This is a major reason for the drug companies crying for more number of drugs be put under OGL.

Drug Price Control Order(DPCO) 1979 imposed price control on 487 bulk drugs in three categories. The TNCs reacted in different ways to thwart the price control measures. They want to court and procured injunctions for stay against Govt. order. They openly violated Govt. order by less or no production of essential basic drugs. The TNCs campaigned that they are not able to earn profit by producing the drugs in India due to DPCO. It will appear from table no. that most of the TNCs improved their performances in the years of 1986-87 and 1987-88 and excepting six, all increased their assets. Aggrigate gross profit of the industry was found to be 17.4 percent during this period. Under the circumstances the Govt. compromised with the Industry and declared new DPCO in 1987. It was properly deserved by WHO in the World Drug Situation(1989)"Already prior to the new Drug Price Order, the prices of all drugs showed a 30% mark-up and drug company shares were selling at a premium." While declaring DPCO'87 the Govt. could not clearly define the criteria for categorisation. They only listed 26 drugs in category I but left the selection of Category II drugs under a Committee. Although the Govt. said in DPCO'87 that the principle of keeping the drugs under Category-I is cover all drugs required under National Health Programme but in reality they considered only six out of eleven diseases covered under National Health Programme.

Prior to fixing the list of drugs under Category-II there was intense lobbying by the industry to aiming to keep as many drugs as possible beyond the price control category. As a result, we find that the TNCs have by large enjoyed excellent exemption from price control. Table No. will show that the 18 top TNCs functioning in India enjoyed price control exemption ranging from 30% to 98%. It is also interesting to note that the Committee for selection of Category-II drugs prepared certain criteria of which we find that the Committee itself violated all these criteria while selecting the drugs. It was found that a large number of drugs like Vitamin A, Vitamin-C, Chlorpropamide, Indomethacin, Clonidine, Hydralazine etc., were left. The Committee declared that drugs with a turn over-more that 50 lakhs per year would come under price control. But this was not made applicable to drugs like

The Committee also decided that no monopoly or near -monopoly drug would be left out of the list. But drugs like, Neosprin, Dilosin, Benedryl, Haemaccel, Zolandin, etc. which maintain almost monopoly share in Sales were not considered. The Committee selected 140 drugs in the Category-II list. This also could not please the industry. Protest came from all of them. In the last one year 13 more drugs were dropped from the list and 20 others are in active consideration. The Govt. also shifted a number of drugs from Category-I to Category-III. This is not all the Committee had to prepare another report in the mid 1989 which virtually recomanded price de-control.

The system of leader price is enjoyed by the TNCs who are mostly brand leaders of the high turn over drugs. The other partners in the industry also follow the leader price but provide trade incentives at a high rate.

Therefore, the consumers are in no way benefited out of this system. There was a system of price equalisation and a fund was maintained under the head Drug Price Equalisations Accounts This fund was abolished. In Supreme Court TNCs were convicted as charging over the Govt. recommended prices. They were ordered to refund the excess profit earn to DPEA but the fund stand abolished It is surprising to know that DPCO'87 had allowed these TNCs to increase prices of almost all drugs for which they were convicted. The other area which contradicts the national interest is the cancellation of pooled price system.

The recent move of the industry which has almost convinced the Govt. is total abolition of DPCO and 'self regulatory price system' would replace it. The Secretary of the Pharmaceuticals Dept. has already announced that the Govt. is in favour of it. The other concern is that in recent past all the new drugs introduce are not only of me too nature but consist of a very high price. Some of them cost Rs. 99 per capsule and Rs. 160 per vial of injection. We need to analyse whether we need them at this moment. Development of science and technology was ruthlessly suppressed in India during the colonial period and the most important devise used was the Patent System 1948 at the initiative of Nehru 'Patent Enquiry Committee' was formed under Justice Bauxi Teckchand. His recommendations were placed by then Minister Shyama Prasad Mukherjee who also tried to introduce a bill in 1953 to change Patent Act. Later, in 1957 another Committee was prepared with Justice N. Rajagopala Ayenger and the Chemical Technologist Dr. S. Venkateswaran. They prepared "Report on the revision of the patent Law." Based on this report attempt was made to introduce a new Patent Act. which was successfully stalled by TNCs for 12 years M. P. Mr. Zoachim Alva complaint that "More than 30 foreign drug companies have declared an unholy war against this bill."

Ultimately, in the bill was passed and Indian Patent Act, 1970 was born. This Act. has been considered as a model to the 3rd World countries. This act has greatly helped the Indian Drug Industry to grow. It does not allow any patent for drugs. Patent is applicable only on process technology that too for a period of maximum 7 years. This has help us to introduce number of drugs before their global patent expired. Technologically Indian Companies were free to develop technology for a large number of drugs for which international patents were to expire much later and they actually produced and marketed these drugs. To-day horizontal transfer of technology helped a large number of small companies to produce bulk drugs some of whom are involved in export also. Similarly, the national research laboratories also developed number of technologies for bulk drug production. This would not have been possible in absence of Indian Patent Act, 1970.

There has been move from some quarter to change Patent Act. and pressures are created to join Paris Convention

The proponent of this change are suggesting this Act. has been a block for import of modern technology. But they have suppressed the fact that the technical colaboration agreements by Indian companies have increased from 183 in 1970 to 1,041 in 1985. In Pharmaceuticals out of 41 technological colaborations during 1979 to 1985 Indian companies were involved in 39 cases where the Indian Patent Act. had not played any restrictive role.

Brazil raised the question of an international patent policy in the 16th General Council of U.N.O. in 1961. In 1972 UNCTAD Conference at Santiago decided that clauses of Paris Convention would be changed in favour of 3rd World Countries.

The UNCTAD draft prepared in 1975 was opposed by Group of 7. In the conferences held from 1979 to 1985 despite opposition from only two countries draft was approved. The whole matter was taken in GATT. Question of Trade related Intellectual Property (TRIP) was raised. Meanwhile USA developed 'The Omnibus Trade & Competitiveness Act' of which super 301 was imposed on Brazil, Japan and India. Brazdl was blamed for the reason that they had kept pharmaceuticals out of Patent system.

In Geneva Conference of GATT India surrendered by accepting the Pumta-Del-Este resolution that in order to make TRID available national laws will be made available. This betrayal and surrender to the pressure of U.S. will ultimately result in to changing of patent Act in favour of the interest of TNCs causing a great harm of self reliance and unlimited price escallation will follow in quick succession.

Import Policy: Policy regarding import has been criticised by both the industry and consumers. We find that there has been world wide criticism of the TNCs for utilising transfer pricing arrangement for earning high profit. The TNCs in India have been ignoring the import restrictionsput on bulk drug, intermediate and other raw materials. In many occasions they were either importing bulk drugs from their own parent organisations and charged a higher price of the same bulk drug in our country while they have not utilised the production capacity installed at their own factory in India. In 1978 drug policy canalisation of import was encouraged but later it was discarded in the mid eighties. The (table no) shows how the TNCs have earned money by simple transfer pricing. A difference of Rs.24,338 per kilogramme becomes enormous when at ton of the drug is imported. In 1987-88 import of 42 bulk drugs were shifted from restricted items to General Licence category. Out of this 42 drugs, only 6 drugs were life saving and essential and 10 drugs had no price control, having unlimited profit potential.

Bulk drugs like Ibuprofen, Pyrazinamide, Corticosteroids, Ephedrine, Methyldopa, Chloroquin, Chloramphenicol which are manufactured here but import is also allowed. Man y TNCs who enjoy monopoly over these drugs do not produce them here as import is allowed and therefore enjoy an excellent scope of utilising transfer pricing system.

Import of Refampicin has been in large quantities and is exempt of excise duty. Inspite of the technology being available in India it is difficult to produce bulk drug as 105% import duty imposed on the raw materials. Some instances of similar cases are given bolow.

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Bulk Drug	% of Duty	Intermediate/raw-materials	% of Duty
Trimethoprim	100%	3,4,5 Trimethoxybenzaldehyde	134%
Refampicin	nil	Raw materials	105%
L-Dopa	nil	Vanillin	135%
Sulphadiazine	100%	Intermediate	135%
Corticosteriods	100%	Intermediate	135%
Chloroquin	nil	Ethozy methylene diethyl malnate	25%

This indicates that the present import policy is discouraging not only production but also development of indigenous technology.

COMMUNITY HEALTH CELL
47/1, (First Floor) St. Marks Road
BANGALORE - 560 001

RESOLUTION ON UNIVERSAL SALT IODISATION PROGRAMME

Endemic goitre and Endemic cretinism are important Public health problems in parts of India especially, in the sub-Himalayan belt. To control this problem the Govt. of India started the National Goitre Control Programme in 1961. The strategy used was to supply iodised salt to people in the affected areas combined with legislation to limit the use of non iodised salt in those areas. The manufacture of iodised salt was entrusted to the Public Sector.

A review of the policy in 1981 found that the National Goitre Control Programme had not made the desired impact and a committee was formed to recommend changes in Policy if required. This committee did not go into all the reasons of failure of the NGCP like virtual absence of Public health education, failure to subsidise the programme effectively, administrative failures in checking smuggling of non iodised salt etc. Instead, strangely they took the position that it was impossible to successfully implement the programme if it is localised to a particular region. Their panacea for all the ills plaguing the programme was 'Universal Iodisation'. This meant totally phasing out of non iodised common salt from the Indian market and replacing it with Iodised Salt by 1992. An important corollary to this was the throwing open of Iodised Salt manufacture to the Private Sector, thus ending the monopoly of Public Sector in this area.

We the delegates of the 3rd All India Peoples Science Congress have serious apprehensions regarding this new policy for the following reasons:

1) The escalation of the scale of operations is likely to adversely affect people living in the goitre endemic areas. The iodised salt manufactured by the private sector is likely to find its way to the Metropolitan and other well developed markets rather than to the real needy living in the goitre endemic areas.

2) Even now the quality of control of iodised salt is not effectively monitored. With the quantum jump in the production, this would become much more difficult to enforce.

3) Privatisation and free market principles as sought to be incorporated into the new policy, by its very dynamics, will cause an inexorable shift to the higher priced iodised, refined salt at the cost of cheaper iodised crystal salt.

4) The cost of salt by current estimates may go up by 100-200%. This would entail an additional burden of Rs.500 crores annually to the Indian consumer. This price differential has already resulted in smuggling of cheaper non-iodised salt into endemic areas.

5) The 'Scientific evidence' supplied in support of the new policy has been questioned seriously and has not been rebutted satisfactorily. Surveys purporting to show 'newer' endemic areas as well as the methods to prove the concept of sub-cretinous brain damage have been challenged on conceptual and methodological grounds. It has also been pointed out that consumption of iodised salt by a normal population may not be as harmless as sought to be projected.

In the light of these facts the delegates of the 3rd AIPSC feel that the present strategy of Universal iodisation is one in which the costs are borne by the consumers and the benefits accrue to the monopolies. Moreover the new policy ignores the fact that endemic goitre and cretinism are problems with diverse developmental and ecological causes. A programme to combat Iodine deficiency should essentially contain flood control measures, checking deforestation, soil improvement, proper use of pesticides and fertilizers and general eco-restoration in addition to salt Iodisation. The Iodisation itself, in order to succeed, should be confined and concentrated to endemic areas only. The birth of babies with endemic cretinism is a tragic waste of human resources. In fact this is the problem which needs to be tackled urgently by a programme implemented vigorously in such regions. The focus should not be allowed to shift from these areas by the imperatives of the free market economy.

The 3rd AIPSC therefore, requests the Govt. of India to review the current policy of Universal Iodisation and drastically revise it. Before formulating a comprehensive new strategy an open discussion should be initiated involving scientists, social workers, economists and peoples science and health movements in the country.

HEALTH

THIRD ALL INDIA PEOPLE'S SCIENCE CONGRESS
8th - 11th March, 1990
at BANGALORE

First information brochure and invitation to
SUB CONGRESS ON HEALTH

FIRST ALL-INDIA MEET OF HEALTH ACTIVISTS

The All-India People's Science Network is a network composed of People's Science Movements from all over the country who are actively engaged in the building of a mass movement for creating scientific awareness and in intervening in key areas to ensure that science and technology is used for the benefit of the people.

The People's Science Movements have, to varying degrees and with varying success, been involved in the field of health. The broad understanding that these groups share on the health situation in the country was formulated in the form of a background paper at the second All-India People's Science Congress held at Calcutta.

It was also decided, at that meet, to evolve a broader consensus on health, to share the experiences of health activists and to evolve a common action programme in issues and areas that cry out for immediate intervention.

It is in this background that we are now holding this convention of health activists from all over India, as part of the 3rd All-India People's Science Congress at Bangalore. The sub-congress on health will start on 9th morning after the common inaugural programme on 8th evening and will close with the plenary session on 11th.

We request your active participation in the congress.

Objectives:

1. Sharing and critical review of experiences of all voluntary organisations and social activists in the field of health.

2. Discussions of main areas for intervention and people's participation in ensuring health for the people.

3. Interaction between groups and individuals involved in health activism and evolving mechanisms for continued interaction and exchange of information.

4. Plan action programmes for future people's participation with specific reference to the on going Bharat Gyan Vigyan Jatha and to future people's science movement activities.

Programme: See separate sheet.

Participants invited:

- AIPSN organisations and socially conscious health professionals, medical students and service doctors association sponsored by AIPSN organisations.
- Health activists from organisations like MFC, VHAI, AIDAN, Students Health Home.
- Leading academicians and professionals who have contributed to or are working on social dimensions of health.
- Representatives of WHO, UNICEF and Ministry of Health and other professional health bodies.

Delegate Fee: Rs.50.00

Address for Communication:

Dr. Amit Sen Gupta
C/o.Delhi Science Forum
B-1 2nd floor, LSC
J-Block, Saket
New Delhi-110 017.

Phone: 665036/6862716

THE PROGRAMME

INAUGURAL SESSION - 8th March, 1990 - 10.00 AM

Key note address on

'HEALTH SITUATION IN INDIA'

Dr.D. Banerjee
Jawaharlal Nehru University, Delhi

SESSION II - 8th March 1990 - 2.00 PM

AIPSN Annual Meeting

SESSION III - 9th March, 1990 - 9.30 AM

SUB CONGRESS ON HEALTH

SESSION - A - **PEOPLE'S INTERVENTION IN HEALTH**

Chairperson - Dr.B.Ekbal

9.30 am - PSM Perspective on Primary Health Care

Dr.T.Sunderaraman

10.00 am - The K.S.S.P & other PSM experiences

Dr.V.Ramankutty, K.S.S.P.

10.30 am - The MFC experience

10.50 am - The Andhra Polyclinic experience

Dr.Sesha Reddy

11.15 am - The VHAI & AIDAN experience

Dr.Mira Shiva

11.45 am - Other Group experiences & discussion

1.00 pm - Lunch

SESSION - B - **PRIORITY AREAS FOR PEOPLE'S INTERVENTION**

Chairperson: Dr.Mira Shiva.

2.00 pm - Drug Policy - Amitava Guha, FMRAI

3.00 pm - The National Health Policy & Vertical Health Programmes

Dr.K.P.Aravindan, KSSP.

4.00 pm - Occupational Health

Dr.Amit Sen Gupta, DSF

5.00 pm - Resolutions on priority areas

10th March 1990

SESSION - C - **WOMEN AND HEALTH**

Chair person : Dr.Imrana Quadeer, **JNU**

9.30 am - Theme papers

Dr.Mohan Ram, JNU

Ms Vimal Balasubramanyan

12.00 - Resolutions on Women and Health.

SESSION - D - **ACTION PROGRAMME ON PRIMARY HEALTH CARE**

Chairperson : Dr.Sesha Reddy

2.30 pm - Presentation of Action Programme

3.00 pm - Discussion and finalisation

SESSION - E - **VALEDICTORY PLENARY SESSION**

9.30 am - Presentation of Sub Congress Proceedings Resolutions

Valedictory remarks.

NB:- In addition to the above programmes, there will be

a) Guest lectures in the evenings

b) Poster presentations.

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PRIMARY HEALTH CARE

Discussions in this area essentially centered on reported proposals to do away with the Village Health Worker (VHW) scheme. Following is the substance of the discussion:

It is believed that there is a move by the Government to scrap the VHW-Scheme. In our view, this is a retrogressive step, contrary to the spirit of the Alma-Ata Declaration , to which the Government of India is a signatory. The VHW is an important, essential element of the Primary Health Care approach to achieve the professed goal of Health for All by 2000 AD.

The perspective behind this scheme is still very much valid and needs to be reiterated. The basic rationale of the VHW Scheme is as follows:

a) Health Services are grossly inadequate in rural India.

b) Substantial proportion of health problems in rural India are of such a nature that they can be competently diagnosed and managed by a health-worker after a short period of training. The health educational work and the work of promoting collective health action by villagers can be effectively done by such a worker. Demystification of medical knowledge can be effectively done through the VHW's work.

c) A health worker coming from the same community is socially and culturally closure to the community and more accountable to the community.

Many health projects in the NGO sector and some PHCs in the Government sector in different countries, validated this basic rationale of the VHW scheme. If in India, the scheme has not performed upto expectations, the fault lies with the implementing departments and not with the scheme itself. The scheme should therefore be implemented with following improvements:

1) **Selection:** There should be no nepotism in the selection of the VHWs. The VHW should be selected by democratic organisations of the people (like panchayats).

2) **Training:** The training of the VHW should be vastly improved to enable them to diagnose and treat simple, commonly occurring ailments at the village level and to give assurance, advice to villagers about ailments and about healthy practices. The educators of VHWs should be well-versed in and should believe in the philosophy and practice of community health.

3) **Drug Kit:** The drug-kit should be expanded to deal with common, simple ailments and the drug-supply should be regular and adequate.

4) Simple, low-cost, appropriate health educational, pictorial material should be provided to VHWs to enable them effectively

carry out health education of villagers. Local art forms should be adapted for health education.

5) The doctor and other PHC staff should not look down upon the VHW but should provide adequate support.

6) Well established, simple, universal remedies from non-allopathic systems of medicine should be taught.

7) The VHW should draw his/her honorarium from the Panchayat and the Panchayat should be provided with funds for this purpose. Accountability to democratically functioning Panchayat is superior to accountability to the health bureaucracy alone since the PHC doctor is not in a position to really assess the sincerity of the VHW.

8) The much better trained and hence much more capable, active VHW would have to spend much more time for health work on a regular basis. It is unrealistic and unfair to except a poor person to regularly spend a couple of hours a day for a pittance of an honorarium especially when nobody in health sector does substantial honorary work. Hence the honorarium of the VHW should be substantially increased, even though the element of voluntary service to the community is reaffirmed.

WOMEN AND HEALTH

Given below is the substance of discussions and recommendations in the area of Women & Health:

The areas requiring urgent attention are those related to systematic discrimination against women from birth onwards - now even before birth as seen in proliferation of sex determination tests and female foeticide. Social discrimination against women is evident in several areas, and results in deterioration of their health status. Thus women from lower socio-economic backgrounds have to withstand a double burden. The issues which must be addressed must include those which have wider social and economic implications.

PSM organisations could work in more detail on some of these areas and evolve demands for action and intervention:

Family Planning: Women's health has been given little or no priority in the health planning process and implementation of the health programmes. Women's health has tended to be confined to family planning or child birth related issues. Ironically, the Family Planning Programme which has substantial amounts of health budget allocated to it has failed to show any decline in the birth rate. Over and above this, the practice of target setting and incentives have led to corruption of health workers and coercion of women. This has marginalised other aspects of primary health care and led to avoidable complications. In the Family Planning programme terminal methods geared at women are pushed in the field. Mass sterilisation programmes without any follow-up measures have assumed serious dimensions, especially since no informed consent is being obtained. In this background PSM organisations could take it upon themselves to:

1) Monitor Family Planning Camps and insist upon proper follow-up measures. This would also involve a critical review of the established and practical norms for such camps.

2) Ensure rational contraceptive care. This would include provision of informed choice of method of contraception, availability of contraceptives and back up curative health services for side effects.

3) Demand for proper back-up health services to take care of complications.

4) Demand for removal of disincentives directed at women eg. no maternal benefits after second child, etc.

Use and Misuse of Science & Technology

1) Prevention, diagnosis and management of other women specific health problems like menstrual disorders, pelvic inflammatory diseases, leucorrhoea, STD, cancer of the cervix, menopausal

problems, infertility, complication during child birth, etc. have to be addressed to with greater care.

2) Eventhough the market is flooded with irrational, useless, directly hazardous drugs, essential medicines required for women's health problems have not been made available at affordable prices. Several medicines known to harm the foetus are freely sold without warning on the label/packing.

3) While there is a proliferation of sophisticated technologies relating to women, simple essential procedures eg. pregnancy testing kits, early abortion etc. are not being made easily accessible.

4) The increasing trend towards unnecessary surgeries like hysterectomies, Caesarean sections etc. should be effectively curtailed.

5) Women's organisations have already been protesting against conduction of unethical trials and introduction of newer reproductive technologies. A widespread people's movement to support this is necessary.

Literacy:

1) Formal schooling to girl children at least upto seventh standard.

2) Proper/correct education regarding menstrual cycle, and reproductive process to school going and non-school going girls.

Sexual Discrimination:

1) Demand for total ban on sex determination and sex-preselection technologies, de-privatisation of the genetic analysis centres.

2) Protest against dowry, physical and mental violence against women, crimes against women, separation from marriage without providing maintenance, etc.

3) Equal wages for equal work, benefits such as maternal leave, etc. must be given by both formal and informal sectors. A consistent demand by PSM should be generated in this regard.

Other Areas:

1) Women have a right to safe and adequate drinking water, good sanitation facilities and efficient non-polluting cook-stoves. PSM organisations could provide informations and work out suitable alternatives in each area according to local needs and resources.

2) PSM could also take up specific health education in several

areas affecting women including the general health issues of the women and their family members.

3) Specific studies may be undertaken for occupational health hazards in women's work such as nursing, agricultural work, tobacco and beedi-rolling, coir, prawn shelling, etc. including domestic work.

4) Appropriate tools and technologies can be developed for women and made accessible at all levels.

5) Health education materials on women & health issues which is already available should be widely circulated and relevant material should be evolved over a period of time in the areas where material is not already available.

Finally, to give this issue a proper thrust, the AIPSN should form a cell for women's health action to take up systematic work in these areas related to women.

OCCUPATIONAL HEALTH

Given below is the substance of discussions & recommendations in the area of Occupational Health:

Identified areas where the AIPSN can do ground work:

1) Gather more data on prevalence of occupational diseases in various parts of the country.

2) Review & popularisation of various acts pertaining to workers health and safety.

3) Demand occupational health oriented training for Doctors employed in factories and ESI scheme.

4) Efforts be made to draw the attention of Ministry of Health towards occupational diseases and improve upon the severely lacking diagnostic facilities.

5) The worker has the right to know about the occupational hazards in his work place. AIPSN with its extensive reach can strive to educate workers on this right. AIPSN should also support the demand on the ground of any working group towards this cause and support the struggles taken up locally.

6) All the constituent member groups should collect information regarding any occupational hazards in their area and report the same to the coordinator of the committee.

7) ILO resolution should be implemented by Government of India in letter and spirit.

8) Pictorial exhibition depicting common occupational hazards be prepared.

Sri M.S.Gurupadaswamy
The Hon'ble Minister for Chemicals & Petrochemicals
Government of India
New Delhi

MEMORANDUM ON PHARMACEUTICAL INDUSTRY

Sir,

The 3rd All-India Peoples Science Congress, in pursuance to discussions in the Health Sub-Congress notes with concern that the new existing drug policy, which was introduced in 1986, is a retrogressive step and has negated even the tentative attempts of the 1979 Policy to work towards a Rational Drug Policy.

It is further noted that the 1986 Policy had not, in any substantial manner, worked towards implementation of the long standing demands of the movement for a rational drug policy. These demands had included ensuring availability of essential drugs, reduction of drug prices, banning of irrational and hazardous drugs; and for encouraging self-reliance in the Industry., Instead the 1986 Policy has resulted in further rise in prices, less availability of essential drugs, more proliferation of irrational drugs and dilution of existing measurers which would ensure a level of self-reliance.

It is hoped that the National Front Government will take immediate measures to implement the promises made in its manifesto regarding implementation of a Rational Drug Policy and thereby scrap the anti-people 1986 Drug Policy.

In this background we wish to submit the following for the consideration of the Government of India:

1) Whereas there is no Drug Policy in the country today but only a pricing and licensing policy, it is necessary to formulate a National Drug Policy keeping in view the necessities of drug production based on the morbidity/ mortality profile in the country. The government must, on a priority basis, draw up a list of drugs essential for the country as also the estimates of demand for these drugs, and ensure their availability at an affordable price.

2) Whereas it has been the policy to use price control mechanisms to ensure production controls, this has been seen to have an adverse effect on production of essential drugs. Even price control mechanisms have been diluted after the 1986 drug policy resulting in spiralling rise in drug prices. It is necessary to strengthen price control mechanisms and at the same time to bring in stringent production control measures which would compel manufacturers to produce essential drugs. It maybe mentioned that the 1978 drug policy contained production control mechanisms, which were never implemented and were formally abandoned in the 1987 drug policy and through other industrial policy decisions. Further, the tentative attempts to encourage generic names have been shelved due to stay orders obtained by Drug Companies. Immediate steps to resolve this issue are needed.

3) Whereas an estimated 60,000 formulations are today available in the market, the WHO lists only 264 as essential drugs, and the estimated list of pharmaceutical entities with useful properties numbers less than a 1000. This proliferation of drugs has resulted in a plethora of useless, inessential, irrational and hazardous drugs. Immediate measures should be taken to ban all irrational and hazardous drugs in the market.

4) Whereas quality control facilities are largely lacking in the country, it is absolutely necessary to immediately upgrade such facilities on a priority basis. The government has admitted, that drug-testing facilities are woefully inadequate. Strangely however, the government now is attempting to shift its responsibility on manufacturers for drug testing. While manufacturers are responsible for ensuring quality drug production, it is ultimately the Govt's responsibility to ensure quality control. The Lentin Commission report, in the aftermath of the JJ Hospital deaths, has clearly brought out the existing criminal nexus between drug manufacturers and officers responsible for drug testing. This is an area which cries out for immediate attention.

5) Whereas today Multinational Corporations control an estimated 60% of the market their contribution towards the production of essential drugs and introduction of new technology is negligible. MNCs deliberately produce less quantities of essential drugs while they attempt to maximize profits by over production of irrational drugs and continue to produce with impunity hazardous drugs which have been banned or restricted in their parent countries. In addition they overprice their products through the mechanism of transfer pricing, and thereby also contribute to the drainage of valuable foreign exchange. Moreover they are primarily interested in the formulation market and have deliberately reduced production of bulk drugs. All this needs to be seen in the background of the fact that the UNIDO has categorized India in the group of countries which possess indigenous technology to produce all essential drugs. In such a situation it is worth reiterating the Hathi Committee report of 1975 which had called for

nationalization of the Multinational Sector in the drug Industry, and to provide leadership role to the Public Sector. It is evident that FERA provisions which consider companies with 40% foreign equity participation as Indian Companies, have not made an impact on the control of MNCs on the market.

6) Whereas, succeeding drug policy statement have mentioned the leading role of the Public Sector in the Industry, the role of the Public Sector has been gradually marginalised. The policy of the Govt. which has contributed to this needs to be reversed. In addition the Public Sector, to be made more efficient, needs to be rid of problems of corruption and bureaucratic inefficiency. The Public Sector has played a major role in the development of self-reliance in the industry, and needs all encouragement.

7) Whereas, drug companies continue to, through this extensive promotional network, propagate their products with the help of false and misleading claims, there is no source of unbiased information on drugs. Steps, legislative if necessary, should be taken to put curbs on such exaggerated and false claims made by drug companies. Concurrently the Govt. should regularly publish material which provides to the medical profession unbiased information on drugs. The National Formulary should be updated and the medical profession should be provided with independent and scientific drug information as is being done even in countries like Sri Lanka and Pakistan.

8) Whereas all products, other than allopathic formulations, are today out of the purview of drug-testing and other control mechanisms there is a need to remedy this situation. The above practice has led to unchecked proliferation of all such products. All products sold as drugs should be brought under the ambit of mechanisms for quality control, drug testing and assessment of therapeutic benefits.

9) Whereas, there are attempts to change the Indian Patent Act of 1970, this Act has helped the Indian Sector to grow significantly. Pressures are being put on the Indian Govt. by the developed countries, specifically the US, to change the Patent Act so as to allow MNCs easier access to the Indian market. Any such change would immediately result in a steep rise in drug prices and immensely harm development of the indigenous drug industry. All such attempts should be restricted and no compromise should be made in this area.

10) Whereas, no centralized authority exists to oversee and monitor functioning of the drug industry, immediate steps would be taken to set up a National Drugs and Therapeutics Authority (NDTA). This body should have representations from all sections and should have statutory powers. Such a body should also be armed with powers to deal with legislative delays which block a number of attempts to cover gaps in the drug policy.

The Congress further demands that while in the past, changes in drug policy have been made without consulting broader sections of the people, in future all such changes should be made only after a debate involving all sections. The present drug policy should be changed on the basis of a nationwide debate on the lines which is now taking place on the issue of granting autonomy to AIR and Doordarshan.

Yours Faithfully,

Sl.No.	Name	Place	Profession	Organisation	Signature

COMMUNITY HEALTH CELL
47/1, (First Floor) St. Marks Road
BANGALORE - 560 001

14-12

MAJOR DECISIONS OF HEALTH SUB-CONGRESS

Following decisions regarding Action Programmes have been finalised:

I) DRUG POLICY

Given indications that the Govt. is seriously considering changes in the present Drug Policy, it has been decided to organise a signature campaign on this issue. The demands will be along the lines of the resolution adopted on Drug Policy at Bangalore. The campaign sheet is attached separately. This may be duplicated by xeroxing/cyclostyling or translated into local language and duplicated, depending on the exigencies of the local situation.

The signature campaign is to start on 7th April, i.e. World Health Day. This should be continued till April 15th. The signatures should be mailed to the following address, and should reach before 25th April:

Amit Sen Gupta
C/O Delhi Science Forum
B-1, 2nd Floor, LSC,
J Block, Saket
New Delhi 110017.

The signatures are to be submitted to the Minister for Chemicals, Sri Gurupadaswamy, on 2nd May (date is as yet tentative) by a delegation representing the AIPSN. On the same day i.e. 2nd May a "Demands Day" to be observed by the PSN organisations all over the country. The demands shall be as articulated in the resolution. The form of observing the "Demands Day" will depend on the local situation. Broadly, it may take the form of meetings, demonstrations before offices of appropriate authorities like State Drug Controller, picketing /leaflet distribution at Chemists' shops, wearing of Badges enumerating demands etc. We would also like to know what other suggestions you organisation has in this regard.

DAFK
to organise

All PSN organisations are to write to the Ministry of Chemicals immediately, demanding action in the area of Drug Policy, along the lines of the Resolution adopted at Bangalore. A copy of the resolution along with a covering letter from your organisation should be sent to the following address:

Sri M.S.Gurupadaswamy
Hon'ble Minister for Chemicals & Petrochemicals
Ministry of Chemicals & Petrochemicals
Shastri Bhawan
New Delhi 110001

A copy of tha above letter should be sent to our Delhi address that is mentioned previously.

II)**Universal Salt Iodisation Policy**

On this issue a National seminar is to be organised in Delhi, some time in June. The tentative venue is Jawaharlal Nehru University - to be organised possibly in collaboration with the Centre for Community Health and Social Medicine in JNU. Efforts will be made to invite experts in this area, including those who support as well as those who oppose the programme. The attempt would be to arrive at a consensus regarding possible changes in the programme.

III)**Other Areas**

Discussions were held at Bangalore regarding possible scope for interventions in the areas of Occuppational Health, Women & Health and Primary Health Care. While no concrete action plans were drawn up, some basic guidelines were formulated as possible areas of intervention. These are given separately in the summary of discussions of the Congress. Some of these recommendations can be followed up in the coming months.

IV)**Bharat Gyan Vigyan Jatha**

The BGVJ, it was felt, is an unique opportunity for expanding contacts of the health movement within the AIPSN. Resources of the AIPSN groups, both in terms of manpower and software, should be made use of to train people in propagation of health component of BGVJ. Details regarding how this activity is to be operationalised shall be circulated once they are finalised.

COMMUNITY HEALTH CELL
47/1, (First Floor) St. Marks Road
BANGALORE - 560 001

RESOLUTION ON PHARMACEUTICAL INDUSTRY

The 3rd All-India Peoples Science Congress, in pursuance to discussions in the Health Sub-Congress notes with concern that the new existing drug policy, which was introduced in 1986, is a retrogressive step and has negated even the tentative attempts of the 1979 Policy to work towards a Rational Drug Policy..

It is further noted that the 1986 Policy had not, in any substantial manner, worked towards implementation of the long standing demands of the movement for a rational drug policy. These demands had included ensuring availability of essential drugs, reduction of drug prices, banning of irrational and hazardous drugs; and for encouraging self-reliance in the Industry., Instead the 1986 Policy has resulted in further rise in prices, less availability of essential drugs, more proliferation of irrational drugs and dilution of existing measurers which would ensure a level of self-reliance.

It is hoped that the National Front Government will take immediate measures to implement the promises made in its manifesto regarding implementation of a Rational Drug Policy and thereby scrap the anti-people 1986 Drug Policy.

The Congress further notes that:

1) Whereas there is no Drug Policy in the country today but only a pricing and licensing policy, it is necessary to formulate a National Drug Policy keeping in view the necessities of drug production based on the morbidity/ mortality profile in the country. The government must, on a priority basis, draw up a list of drugs essential for the country as also the estimates of demand for these drugs, and ensure their availability at an affordable price.

2) Whereas it has been the policy to use price control mechanisms to ensure production controls, this has been seen to have an adverse effect on production of essential drugs. Even price control mechanisms have been diluted after the 1986 drug policy resulting in spiralling rise in drug prices. It is necessary to strengthen price control mechanisms and at the same time to bring in stringent production control measures which would compel manufacturers to produce essential drugs. It maybe mentioned that the 1978 drug policy contained production control mechanisms, which were never implemented and were formally abandoned in the 1987 drug policy and through other industrial policy decisions. Further, the tentative attempts to encourage generic names have been shelved due to stay orders obtained by Drug Companies. Immediate steps to resolve this issue are needed.

3) Whereas an estimated 60,000 formulations are today available in the market, the WHO lists only 264 as essential drugs, and the estimated list of pharmaceutical entities with useful

properties numbers less than a 1000. This proliferation of drugs has resulted in a plethora of useless, inessential, irrational and hazardous drugs. Immediate measures should be taken to ban all irrational and hazardous drugs in the market.

4) Whereas quality control facilities are largely lacking in the country, it is absolutely necessary to immediately upgrade such facilities on a priority basis. The government has admitted, that drug-testing facilities are woefully inadequate. Strangely however, the government now is attempting to shift its responsibility on manufacturers for drug testing. While manufacturers are responsible for ensuring quality drug production, it is ultimately the Govt's responsibility to ensure quality control. The Lentin Commission report, in the aftermath of the JJ Hospital deaths, has clearly brought out the existing criminal nexus between drug manufacturers and officers responsible for drug testing. This is an area which cries out for immediate attention.

5) Whereas today Multinational Corporations control an estimated 60% of the market their contribution towards the production of essential drugs and introduction of new technology is negligible. MNCs deliberately produce less quantities of essential drugs while they attempt to maximize profits by over production of irrational drugs and continue to produce with impunity hazardous drugs which have been banned or restricted in their parent countries. In addition they overprice their products through the mechanism of transfer pricing, and thereby also contribute to the drainage of valuable foreign exchange. Moreover they are primarily interested in the formulation market and have deliberately reduced production of bulk drugs. All this needs to be seen in the background of the fact that the UNIDO has categorized India in the group of countries which possess indigenous technology to produce all essential drugs. In such a situation it is worth reiterating the Hathi Committee report of 1975 which had called for nationalization of the Multinational Sector in the drug Industry, and to provide leadership role to the Public Sector. It is evident that FERA provisions which consider companies with 40% foreign equity participation as Indian Companies, have not made an impact on the control of MNCs on the market.

6) Whereas, succeeding drug policy statement have mentioned the leading role of the Public Sector in the Industry, the role of the Public Sector has been gradually marginalised. The policy of the Govt. which has contributed to this needs to be reversed. In addition the Public Sector, to be made more efficient, needs to be rid of problems of corruption and bureaucratic inefficiency. The Public Sector has played a major role in the development of self-reliance in the industry, and needs all encouragement.

7) Whereas, drug companies continue to, through this extensive promotional network, propagate their products with the help of false and misleading claims, there is no source of unbiased

information on drugs. Steps, legislative if necessary, should be taken to put curbs on such exaggerated and false claims made by drug companies. Concurrently the Govt. should regularly publish material which provides to the medical profession unbiased information on drugs. The National Formulary should be updated and the medical profession should be provided with independent and scientific drug information as is being done even in countries like Sri Lanka and Pakistan.

8) Whereas all products, other than allopathic formulations, are today out of the purview of drug-testing and other control mechanisms there is a need to remedy this situation. The above practice has led to unchecked proliferation of all such products. All products sold as drugs should be brought under the ambit of mechanisms for quality control, drug testing and assessment of therapeutic benefits.

9) Whereas, there are attempts to change the Indian Patent Act of 1970, this Act has helped the Indian Sector to grow significantly. Pressures are being put on the Indian Govt. by the developed countries, specifically the US, to change the Patent Act so as to allow MNCs easier access to the Indian market. Any such change would immediately result in a steep rise in drug prices and immensely harm development of the indigenous drug industry. All such attempts should be restricted and no compromise should be made in this area.

10) Whereas, no centralized authority exists to oversee and monitor functioning of the drug industry, immediate steps would be taken to set up a National Drugs and Therapeutics Authority (NDTA). This body should have representations from all sections and should have statutory powers. Such a body should also be armed with powers to deal with legislative delays which block a number of attempts to cover gaps in the drug policy.

The Congress further demands that while in the past, changes in drug policy have been made without consulting broader sections of the people, in future all such changes should be made only after a debate involving all sections. The present drug policy should be changed on the basis of a nationwide debate on the lines which is now taking place on the issue of granting autonomy to AIR and Doordarshan.

KARNATAKA RAJYA VIJNANA PARISHAT

Indian Institute of Science Campus, Bangalore - 12.

Phone: 340509

THIRD ALL INDIA PEOPLE'S SCIENCE CONGRESS

VIDYANAGAR, BANGALORE

8 - 11 March 1990

Dear Sir/Madam,

As you are already aware the Third All India People's Science Congress will be held at Vidyanagar, Bangalore Dist. during 8 - 11 March 1990.

Delegates are requested to feeling the required proforma already sent by our office and send it alongwith the delegate fee of Rs.50.00 in the form of DD. Your early reply enables us to arrange for return tickets, if needed. Vidyanagar is about 25 KMs from Bangalore Bus station/Railway Station along Bangalore Hyderabad Highway. After 25 KMs one find deviation arrowmark in right side indicating the route to Jayaprakash Narayan Youth Centre which happens to the venue of AIPS Congress.

Following City Buses with Red Board and route No: From K.R. Market 281, 282 283 You have to get down at Jayaprakash Narayan Youth Centre stop. Actual venue meeting is located at about 3 KMs. Arrangements are being made to provide transport facility from the busstand to Jayaprakash Narayan Youth Centre Vidyanagar.

Delegates will be received by our volunteers both at city bus station and city Railway Station.

Vidyanagar as a weather similar to that of Bangalore. One can manage with minimum luggage. A cot, bed and bed spread will be provided.

Tentative programme of each session and invitation is enclosed.

With regards,

Yours sincerely,

(M.A. SETHU RAO)
Hon. Secretary.

KARNATAKA RAJYA VIJNANA PARISHAT

Indian Institute of Science Campus, Bangalore 12

THIRD ALL INDIA PEOPLE'S SCIENCE CONGRESS

VIDYANAGAR, BANGALORE

08-03-1990			
	Session I	10-00 - 13-00	Inauguration
	Session II	14-00 - 17-30	AIPSN Annual Meeting
09-03-1990			Sub-Congress
	Session III	09-30 - 13-00	Health Self Reliance Literacy
	Session IV	14-00 - 17-30	Health Self Reliance Literacy
10-03-1990			
	Session V	09-30 - 13-00	Health Self Reliance Literacy
	Session VI	14-00 - 17-30	Health Self Reliance Literacy
11-03-1990			
	Session VII	09-30 - 13-00	Valedictory & Plenary

SESSION 6 (L) FUTURE PROGRAMME

CHAIRMAN

1. Literacy status in India and its perspectives — Shri Lingadevaru Halemane
2. Functional involvement of PSMs — Dr. S.C. Behar
3. Appropriate methodology in Non-Formal Education of Girl- Child & Illiterate Women — Dr. Probal Sarkar

SELF RELIANCE CONGRESS

9th March 1990
Session 3(S) Chairman : Dr. A.D. Damadoran

0900-1300 H

Conceptual Issues of Self Reliance
– Dr. Prabir Purkayastha, Dr. Venkatesh B. Athtreya

Research and Development in Scientific And Technological Self Reliance
– Prof. A.K.N. Reddy

Scientific Institutions in S&T Innovation and Manpower Generation
– Prof. S.K. Rangarajan

Scientific Institutions and Self Reliance
– Shri. Dinesh Abrol

Discussions

1300-1400 H LUNCH

Sub Group 4 (S)
1400-1730 H

Theme Papers
Chairperson: Dr. A.A. Gopalkrishna

Theme Paper on Energy
– Shri. Ashok Rao

Theme Paper on Electronics
– Shri. K.P. Nambiar

Theme Paper on Natural Resources
– Prof. V.K. Gaur

Discussions

Sub Group 4(S.1) 1400 - 1730 H	Theme papers Chairperson: Prof. M. Mahadevappa
	Theme Paper on Agriculture – Dr. S.K. Sinha
	Theme Paper on Seeds – Smt. Usha Menon
	Theme Paper on Mass Consumption Goods – Shri. Santosh Choubey
	Discussion
1830 - 1930	
10th March 1990 **Session 5 (S)** 0930-1300 H	Presentation by PSMs Chairperson:
	Presentation on Energy – FOSET
	Presentation on Electronics – DSF
	Presentation on Electronics – FSD
	Presentation on Oil Exploration – PBVM
1300-1400 H	LUNCH
Session 5 (S1)	Chairperson: Prof. M. Mahadevappa
	Presentation on Agriculture – Dr. Pathiyoor Gopinath
	Presentation on Agriculture – Shri. Praful Chandra.
Session 6 (S) 1400 - 1730 H	Action Programme on Self Reliance Chairperson: Shri. S. Rajagopalan
	Presentation of Discussions on Energy, Electronics and Natural Resources
	Presentation of Discussions on Agriculture, Seeds and Mass Consumption Goods
	Action programme and Resolution

HEALTH CONGRESS

9-3-1990

SESSION - (3.H) - PEOPLE'S INTERVENTION IN HEALTH

Chairman Dr.B.Ekbal

9.30 H – PSM Prespective on Primary Health Care
Dr. T. Sundararaman

10.00 H – The K.S.S.P & other PSM experiences
Dr. A. Ramankutty, K.S.S.P.

10.30. H – The MFC experience

10.50 H – The Andhra Polyclinic experience
Dr. Sesha Reddy

11.15 H – The VHAI & AIDAn experience
Dr Mira Shiva

11.45 H – Other Group experiences & discussion

13.00 H – Lunch

SESSION – (4H) – PRIORITY AREAS FOR PEOPLE'S INTERVENTION

Chairperson: Dr. Mira Shiva

14.00 H – Drug Policy - Amitava Guha. FMRAI

15.00 H – The National Health Policy & Vertical Health Programmes
Dr. K.P. Aravindan, KSSP.

16.00 H – Occupational Health
Dr. Amit Sen Gupta, DSF.

17.00 H – Resolutions on priority areas

10th March 1990

SESSION - 5(H) - WOMEN AND HEALTH

Chairperson : Dr. Imrana Quadeer, JNU

0930 H – Theme Papers – Dr. Mohan Ram JNU
Ms. Vimal Balasubramanyan

1300 H – Resolutions on Women and Health.

SESSION -6 (H)- ACTION PROGRAMME ON PRIMARY HEALTH CARE

Chairperson : Dr. Sesha Reddy

1400 H – Presentation of Action Programme

1500 H – Discussion and finalisation

March 1990

VALEDICTORY PLENARY SESSION

0930 -1300 H — Presentation of Sub Congress Proceedings and Resolutions

Valedictory remarks.

Popular Science Lecture Programmes

08-03-1990

1830-1930 H	: (1A)	Dr. Bhaskar Datta	First 3 minutes
1830-1930 H	: (1B)	Dr. Raghavendra Gadagkar	Insects

09-03-1990

1830-1930 H	: (2A)	Dr. A.G.V. Reddy	Geological Exploration
1830-1930 H	: (2B)	Prof. Rama Prasad	Water Resources

10-03-1990

1830-1930 H	: (3A)	Dr. V. Raja Raman	Computers
1830-1930 H	: (3B)	Dr. J. Sreenivasan	Global Warming

Karnataka Rajya Vijnana Parishat
Indian Institute of Science Campus, Bangalore 560 012

THIRD ALL INDIA PEOPLE'S SCIENCE CONGRESS
VIDYANAGAR, BANGALORE
8 - 11, March 1990

8 March 1990

SESSION : 1	INAUGURATION	
10.00 - 13.00 H	Welcome Address	Prof. J. R. Lakshmana Rao President , KRVP
	About AIPSN	Prof. B. M. Udgaonkar President, AIPSN
	Inaugural Address	Shri K.H. Ranganath Hon'ble Minister for Education, Agriculture & Forests
	President's Remarks	Prof. C.N.R. Rao Director, IISc.,
	Role of NCSTC	Dr. Narender K. Sehgal (Dr Menon) Director, NCSTC
	Role of DST(K)	Dept. of Science & Technology Govt. of Karnataka
	Vote of thanks	Shri M.A. Sethu Rao Secretary, KRVP
	COFFEE	
	Keynote Address 1	Health - Dr. D. Banerjee
	Keynote Address 2	Literacy - Dr. M.P. Parameswaran
	Keynote Address 3	Self Reliance – Dr. Prabir Purakayastha and Dr. Venkatesh B. Athreya
1300 - 1400 H	LUNCH	
SESSION : 2		
1400 - 1630 H	Convenors' Meeting	
1630 - 1830 H	Discussion on Narmada Project	

Popular Science Lecture Programmes – Refer to last page

LITERACY SUB CONGRESS

09-03-90

SESSION 3(L)

CHAIRMAN:

0930-1300 H	1. Literacy Programmes in 8th Five Year Plan	Dr. L. Misra
	2. Relapse and Recurrence JSN & Primary Education	Dr. A. K. Jalaluddin
	3. Science & Literacy	Dr. Sanjay Biswas
1300-1400 H	LUNCH	

SESSION 4 (L) CHAIRMAN – Shri. S. Achyutan

1400-1800 H		Experience of Literacy Programme	
	i.	1978 NAE, A.K. Sinha	
	ii.	Gujarat	Dr. Ramlal Parikh
	iii.	Karnataka	Shri. Madan Gopal
	iv.	Tamilnadu	Shri. Ranjani Doss
	v.	Kerala	KSSP
	vi.	Pondicherry	Shri. Mathew Samuel
	vii.	Rajasthan	Shri. RameshThanvi
	viii	West Bengal	Shri. Sakharatha Abhyan
	ix.	Srilanka, Ethiopia,	Mrs. Sadhana Saxena
		Algeria, Tanzania, Cuba, Vietnam, China	Shri. B. K. Shukla

10-3-1990

SESSION 5(L)

0930-1300 H		**PSM & LITERACY**	
		CHAIRMAN: Dr. G. Ramakrishna	
	i.	Science and Content of Literacy	Dr. Anitha Rampal
	II.	Unifying role of Science	Dr. Vinod Raina
	iii.	Relevance of PSM Experience	Shri. R. Radhakrishnan
	iv.	BGVJ & BJVJ	Dr. T. Sunderaraman
1300 - 1400 H		LUNCH	

Phones: 6862716/665036
Grams: SCIFORUM

ALL INDIA PEOPLE'S SCIENCE NETWORK

B-1, 2nd Floor, LSC, J-Block, Saket, New Delhi 110017

18/2/90

To

Dr. S.P. Telang.
Community Health Cell.
Bangalore.

Dear Dr. Telang

We thank you for your letter confirming participation at the 3rd All India Peoples Science Congress at Bangalore. Please find attached details regarding accomodation and travel arrangements aqt Bangalore. If you have not done so already, please communicate your travel plans to the following address.

Dr.M.A.Sethu Rao
Karnataka Rajya Vigyan Parishat
Indian Institute of Science Campus
Bangalore 560012

We look forward to meeting you in Bangalore.

Thanking You

Yours Sincerely

Amit Sen Gupta

Dr.Amit Sen Gupta
(for All India Peoples Science Network)

P.S.: Delegate fee of Rs 50/- may be paid at Bangalore as it may be too late now to send D.D.

Programme:

The programmee for the All India Peoples Science Congress is as given below :

08.03.90	- Session-I	10.00 - 13.00	Inaugural session
	Session-II	14.00 - 17.30	AIPSN Annual Meeting
09.03.90	Session-III	09.30 - 13.00	Parallel
	Session-IV	14.00 - 17.30	Health,
			Self Reliance &
10.03.90	Session-V	09.30 - 13.00	Literacy
	Session-VI	09.30 - 17.30	Sub Congresses
11.03.90	Session-VII	09.30 - 13.00	Valedictory Plenary session

Given below is the programme for the SUB CONGRESS ON HEALTH to be held in Bangalore as part of 3rd All India Peoples Science Congress:

SESSION I: PEOPLES INTERVENTION IN HEALTH
(9th March, 9.30 AM to 1.00 PM.)

Chairperson: Dr.B.Ekbal

9.30 PM. - Primary Health Care and perspective of the Peoples Science Movement.
* Dr.T.Sundararaman

10.00 AM to 1.00 PM - Critical review of experiences of various organisations in the field of health
* Presentations by representatives of various organisations

SESSION II: PRIORITY AREAS FOR PEOPLES INTERVENTION
(9th March, 2.00 PM to 5.30 PM)

Chairperson: Dr.Mira Shiva

2.00 PM - Drug Policy
* Sri.Amitava Guha

3.00 PM - National Health Policy and Vertical Health Programmes.
* Dr.K.P.Aravindan

4.00 PM - Occupational Health
* Dr.Mahesh Mansukhani

SESSION III: WOMEN AND HEALTH
(10th March, 9.30 AM to 1.00 PM)

Chairperson: Dr.Imrana Quadir.

9.30 AM - Family Planning programme
* Dr.Mohan Rao

11.00 AM - Maternal and Child Health

SESSION IV : ACTION PROGRAMME ON PRIMARY HEALTH CARE
(10th March, 2.00 PM to 5.30 PM)

2.00 PM - Presentation of Action Programme
* Dr.T.Sundararaman

3.00 PM - Discussion and finalisation of Action Programme

In addition to the above there will be:
a) Guest lectures in the evenings
b) Poster presentations

KARNATAKA RAJYA VIJNANA PARISHAT

Indian Institute of Science Campus, Bangalore - 12.

Phone: 340509

THIRD ALL INDIA PEOPLE'S SCIENCE CONGRESS

VIDYANAGAR, BANGALORE

8 - 11 March 1990

Dear Sir/Madam,

As you are already aware the Third All India People's Science Congress will be held at Vidyanagar, Bangalore Dist. during 8 - 11 March 1990.

Delegates are requested to feeling the required proforma already sent by our office and send it alongwith the delegate fee of Rs.50.00 in the form of DD. Your early reply enables us to arrange for return tickets, if needed. Vidyanagar is abqut 25 KMs from Bangalore Bus station/Railway Station along Bangalore Hyderabad Highway. After 25 KMs one find deviation arrowmark in right side indicating the route to Jayaprakash Narayan Youth Centre which happens to the venue of AIPS Congress.

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Delegates will be received by our volunteers both at city bus station and city Railway Station.

Vidyanagar as a weather similar to that of Bangalore. One can manage with minimum luggage. A cot, bed and bed spread will be provided.

Tentative programme of each session and invitation is enclosed.

With regards,

Yours sincerely,

(M.A. SETHU RAO)
Hon. Secretary.

Karnataka Rajya Vijnana Parishat

Indian Institute of Science Campus, Bangalore-560 012, India.

Telephone : 340509

Telex : 0845-8952 KCST-IN
Telegram : KRVP Science

THIRD ALL INDIA PEOPLE'S SCIENCE CONGRESS, VIDYANAGAR, BANGALORE

KRVP NO. 8-11/AIPSC/887 02.03.1990

Dr. Gopinath,
Community Health Cell,
W/1, St. Mark's Road,
Bangalore 560 001.

Dear Sir,

Karnataka Rajya Vijnana Parishat is holding All India People's Science Congress at Vidyanagar during 8 - 11, March 1990. There will be three sub-congresses on Literacy, Health and Self-Reliance. I am herewith enclosing the invitation of inaugural function and the proforma for delegates. I request you to kindly send the delegates with duly filled up proforma along with delegate fee of Rs. 50/- (Rupees fifty) only/delegate. About 10 members can be accommodated with lodging facility at Vidyanagar and others can participate by making their own transport arrangements from Bangalore to Vidyanagar.

This letter is in continuation with your enquiry over telephone about the Third All India People's Science Congress.

With regards,

Yours sincerely,

for (M.A. SETHU RAO)
Hon. Secretary

KARNATAKA RAJYA VIJNANA PARISHAT
Indian Institute of Science Campus, Bangalore 12

Phone: 340509

THIRD ALL INDIA PEOPLE'S SCIENCE CONGRESS, BANGALORE
8 - 11 March 1990

Format for Delegates

Name :

Age :

Sex : M / F

Residential Address :

Occupation :

Phone : Resi: Office :

Delegate fee Rs.50/- : D.D. No.

sent on : Date :

Return journey reservation required : Yea / No
If yes, Please give details
Train No. . . . . To . . . . .
. . . . . Date . . . . . .
Rs. . . . . sent on . . . . . .
ny DD No. . . . . .

Mode of Transport : Please give details
(Train / Bus / Air)

Any other information :

I am enclosing a DD No. . . . . for Rs.50/- drawn in favour of "the Secretary , Karnataka Rajya Vijnana Parishat, Bangalore. .

Signature

PS: All communications to be addressed to the Secretary, Karnataka Rajya Vijnana Parishat, Indian Institute of Science Campus, Bangalo e 560 012, Karnataka.

KARNATAKA RAJYA VIJNANA PARISHAT
Indian Institute of Science Campus, Bangalore 12

THIRD ALL INDIA PEOPLE'S SCIENCE CONGRESS, VIDYANAGAR, BANGALORE

8 - 11 March 1990

The All-India People's Science Network is a network composed of People's Science Movements from all over the country who are actively engaged in the building of a mass movement for creating scientific awareness and in intervening in key areas to ensure that science and technology is used for the benefit of the people.

The People's Science Groups in the country have a concern that although thecountry has built a certain level of Scientific and Technological infrastructure, its subsequent development has undergone considerable erosion in the recent years. On the one hand, the phenomenon of braindrain continues unabated, on the other, the scientific community of the country is accused of "not delivering the goods". Hence, there is a thrust towards import of know-how, often ignoring these successes(no matter how limited) of Indian scientists. It is the contention of the PSM's in the country, that even though Indian Science may not have produced the desired result, within the desired time-frame, attempts to bypass it are detrimental to the country's interests. While as scientists we must learn from the body knowledge that is being perpetually expanded by the scientists all over the world, the Indian society requires a sustained mechanism to contribute to and to absorb from this growing fund of scientific knowledge. With this in mind, we endeavour in this congress, to share our understanding with the members of the Indian Scientific Community.

KRVP is now organising Third All India People's Science Congress at Vidyanagar, Bangalore from 8th March to 11th March 1990. As a part of the cohgress these will be parallel subcongresses on Health, Literacy and Self Reliance.

Objectives:

1. Sharing and critical review of experience of all voluntary organisations and social activists in the field of health

2. Discussions of main areas for intervention and people's Participation in ensuring health for the people.

3. Interaction between groups and individuals involved in health activism and evolving mechanisms for continued interaction and exchange of information.

4. Plan action programmes for future people's participation with specific reference to the ongoing Bharat Gyan Vigyan Jatha and to future people's science movement activities.

Programme:

Participants invited:

- AIPSN Organisations and Scientists, Engineers and Doctors, Sponsored by AIPSN Organisations.

- PSM activists and Members of Professional bodies and unions concerned about issues of Scientific, Technological and Industrial Self-Reliance

- Leading academicians, Journalists and Technocrats, etc.

Delegate Fee: Rs.50.00; draft to be drawn in favour of The Secretary, Karnataka Rajya Vijnana Parishat, Indian Institute of Science Campus, Bangalore 560 012.

Address for Communication:

Sri. M.A. Sethu Rao,
Karnataka Rajya Vijnana Parishat,
Indian Institute of Science Campus,
Bangalore - 560 012.

Phone : 340509

* Vidyanagar is about 25 Kms. from Bangalore and has dormitory lodging facilities. If accommodation in hotels in Bangalore is required, Kindly write to us immediately.

KARNATAKA RAJYA VIJNANA PARISHAT
Indian Institute of Science Campus, Bangalore 12

Phone:
Off : 340509
Resi: 321168

THIRD ALL INDIA PEOPLE'S SCIENCE CONGRESS, VIDYANAGAR BANGALORE

Information to delegates & Invitees

1. Our Volunteers with badges will be present at Bangalore City Railway Station(city side) and Bangalore Bus Station (Platform No.1)
2. Buses/Matadors with banners will be available from Bangalore City Railway Station and there is a regular city bus to Vidyanagar - Route No. 282 (via Majestic)
3. On the way to Vidyanagar Buses will halt at KRVP/KSCST office at Indian Institute of Science and will pick up delegates
4. Our volunteers will be present at the Airport and will take invitees to the congress venue
5. Mess at Vidyanagar will start from the evening of 7th March 1990
6. For any assistance kindly contact

		Phone:
Shri G. Panduranga & Shri Visweswara	Asst. Administrative Officer KSCST I.I.Sc. Bangalore	341652 343370

To,

Dr. S.P. Tekur

Community health Cell.

47/1 Ist Floor St Marks Road

B-lore-1.

COMH-3.

Science for the People! Science for the Nation!

9th ALL INDIA PEOPLE'S SCIENCE CONGRESS 2001

New College, CHENNAI 19TH – 22ND December

Newsletter Day Three

AIPSC 9th SCIENCE FOR THE PEOPLE SCIENCE FOR THE NATION CHENNAI-2001

Onwards to day 3 of our Congress and the final edition of the newsletter. People's spirits seem a bit dampened by the December rains lashing Chennai. Where are the vibrant cultural performances from our activists across the country? Why haven't we had teams competing with each other for stage space after dinner as we did at the Nalanda Congress?

As we have not been getting much feedback on the newsletter, we are assuming that you are bored by our long summary accounts of the plenary sessions. We'll give you more cartoons and keep the focus on the divergent perspectives of the delegates on where they think the Science Movement should be consolidating its energies in the years to come.

S&t and livelihood interventions

Dr. Raghunandan, DSF provided an overview of PSM work in livelihood issues. Two dominant models for intervention in S&T in rural areas: (i) small scale industries that support capital-intensive urban industries as their ancillaries 2) Gandhian approach of KVIC industries. The PSMs have been trying to evolve an alternative to both approaches. We find the technology applied in KVIC to be household based with very low productivity. Our focus is on using local resources, local skills and sourcing local markets for rural industrialization. There is a great need for innovative application of S&T as technology for rural industrialization is not available off the shelf. Our approach avoids the pitfall of " big is best" and "small is beautiful". Small units can be networked into big system. The idea is not for the PSMs to set up industries but to develop working models. This can also be a weapon against globalization.

Joginder Walia, Himachal :
After our intervention in organizing artisans, the percentage that went to middlemen has reduced. Now artisans decide how their profits should be invested.

Soap sales, Sujatha, Kerala
We require know how even for simple technology. In the IRTC produced soaps the main ingredient is coconut oil as 60% of households use it. Marketing is directly through women's groups.

Fruit processing, Gautam Ray , PBVM, FOSET
There is enough space because it can be consumed locally despite the aggressive marketing of MNCs. Technology is not the problem in this case. Marketing is the more critical issue.

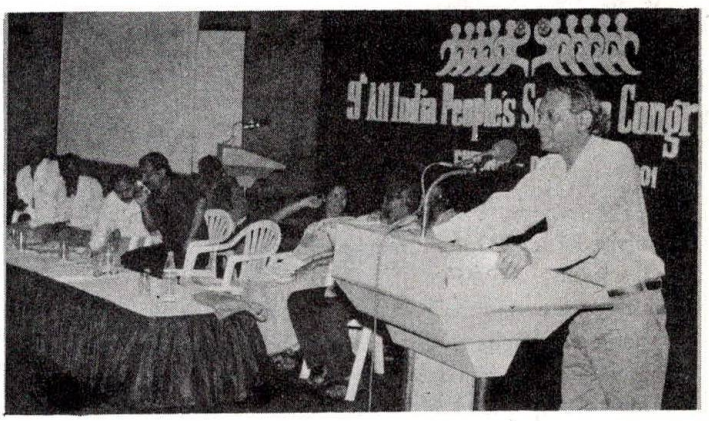
Globalization, Infrastructure and S&T

Free Markets, Unfree labour

Dr.A.K. Bagchi: I have no problem with the notion of globalization as continous interaction between people.But today it is increasingly manifested as market fundamentalism, as distorted markets. After 4 years of WTO in 99, developing countries of the world exported 174 billion dollars of agrl goods. Subsidies of rich to their own agricultural sector is 360 billion dollars. So where is the free trade?

WTO converts process to product patents. Consumers were benefiting from process patents. This has been overturned in the name of free trade. There is a conspiracy to break the power of labour and to increase the power of capital. There is growing restriction of entry of labour from third to first world.

The Govt of India guarantees 16% profit for foreign corporations which are given an absolutely free run. Enron is the best example.



Dr.Ashok Jhunjunwala, Professor, IIT:
Infrastructural cost per telephone line for any operator in India currently is Rs.30,000. To break even, each family needs to spend Rs.1000 per month. Only 2-3% can afford it today. If cost comes down to 10,000, 50% of the population will be able to afford it. For the West, 30 dollars per month is the expense per family which everyone can afford. As the market is saturated, the West is not going to develop low cost technology. We need to do it. At IIT Chennai, we have developed CORDECT, a wireless technology at 60% of current cost.
However the Cable TV line cost is 25 dollars per month in US and only 2 dollars in India. This is because we use low cost technology supplemented by human power. So we are trying to develop the same for telephones and internet.

Health Session

Eloquent Silence

Dr. Amit Sen Gupta, DSF: The National Health Policy has been released unilaterally by the Centre without even consulting the State Governments when Health is supposed to be a state subject. The omission of the concept of comprehensive and universal health care emphasized by the NHP 83 and by our commitment to the Alma Ata declaration of 78 points to an eloquent silence.

The Draft shows no reflection of the current understanding that Population policy never works without accompanying socio economic changes. The issue of rational drugs has not even been mentioned and appears to have been relegated to the Industries Ministry. The fragmentary, technocratic and vertical approach to health care is reflected clearly in the document.

The brief paragraph on women's health and the complete absence of any mention of child health are very disturbing. We see this policy ultimately as a prescription for health privatization as revealed for instance through the intention to subcontract PHCs to NGOs.

Informed facilitator or marketing agent ?

Dr.K.S.Reddy, JIPMER

Health care was in the hands of people before the age of medical colleges. The doctor was only a facilitator. Then he started to monopolize medical practise. Then he went a step ahead and thought that he was God. From there it was only one more step for medicine to become a business. Only here the seller also sets the demand.

The medical profession is now addicted to profits and the doctor has become a marketing agent. The medical student no longer makes connection with the social context of medical practise. The Public Sector has to be our focus and we have to make it accountable. The State cannot wash its hands off providing accessible health care to all.

TINA to TIPA

Dr.B.Ekbal, Vice Chancellor, Kerala University and KSSP:

The fact that the GDP of several Multinational companies is much more than that of countries indicates the kind of world we live in today. This stark inequality certainly has an influence on health status of people, directly through the implementation of the structural adjustment programmes and indirectly through increasing poverty and unemployment.

There has been a 50% decline in spending on health care in Sub Saharan Africa after SAP policies. In India, public health expenditure is only about 21% of total health expenditure. In all developed countries, the reverse is the case except for US where it is less than half of total expenditure. There is no Alternative syndrome needs to be replaced by there is a People's Alternative syndrome. We need to fight for a National Health Policy with Primary health care as the basis, people's participation in health planning and a rational drug policy.

Philosophy of globalization - "what is mine is mine, what is yours is also mine".

A.K. Bagchi

We are surprised at the breadth of governance failures across times, across governments and across agencies from 92 upto 99. This one project could lead to the declaration of "Plan Holiday" by Maharastra government.
High powered Godbole Committee that enquired into the Enron Power Project.

In 1995, in its presentation to the Government, Enron promised a fixed tariff of Rs.2.4 per unit. It sold power to the Maharastra Electricity board this year at an average cost of Rs.5.3 per unit.
Shanthanu

Micro soft charges Rs.22,000 for its MS Office programme. We are working to provide a similar programme in local languages for Rs.300 to each village kiosk.
Ashok Jhunjunwala

At the field level, our work must be focused on interventions such as literacy, Continuing Education, health to more systematically build the capacities of elected Panchayat members so that decentralization really means power to the people.
Asha Mishra, Samata Coordinator

Interview with P.Sainath on his Photo Exhibition
So far 45,000 people have seen it in different cities. What is important is that those who have seen it also belong to the same class of women who are featured in the photos. About 30,000 agricultural labourer women saw it at the AIDWA Conference at Vizag. The response from students in women's colleges has also been overwhelming. At Stella Maris, Madras, Kanoria College, Jaipur and Miranda House, Delhi the girls wrote poems in the comments note book. I am very happy as I am just about to take it to Pudukottai where it is being hosted by the quarry women where the first shot was taken some years ago. I think it appeals to people as this is really a hard hitting political document minus jargon.

A Satellite session was held in the office of the Accountants' General (A&E) Tamilnadu in which Prof.T.R.Janardhanan, KSSP addressed a gathering of staff on the topic of "Environment and Pollution" which also had an overwhelming response from the administration that they asked for more such sessions in the future.

DELEGATE'S DISCOURSE....

AIPSN's struggles should be oriented towards developing alternatives both materially and conceptually for rural based self reliance. Our campaign should be pressurizing the public sector to regain its leading role within the capital intensive sector. We also need to systematically campaign on public policy issues like drugs and health
Amitava Guha, General Secretary, FMRAI

At this Congress, our focus has been on preparing ourselves for an onslaught against globalization and liberalization. I feel that we need to mobilize the rural poor to launch enterprises to counter the invasion of foreign products. Also there are thousands of small groups engaged in environmental struggles. Can we think of uniting the various groups to fight a combined battle against the degradation of the environment ?
M.K. Prasad, President, AIPSN

We must continue to organize women who have come into our movement through literacy in ongoing struggles for social equality. We need to strengthen women through information and technology. How do we build the leadership capabilities of women? How do we struggle to build women's independent identity and a consciousness of their rights as women?
Pushpa, Bihar

I feel that we must continue our anti-superstition campaign in villages. Also we need to think more into how we can use Science and technology inputs to increase women's earning capacity and reduce the burden of their daily labour Our work must be more intensely focused towards the needs of villages and the rural poor.
Narayanasamy, Tamilnadu

Released : Book "Health and Healing" by Dr.Shyam Ashtekar on Primary Health Care for village health workers
&
Health Calendar by UP BGVS

Our biggest task will be to fight American Imperialism which is wrongly being called globalization. We see its brutal face in Afghanistan now. Our biggest and immediate challenge is to safeguard the subcontinent. Also we need to challenge the feudal and backward mentality of the fascist Indian state which is colluding with American Imperialism. Finally, I feel we need an Education Assembly just like the PHA, Dacca to carry forward this campaign.
Rakesh Gairola, UP

I'm happy about the Congress. I don't see it as really setting a direction as that is already there in the work we are doing. This is more of an inspiration, a morale booster for us. We need to intensify our work with poor women and with Dalits as well - the most deprived section of our population.
Vijayalakshmi, AP

Our direction - towards building mass movements, initiating, associating with and cooperating in mass movements.
Gurjeet, Punjab

"I feel that even this Congress should have been more linked to our existing work on the field. It is still heavily English dominated, male dominated and lecture dominated. People have come from a great distance at heavy personal cost and what we do here should meet their needs. About the future, we actually just need to consolidate the work we have been already doing in the areas of literacy health, education, enterprises. We have not really been consolidating programmatic action in the larger national sense."
Anita Rampal, BGVS

I think that given the current attacks on history and Science it has become very important to bring back the debates on Science and Reason. A strong assault on the celebration of the so-called "Indian" Science by the government is called for particularly as this is being counterposed to "Western" Science which is actually a product of Babylonian, Greek, Chinese and several other civilizations. What we are abandoning in the process is actually our rights over the common heritage of human science that we have also enriched. We really also need to engage much more seriously with mobilizing progressives within the scientific community as this is the primary area of the Science Movement.
Prabir Purkayastha