A FUNDAMENTAL SHIFT IN THE APPROACH TO INTERNATIONAL HEALTH BY WHO, UNICEF, AND THE WORLD BANK: INSTANCES OF THE PRACTICE OF "INTELLECTUAL FASCISM" AND TOTALITARIANISM IN SOME ASIAN COUNTRIES

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Navarro has used the term "intellectual fascism" to depict the intellectual situation in the McCarthy era. Intellectual fascism is now more malignant in the poor countries of the world. The Indian Subcontinent, China, and some other Asian countries provide the context. The struggles of the working class culminated in the Alma-Ata Declaration of self-reliance in health by the peoples of the world. To protect their commercial and political interests, retribution from the rich countries was sharp and swift. they "invented" Selective Primary Health Care and used WHO, UNICEF, the World Bank, and other agencies to let loose on poor countries a barrage of "international initiatives" as global program on immunization, AIDS, and tuberculosis. These programs were astonishingly defective in concept, design, and implementation. The agencies refused to take note of such criticisms when they were published by others. They have been fascistic, ahistorical, grossly unscientific, and Goebbelsian propagandists. The conscience keepers of public health have mostly kept quiet.

OVERVIEW

Giving a personal account of studies on class, health, and quality of life during 1965–1977 in the United States, Vicente Navarro (1) has brought back chilling memories of the dreaded McCarthyism which overshadowed almost every facet of intellectual life in that country. He has, very appropriately, used the term, "intellectual fascism" to describe this phenomenon. The intellectual fascism that is being practiced by the rich countries of the world on the health services of the poor, dependent countries is of an even more malignant variety. There is an unholy nexus between the ruling classes of the rich and the poor countries in in

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imposing health programs on the poor, because it serves their commercial and political interests. Even the most cogent, well-documented, and well-argued observations questioning the scientific validity of these programs are ignored. Making use of the market-generated information revolution, the rich have brainwashed the helpless masses of the poor to sell their programs. They have also ignored the fact that health policy formulation is a highly complex process, requiring optimization of very complex systems. The task becomes even more complicated when it has to be performed in the context of poor, non-Western countries. These considerations have received scant attention from the health policy experts hired by rich countries.

Asia is a huge continent, with extreme variations in geography, population, ethnic composition, and political commitments. In this report, only the countries that fall in the "median" positions will be taken into account. Among them, again, very brief references will be made to the cases of health service developments on the Indian subcontinent and in China to provide a setting for discussion. Together they account for more than two-fifths of the entire population of the world, and a much higher proportion of the world's poor.

The long experience of India in developing its health services has escaped the attention of scholars from the rich countries, of both the hired and the "progressive" varieties. It has been a most virulent form of intellectual fascism. These scholars were actively ahistorical, apolitical, and atheoretical. After Independence, India's ruling class, which had led the freedom struggle against the colonial rulers, was impelled by the working class to fulfill the promises it had made while mobilizing them for the struggle. This was the compelling motive force for its ushering in very ambitious health programs to cover the needs of the unserved and the undeserved during the first two decades of independence, even though the country faced massive problems.

The situation in China is entirely different from that in India. Significantly, the two major ideas in public health that emanated from China—the barefoot doctor and the use of the traditional Chinese systems of medicine in their health services—are the outcomes of the revolutionary movement, particularly the Long March. Unfortunately, China also adopted the now well-discredited Soviet model, which failed to work. Deng Xiaoping's move to promote "market socialism" dealt an almost deadly blow to the village commune system, which sustained the barefoot doctors.

Other Asian countries such as Sri Lanka, Pakistan, Bangladesh, Malaysia, Indonesia, Thailand, and the Philippines have also made "progress" in developing their health services. The four last-named countries were among those specially favored by the world capital for stimulating rapid economic growth during the past two decades. Even at the peak of their growth phase, serious flaws have been observed in the health services in the form of rapid privatization leading to gross overcapacity in private hospitals and almost criminal neglect of the poor because of further decay of the already inadequate health services for the poor people.

One can well imagine the health and health service consequences of the severe financial crises that have overtaken these "Tiger" countries since 1997.

The ferment in the development of health services in Asia and elsewhere during the 1960s and 1970s triggered major changes in World Health Organization (WHO) policies. The Alma-Ata Declaration on Primary Health Care was the culmination of the chain reaction. Apparently for tactical reasons, all the rich countries of the world signed the Declaration. But their retribution for such a daredevil declaration by the poor was swift and sharp. As it from nowhere, they "invented" the concept of Selective Primary Health Care (SPHC). A large number of concerned scholars categorically questioned the scientific validity of the concept, but all failed to make any impression on the exponents of SPHC.

Two main issues stand out from the awesome manifestation of power by the rich countries in imposing their will on the poor. First, although they lay claim to being the inheritors of the European Enlightenment, which involves a deep commitment to the scientific method, they have shown contemptuous disregard for these principles whenever, scientific data stood in the way of their commercial and political interests. Second, the bulk of public health scholars, who proclaim their allegiance to the scientific method and commitment to social justice, found it worthwhile to remain silent while such active desecration took place.

As a follow-up, the ruling classes of the countries of the world exercised their control over international organizations such as UNICEF, WHO, and the World Bank (WB) to get them started with formulating some selected programs as "global initiatives." These were bristling with inconsistencies, contradictions, and patent scientific infirmities. Even the main planks for the formulation of these initiatives were profoundly flawed. First, how can one have a "prefabricated" global initiative given the extreme variations among and often within poor countries? Second, selection of health problems for action conformed more to the special interests of the rich countries than the poor. Third, a technocentric approach to problem-solving was adopted. Fourth, there is an obvious contradiction in the scientific bases of the claim that the suggested globe-embracing programs are cost-effective given the profound variations among and within countries. Fifth, by their very nature, international initiatives cannot promote community self-reliance. Sixth, there is the key question of dependence and sustainability; "donors" have used their tremendous influence on the pliable ruling classes of the poor countries to ensure that the ill-conceived, ill-designed, and ill-managed global initiatives are given priority over the ongoing work of the health organizations. Finally, and above all, these programs are the very antitheses of the Alma-Ata Declaration.

It is grimly ironic that soon after the leadership given by WHO and UNICEF in writing one of the brightest chapters in the history of public health practice, in the form of acceptance of the Alma-Ata Declaration by all countries of the world in 1978, the ruling classes should have started the international initiatives that opened one of the darkest chapters. By the early 1980s, UNICEF let loose a

barrage of global initiatives on the poor countries of the world. WHO and the World Bank lent the full weight of their considerable prestige and influence in strengthening this menacing trend in public health thinking and action.

The outbreak of the AIDS epidemic in 1982, which later took the form of a pandemic, legitimately thrust on WHO the onerous responsibility for action on a global scale. It developed the Global Programme for AIDS. Despite the bewildering variations in the epidemiological behavior of the disease—including its complex social and cultural dimensions, which required a very flexible approach to program formulation—the program conformed to a set pattern which was principally shaped in the United States.

WHO's declaration of the tuberculosis problem as a "Global Emergency" was a totally surprising move. The database to justify such a sweeping declaration was virtually nonexistent. Ironically, allocation of overriding priority to the international initiatives, all down the line, led to the neglect of other services provided at the peripheral or grassroots level. This included tuberculosis work. WHO had also launched two other global programs with considerable fanfare. One was the Diarrheal Disease control programme and the other was meant to deal with acute respiratory infections in infants and children. Mercifully, these programs failed right at the take-off stage. The World Bank had joined WHO to launch yet another international initiative called the Safe Motherhood Initiative. This too has a very long way to go.

Some high-profile research administrators got together to set up a global Commission on Health Research and Development in 1987. Practice of Essential National Health Research was the centerpiece of the report. Even the very scanty materials produced to document progress in its implementation leaves little doubt that the initiatives taken could have little impact on the strengthening of health services in the countries of the world.

It should come as no surprise that virtually every global initiative taken by WHO, UNICEF, and the World Bank since the promotion of SPHC by the rich countries suffered from serious infirmities. Remarkably, even when these infirmities were pointed out to the organizations, they failed even to enter into discussion on the issues raised or take any corrective measures. It is not necessary here to make a comprehensive critique of all the programs. Only three of the major ones—on immunization, AIDS, and tuberculosis—will be taken up here, and these only very briefly.

Even a very broad analysis of the process of policy and program formulation and implementation of the immunization program (EPI/UPI) reveals that the apical organizations of international public health have shown scant regard for some of the fundamental principles of public health practice. They have dared to launch a global/universal immunization program without caring to have a reasonably reliable epidemiological baseline. They have tended to "homogenize" the situation; even the 100 or so poor countries have widely varying parameters. When there is no epidemiological baseline, how is it possible to assess the

epidemiological impact of the program? Without paying any attention to these vital infirmities, the WHO/UNICEF/WB establishment has not hesitated to repeat in 1998 the wild claim that: "Today 80 percent of the world's children receive this form of protection against childhood diseases their first year of life."

WHO and UNICEF had joined the Government of India to get the Indian program systematically evaluated in 1989. The results were published in the form of a book, which was widely circulated. The findings seriously questioned the claims by WHO/UNICEF/WB. Another all-India study conducted in 1992–1993 revealed that at the national level as few as 35.4 percent of eligible children were fully protected, with the coverage hovering around 9 to 22 percent among many of the highly populated states with the poorest records of infant mortality. If the situation is so bad in India, the conditions prevailing in the world's least developed countries, and many more, will certainly not be any better.

The same trend was followed when WHO, along with a large number of U.N. agencies, set out to design the Global Programme for AIDS (GPA), which was principally directed toward the poor countries. Despite the efforts by WHO/WB officials and their Indian camp followers to control information and extensively spread unsubstantiated information, it was possible, as early as in 1992, to bring out a monograph that called into question a number of critical assumptions in the formulation of the GPA in India. This too was disregarded.

The justification given by WHO/WB for launching the Global Programme for Tuberculosis (GPT) is even more fantastic and incredibly contradictory. Out of the blue, as it were, in the early 1990s, WHO/WB sounded a maximum-alert alarm bell to proclaim that tuberculosis had become a "Global Emergency" and the GPT was the way of tackling it. Once again, despite putting on a cloak of secrecy while selling the program in India, a comprehensive document was prepared pointing out major epidemiological, sociological, economic, and organizational and management flaws in the GPT. But this did not deter the authorities from pushing on with their doomed venture.

A very large area is covered in this report to demonstrate how the imposition of an enormous, high-priority, prefabricated health service agenda of the rich countries on the poor ones has virtually decimated the somewhat promising growth of people-oriented health services in a country such as India. The overriding priority assigned to a Malthusian family planning program for over four decades by the ruling classes, both national and international, has also had a devastating impact on the growth and development of the health services in India. As described later, Nicholas Demerath, Sr., has given a well-documented account of the various ways in which India's family planning program has been influenced by the U.S. government (U.S. AID) and other U.S. agencies.

In conclusion, let me list just a few of the major areas of distortion. First, the "public health" practiced by exponents of the international initiatives is starkly ahistorical. Second, the scientific term "epidemiology," which forms the foundation of public health practice, has been grossly misused by the new breed of

experts. Third, suppression of information, use of doctored information, spread of misinformation and disinformation, and lack of effective evaluation/surveillance are expected outcomes. Fourth, directors-general of two top public health institutions in India extended their support to the GPT, even though serious flaws in the program were repeatedly brought to their attention. After they endorsed the WHO/WB program, they found highly lucrative positions in WHO. This and many other such instances mark the rock-bottom of the moral and ethical standards of the parties concerned. Finally, those who are expected to be the conscience keepers of ethics and morality in public health practice are perhaps the worst offenders in inflicting such a humiliation on the poor peoples of the world.

The line of action for those few who still attach high value to intellectual and moral integrity, and are prepared to pay the sort of price mentioned by Navarro, emerges from the analysis presented in this report.

INTELLECTUAL FASCISM

Giving a personal account of studies on class, health, and quality of life during 1965–1997 in the United States, Vicente Navarro notes that "terms such as class, working class (not to mention class struggle), and just plain capitalism were dismissed as ideological. No serious scholar, aware of the penalty it would carry, would dare to use these terms" (1, p. 391). He has, to my mind very appropriately, used the term "intellectual fascism," whose "destructive powers could be even worse than the fascism I had experienced in Spain" (1, p. 392), to describe this phenomenon.

The intellectual fascism that is being practiced by the rich countries of the world against the poor, dependent countries is of an even more malignant variety. In the field of health, to subserve their commercial and political interests, the ruling classes of the rich and the poor countries have formed an unholy nexus which enables them to impose prefabricated, technocentric, dependence-producing health programs on the poor. These interests are so powerful that even most cogent, well-documented, and well-argued observations calling into question the scientific validity of these programs are simply ignored. When it comes to protecting their interests, the special brand of intellectuals/scholars who are hired by the ruling classes are ruthless, unscrupulous, and nonchalant (2). The Bhopal tragedy of 1984 (3–10), in which the Union Carbide Corporation got away so lightly with the consequences of its criminal neglect—which led to the spraying of the deadly chemical methyl isocyanate on hundreds of thousands of people, leading to the death of thousands and severe health damage to scores of thousands—provides an awe-inspiring case study demonstrating the power of the nexus of the ruling classes.

The ruling classes of the rich countries have also mobilized a number of international agencies and myriad bilateral and "voluntary" agencies or

nongovernmental organizations to implement their agenda for action. Suppression of information, doctoring of information, misinformation, and disinformation have been freely used as means to push their agenda. Making use of the market-generated information revolution, they have employed the approach of social marketing (11, 12) to brainwash the helpless masses of the poor so as to sell their programs. The way in which the "experts" employed by the World Bank have twisted and distorted the meaning of health policy formulation almost beyond recognition, by bringing it down to the level of health financing (13), provides a startling instance of this new brand of scholarship from the rich countries.

Lest they "forget" the essence of health policy formulation by hiding themselves in the jungle of the massive, programmed information onslaught, it is worthwhile to "remind" the hired experts about some of its basic concepts. ("Man's struggle against oppression is a struggle between memory and forgetfulness"—Milan Kundera.) Health policy formulation is a highly complex process, requiring optimization of very complex systems. For this purpose, epidemiological, medical and public health, and organizational and management issues are visualized in their social, cultural, and economic contexts so as to crystallize them in the form of policies based on constitutional and other types of political commitments (14). The task becomes even more complicated when it has to be performed in the context of poor, non-Western countries. Western medicine is, after all, Western in origin. Furthermore, it has been grafted onto countries that already had ways of coping with their health problems. The grafting was done usually against the background of colonial conquest, as in the case of India, or in blatant imperialistic settings, as in the case of China. Differences in the ecology of diseases, availability of resources, cultural meanings of health problems and health practices, formulation of appropriate technologies and economic production practices are some other important determining factors. These considerations have received scant attention from the health policy experts hired by rich countries (15).

EARLY EFFORTS TO DEVELOP HEALTH SERVICES IN SOME ASIAN COUNTRIES

Countries of Asia

Asia is a huge continent, with wide variations in geography, population, ethnic composition, and political commitments. For instance, there are Japan and South Korea at one extreme, and Nepal, Bhutan, and Afghanistan at the other. Here I will discuss the role of foreign and international agencies and other organizations in health policy formulation in terms of those Asian countries occupying median positions. A very brief reference will be made to the cases of health service developments on the Indian subcontinent and in China to provide a setting for

discussion. Together they account for more than two-fifths of the entire population of the world, and a much higher proportion of the world's poor. Besides, many of the observations made about India and China are also relevant, to varying degrees, to many other Asian countries in "median" positions. It also so happens that information available on development of health service systems in these other Asian countries is very scanty and often of rather unreliable quality.

Health Service Development on the Indian Subcontinent

The long experience of India in developing its health services has escaped the attention of scholars from the rich countries, of both the hired and the "progressive" varieties. Indeed, the former category has actively ostracized the indigenous scholarship, apparently to create "space" for justifying the agenda handed down to them by their paymasters; it has been a most virulent form of intellectual fascism. As pointed out by Navarro (1, 16), and earlier noted by John McKinlay (17) in a slightly different context, these scholars were actively ahistorical, apolitical, and atheoretical. Such an approach subserves the class interests of the rulers. Obviously, this normally would require considerable elaboration (e.g., 18), but in the present context I will present only a bare outline of India's experience.

The British inducted Western medicine in India in the wake of their colonial conquest in the latter half of the 18th century, primarily to strengthen their exploitative machinery—the army, the civil service, the European business class, and a wafer thin, uppermost crust of native collaborators (18). Reciprocally, this further weakened the native working class, which constituted more than 98 percent of the population. They were further pauperized due to colonial exploitation, thus further increasing the disease load, and were made to lose the indigenous coping mechanisms that they had developed over the course of centuries (18).

As a dialectic response, the people of India launched an anti-colonial freedom struggle, which became a mass movement, leading to the overthrow of the colonial rulers in 1947 (19). The reports of the National Health Sub-committee of the National Planning Committee of the Indian National Congress in 1940 (20) and the famous Bhore Committee (21) (which, incidentally, was spearheaded by "foreign" experts such as John Grant and Henry Sigerist) in 1946 provided the basis for the formation of a blueprint for building an egalitarian health service for free India.

After Independence, the ruling class, which had led the freedom struggle, was impelled by those of the working class to fulfill the promises it had made while mobilizing them for the struggle. This was the motive force for ushering in very ambitious health programs to cover the needs of the unserved and the underserved, even though the country faced massive problems—accentuated severalfold in the wake of Partition. A nationwide network of Primary Health Centres

(22) for the rural population was established from 1952 to provide integrated health services to entire populations, as part of a still more ambitious Community Development Programme (23). The Primary Health Centres formed the sheet anchor for developing the other important facets of the health service system—for example, people-oriented manpower development (24–27), research (28, 29), regionalization of the health services (30), inclusion of the indigenous systems of medicine (31), and so on. Very well-designed public health research on tuberculosis conducted in India had a far-reaching influence on tuberculosis programs all over the world, including in the rich countries. This research showed that home treatment is as good as sanatorium treatment (32); that the BCG vaccine has little protective value, at least for adults (33, 34); that a substantial proportion of tuberculosis patients in a population were already seeking assistance at Primary Health Centres and other health institutions; and that sputum smear examination is the most reliable diagnostic tool (35–37).

The major political upheaval that followed imposition of the National Emergency in 1975–1977 was instrumental in adoption of the program of entrusting "people's health in people's hands" (38); using community health workers chosen by the people themselves has been another landmark. These movements culminated in enunciation of the National Health Policy in 1982 (39), which proclaimed that:

> The prevailing policy in regard to education and training of medical and health personnel, at various levels, has resulted in the development of a cultural gap between the people and the personnel providing care. The various health programmes have, by and large, failed to involve individuals and families in establishing a self-reliant community . . . the ultimate goal of achieving a satisfactory health status for all our people cannot be secured without involving the community in the identification of their health needs and priorities as well as in the implementation and management of various health and related programmes.

As discussed later, the approach adopted by the special brand of experts hired by the rich countries and their camp followers is diametrically opposed to that envisaged in the National Health Policy. Incidentally, as also pointed out by Navarro (1), the emphasis on democratization of community health services is also conspicuously missing in the approach adopted by the erstwhile "socialist countries" (including China) and those European countries that have set up national health services.

Health Service Development in China

The situation in China is entirely different from that in India. China had the most blatant form of imperialistic exploitation, as symbolized by the Opium

Wars; feudal monarchy; the revolution of 1912; the KMT of Chiang-Kai-shek and their pathetic, supplicant-level dependence relationship with the United States in almost all spheres; the Japanese war of aggression; the revolutionary movement by the Chinese Communist Party, including the fabled Long March, leading to its ultimate victory and establishment of the People's Republic of China in 1948.

The United Missions Medical College was China's first medical college, started in 1925 (40). In contrast, India had three government-funded medical colleges by 1835 (41). Significantly, the two major ideas in public health that emanated from China—the barefoot doctor and use of the traditional Chinese systems of medicine in the health services (42)—are the outcome of the revolutionary movement, particularly the Long March. Unfortunately, China also adopted the now well-discredited Soviet model, which failed to work. In sheer frustration, Mao had exclaimed, as late as in 1965 (43):

> Tell the Ministry of Public Health that it works only for fifteen percent of the population of the country and this fifteen percent is mainly composed of gentlemen while the broad masses of peasants do not get medical treatment . . . why not change its [Ministry of Public Health's] name into the Ministry of Urban Health, the Ministry of Gentlemen's Health or even the Ministry of Urban Gentlemen's Health?

Deng Xiaoping's move to promote "market socialism" dealt an almost deadly blow to the village commune system, which sustained the barefoot doctors. Even though critical of the Soviet model of health services, Navarro (1) has also observed how the capitalist model adopted by post-Soviet Russia has led to a disastrous collapse of the health service system of that country. Almost grudgingly, he also concedes that "the same process is now underway in China." It is a profound irony that, having brought about the collapse of the earlier socialist system, China is now asking for help from WHO's Division for Intensive Cooperation with Countries and Peoples in Greatest Need "to solve problems in health financing in connection with re-establishment of the country's Rural Cooperative Medical System" (44). China also created a most embarrassing situation for other countries when it accepted the World Bank/WHO-supported tuberculosis program with alacrity, turning a blind eye to the myriad scientific design flaws repeatedly pointed out by scholars from other countries (45–47). That China should now adopt an openly coercive policy of one-child families, while earlier it had described the dangers of population growth as a trait of the capitalist system, is yet another indication of grave flaws in its population policies and planning. Incidentally, no political leader would dare even to think of a similar approach for India, for fear of a backlash from the people.

The "Tiger" and Other Asian Countries

The state of Kerala in India (population 30 million) (48, 49) an Sri Lanka (50) (population 16 million) stand out sharply among all the low-income countries in having remarkably good health and mortality statistics. Other Asian countries such as Pakistan, Bangladesh, Malaysis, Indonesia, Thailand, and the Philippines have also made "progress" in developing their health services.

The four last-named countries were among those specially favored by the world capital for stimulating rapid economic growth during the past two decades. Even at the peak of their growth phase, serious flaws have been observed in their health services in the form of rapid privatization leading to gross overcapacity in private hospitals and almost criminal neglect of the poor because of further decay of the already inadequate health services for the poor (51). In a recent article, Barraclough (51) has described how the conglomerate corporations of Malaysis, which often own plantations, also run the leading private hospitals, using the latest technology. He points out the paradox that the workers on the rubber and palm estates are the poorest in the country. Conforming to laws originating in the colonial period, the services now being provided to them are "woefully inadequate and offer little more than treatment of minor ailments and first-aid." Given such a situation in 1994 in one particularly "successful" "Tiger" country, one can well imagine the health and health service consequences of the severe financial crises that have overtaken these "Tiger" countries since 1997. Although some of these consequences are already visible in the form of a sharp deterioration in health and mortality statistics and an acute scarcity and sharp rise in price of drugs, the full impact of the crises on the health service systems has yet to be systematically assessed.

THE ROAD TO ALMA-ATA AND THE RESPONSE OF THE RICH

The Alma-Ata Declaration: A Watershed in Public Health Practice

This very broad account of the evolution of health service systems in the two Asian giants, and a mere mention of the state of affairs in many other Asian countries, set the stage for understanding and analyzing the practice of intellectual fascism by a syndicate of the world's ruling classes, with those that are rich and powerful setting the agenda for action. The ferment in the development of health services in Asia and elsewhere in the world during the 1960s and 1970s triggered major changes in WHO policies. The Alma-Ata Declaration on Primary Health Care (52) was the culmination of the chain reaction. Health as a fundamental human right, community self-reliance, intersectoral action for health, social control over health services, use of appropriate technology, encouragement of traditional systems of medicine, essential drugs—these are

some components of the Declaration. It also contained a detailed definition of Primary Health Care.

The Invention of Selective Primary Health Care

Apparently for tactical reasons, all the rich countries of the world signed the Alma-Ata Declaration even though it shook the very foundations of the conventional thinking on international public health as hitherto practiced by these countries. The Declaration marked a watershed. It was also clear to the rich countries that such a declaration of self-reliance by the poor peoples of the world was against their class interests. They saw its "subversive" character. Navarro (1) has described how the use of such radical terminology as "class interests" has long been seen in the United States as "too ideological," with the enjoinment that such things have to be "value free"—forgetting that this is itself a most value-laden term. The retribution for such a daredevil act as the Alma-Ata Declaration was swift and sharp.

As if from "nowhere," the rich nations "invented" the concept of Selective Primary Health Care (53). The justification was that Primary Health Care was good, but was too ambitious; one therefore should be selective in choosing areas that are cost-effective. To legitimize such a fragile stand, they got hold of a very poorly designed, and even more poorly conducted and analyzed, study in Haiti. The principal author was then an "assistant clinical professor of medicine" at Harvard. Such a paper would have been rejected out of hand by even the poorest academic journal in a developing country. That it found ready acceptance for publication in the prestigious *New England Medical Journal* speaks volumes about the intensity of intellectual fascism that still prevails in the United States.

More than 80 scholars from schools of tropical medicine and other public health institutions in Europe and from the United States, Africa, and Asia gathered at Antwerp to discuss SPHC. In the Antwerp Declaration (54, 55) they categorically questioned the scientific validity of the concept. *Social Science and Medicine* (56) brought out a special issue with a detailed account of the deliberations at Antwerp. There were articles on the subject in the *Economic and Political Weekly* (Bombay) (57) and the *International Journal of Health Services* (58). *The Journal of the Indian Medical Association* (2) carried a leading article on the subject. All these and many others (e.g., 58–62) failed to make any impression on the exponents of SPHC. The latter went on to organize a high-profile meeting attended by top executives of WHO, UNICEF, the World Bank, and many other agencies, as well as like-minded persons who called themselves public health scholars, at Bellagio, Italy (63), thus getting a resounding endorsement for SPHC. After two years, they organized a similar meeting at Cartagena in Columbia (64) (called Bellagio-II) to get a similar endorsement.

Two main issues stand out from the awesome manifestation of power by the rich countries in imposing their will on the poor. First, although they lay claim to

being the inheritors of the European Enlightenment, which involves a deep commitment to the scientific method, they have shown contemptuous disregard for these principles whenever scientific data stood in the way of their commercial and political interests. Second, despite the brave scholars who stood up to the bullies at Antwerp and at other forums, the bulk of public health scholars, who proclaim an allegiance to the scientific method and commitment to social justice, including the Alma-Ata Declaration, found it worthwhile to exercise discretion—the better part of valor. They remained silent on the most blatant desecration of scientific principles and methods, presumably to avoid the anger of the most powerful country and its camp followers. This brand of "intellectuals," who belong to the middle class and attained their positions of importance by putting on a mask of progressivism, can also be said to harbor at least some traits of intellectual fascism, which they try to hide deep within them. They too need be exposed. Where were they when China started its pogrom of enforcing the norm of a single-child family, or when Indira Gandhi imposed a National Emergency and let loose a reign of terror, and used force to sterilize millions of people against their will (65)? The Vietnam "war hero" and then President of the World Bank, Robert McNamara visited India at that time and is on record praising India for its achievement in fighting the menace of population explosion (66).

LETTING LOOSE A BARRAGE OF INTERNATIONAL INITIATIVES

UNICEF's Primacy in Imposing International Initiatives

As a follow-up to acceptance of Selective Primary Health Care, the ruling classes exercised their control over international organizations such as UNICEF, WHO, and the World Bank to get them started with formulating some selected programs as "global initiatives" for implementation in the poor countries. The brief accounts of the evolution of health services in India and China and mention of some other Asian countries will provide the context for understanding how different has been the conceptualization, formulation, and implementation aspects of these initiatives undertaken by the triad (WHO, UNICEF, and the World Bank). On the basis of this description it is possible to list some major aspects of their actions.

1. Even the main planks for formulation of these initiatives were profoundly flawed. How can one have a "prefabricated" global initiative when one takes into account the extreme variations among and often within the poor countries? This very obvious determining factor escaped attention, or, more likely, was deliberately overlooked, when the initiatives were formulated. The situation bears an uncanny resemblance to the economic "rescue packages" of the International Monetary Fund (IMF).

2. Selection of health problems for action conformed more to the special interests of the rich countries than to the specific epidemiological situations in the various poor countries.

3. A technocentric approach to problem-solving was adopted, not because it provided the "optimal solution" (67, 68), but because this was "friendly" to the economic interests of the rich countries. The biotechnology, refrigeration, and drug industries, particularly in the private sector, are some examples. There was, besides, the opportunity for the creation of high-salaried employment in rich countries, for hirelings who could then exercise the enormous power bestowed on them to perform the jobs assigned by their paymasters.

4. There is an obvious contradiction in the specific bases of claims that the suggested globe-embracing programs are cost-effective, given the profound variations among and within countries. Presumably because of this, no serious efforts were made to assess cost-effectiveness at the time of program formulation. The claim of cost-effectiveness by once highly respected organizations such as WHO and UNICEF is an example of the blatant spread of almost manifest disinformation. The latest instance of this almost deliberate effort to avoid subjecting their assumptions to objective evaluation comes from the failure of WHO/WB to set up reliable baseline data on "Annual Rate of Infection" (69) for monitoring the progress of the huge Global Programme of Tuberculosis which they had launched.

5. By their very nature, international initiatives cannot promote community self-reliance.

6. Because countries receive a considerable proportion of the funds from outside, there is the key question of dependence and sustainability—apart from the real danger of vulnerability to political exploitation by the "donors."

7. The "donors" have used their tremendous influence on the pliable ruling classes of the poor countries to get overriding priority assigned to the ill-conceived, ill-designed, and ill-managed global initiatives at the expense of the ongoing work of the health organizations. In India, for example, the primacy given to the programs pushed by the WHO/UNICEF/WB triad, along with an almost frenzied preoccupation with the family planning program, has had a devastating impact on almost every facet of organization, management, and growth of the health services infrastructure. In the case of China, as (under) stated by Navarro (1), it was more an overt political decision by the oligarchic ruling class to shift investment away from the people-based health services; privatization was the slogan for socialist market orientation.

8. Above all, these programs are the very antitheses of the Alma-Ata Declaration and, in the case of India, of its National Health policy (39), which envisaged "involving the community in the identification of its health needs and priorities as well as in the implementation and management of the various health and related programmes."

It is grimly ironic that soon after the leadership given by WHO and UNICEF in writing one of the brightest chapters in public health practice—acceptance of the

Alma-Ata Declaration in 1978—by all countries of the world the ruling classes should have started the international initiatives that opened one of its darkest chapters. The oppressed peoples of the world will have to pay yet another installment to their oppressors before their tormentors are again forced to admit their mistakes and to abandon their ill-conceived misadventures, so that the oppressed can then resume their long, grinding struggle toward access to people-oriented services for their populations (57). Using the hindsight of 1998, it is appalling to find so few who have had the courage of their convictions to call the bluff of the tormentors of the oppressed.

By the early 1980s, the triad of WHO, UNICEF, and the World Bank had started to give a global form to the grossly inadequate but politically and economically important concept of Selective Primary Health Care. UNICEF opened up a barrage of global initiatives on the poor countries of the world. WHO and the World Bank lent the full weight of their considerable prestige and influence in strengthening this menacing trend in public health thinking and action. At first, UNICEF came up with four areas for "special" attention in child health: Growth Monitoring, Oral Rehydration, Breast Feeding Promotion, and Immunization (GOB) (70, 71). It was soon impelled to add to the list: Fertility Promotion, Feeding Programme, Female Development, thus making it GOBI-FFF (72). Again, it had to backtrack and focus its attention only on immunization. This project was named the Universal Programme of Immunization (UPI) (73, 74), or simply the strengthening of WHO's pre-existing Extended Programme of Immunization (EPI) (75). It is not difficult to visualize the impact of such a fickle-minded approach on the world's utterly dependent, poorest of the poor countries. At a later stage, there was yet another turnaround, when one of the six diseases—poliomyelitis—was singled out for eradication from the globe (76, 77). Thus, the disturbing signals were already there on the quality of care and on the considerations that had gone into the triad's drawing up policies and plans for acting globally to fulfill the responsibility assigned to the three agencies in their respective constitutions.

In the world of the poor, with virtually no system even to record births and deaths, not to mention a dependable health information and evaluation system, "experts" hired by UNICEF, WHO, and many affluent countries of the world made the pronouncement that six immunizable diseases—tetanus, pertussis diphtheria, tuberculosis, poliomyelitis, and measles account for most deaths among infants. It was assumed that a massive program of vaccination against these six diseases would create a strong enough "herd immunity" to eliminate them as public health problems, if not total eradicating them within five years, presumably as in the case of smallpox (74).

To cope with the mind-boggling task of immunizing hundreds of millions of infants, particularly those living under the most primitive conditions in extremely remote areas of the very large number of the world's poorest countries (where, incidentally, a much higher incidence of the six diseases would be expected),

experts from UNICEF/WHO suggested an intensive program of mass communication, using the new technological advances. The globally telecast pop extravaganza organized by the Irish pop star, Bob Geldof at London's Wembley Stadium in the form of "Band Aid," and later, a still bigger show at the same place under the label "World Aid" (12), are two outstanding instances of appeals to the "charitable instincts" of the rich to contribute to UNICEF's crusade against the six diseases "to save the lives of the poor." The rank hypocrisy of the over- affluent rich, throwing away hundreds of billions of dollars to sustain their vulgar "entertainment industry," could not have been more blatant. There were, incidentally, few protests from the concerned people of the world at this patently indecent insult to the poor by the rich. These are the modern-day Marie Antoinettes, the only difference being that their number has swollen to the hundreds of millions, brainwashed by the potent weapons provided by the so-called information revolution. UNICEF also hired experts from the marketing field and gave the name "social marketing" to these techniques used to "fight" its crusade against the six diseases. Indeed, in order to sell its ideas, particularly to the burgeoning proportion of the gullible, it claimed that the movement for immunization would lead to "mass mobilization" of the people of poor countries for other health and development work (11, 72).

As I will briefly mention later, the propaganda blitz let loose on the poor countries of the world to promote EPI/UPI has apparently been "forgotten" within a few years, because it has served the purpose for which it was generated. The informatics industry, moving fast in the information highways in the rich countries, has found new pastures for helping to launch new international crusades against other specific diseases (45). The experts also seem to have conveniently "forgotten" about the data that had seriously questioned the very bases of the program (54–62). They, too, seem to have moved on to new pastures, to carry on new crusades. Public health experts at WHO also fully endorsed the UNICEF initiative on EPI/UPI, and WHO undertook to use its far-flung organizational outreach in different countries to push this program (74–76). It has also undertaken the task of running the global program for eradicating poliomyelitis by 2000 (77).

The WHO Global Programme for AIDS (GPA)

The outbreak of the AIDS epidemic in 1982, which later took the form of a pandemic, legitimately thrust on WHO the onerous responsibility for action on a global scale. It developed the Global Programme for AIDS. Despite the bewildering variations in the epidemiological behavior of the disease, including complex social and cultural dimensions that required a very flexible approach to program formulation, the GPA conformed to a set pattern that was principally shaped in the United States (78). As pointed out later, this proved to be its Achilles' heel. At

a later stage, implementation of the GPA was entrusted to an inter-agency U.N. organization called UNAIDS.

The WHO/WB Global Programme for Tuberculosis (GPT)

The World Health Organization's declaration of the tuberculosis problem as a "Global Emergency" was a totally surprising move. The database to justify such a sweeping declaration was virtually nonexistent. It has been accepted (e.g., 35–37, 79) worldwide for more than four decades that public health programs against tuberculosis are based on general health services, which are expected to take on the task of diagnosing and treating the bulk of tuberculosis cases in the poor countries. Ironically, allocation of overriding priority to the international initiatives, all down the line, led to the neglect of other services provided at the peripheral or grassroots level. This included tuberculosis work.

What made the very perpetrators of the decline in tuberculosis care work up such an intense concern for the disease as a public health problem is an interesting case study for scholars interested in a more detailed study of the political economy of health services. One plausible explanation might be the sudden awakening to the problem in the United States and other rich countries when their AIDS epidemics activated the dormant primary foci in many persons with AIDS, and this led to spread of tuberculosis to others. This triggered alarm bells for the ruling class, which, in the course of its exponential polarization from the poor, has created a sterile/sanitized world for itself. An irrational and therefore very malignant fear of microbes struck terror in the hearts of the rich. One consequence of this mass hysteria against germs, which received support from the once sober and highly respected International Union Against Tuberculosis and Lung Disease (e.g., 45–47, 80), was that these unfounded fears (as will be elaborated later) took the entire world back a century to the days of the long-discarded single-etiology theory of diseases. What is worse, this observation on tuberculosis in the rich countries was extrapolated to the entire world. Already, as the AIDS epidemic seemed to attain a plateau in the rich countries, poor countries were singled out as the "rich" breeding grounds for a devastating spread of the AIDS pandemic. As almost a majority of the adult populations in these countries had acquired primary tubercle foci, a fear complex was actively generated to claim that this would lead to widespread outbreaks of tuberculosis, hence the declaration of the Global Emergency. Incidentally, subsequent experience has shown that both fears proved to be unfounded. Black Africa is very much there, in spite of the rapid phase of spread of AIDS; there is no tuberculosis epidemic even in this region. The incidence/prevalence of AIDS and tuberculosis is a tiny fraction of what was predicted by the WHO/WB experts in North Africa, in Central, West, South, Southeast, and East Asia, and in South America (81, 82). All these facts speak volumes about the technical competence of those who rule over the destiny of the world's health services, particularly in the poor regions.

Sticking tenaciously to the single-etiology theory, despite overwhelming evidence to the contrary, and the (virtual?) "reality" of the Global Emergency, a strategy was developed for the GPT. It consisted of making a massive effort to identify tuberculosis cases in entire populations, then subjecting them to Directly Observed Treatment with Shortcourse chemotherapy (DOTS) (83). Starting with China (45, 46), which did not find anything amiss in the DOTS approach, WHO and the World Bank have come together and managed to successfully "push through" this approach to the poor countries of the world.

WHO's Other Efforts to Launch Global Initiatives

The World Health Organization had also launched two other global programs with considerable fanfare. One was the Diarrheal Disease Control Programme (84), with Oral Rehydration Treatment as its centerpiece. The other program was meant to deal with acute respiratory infections in infants and children (85); it envisaged timely administration of antibacterial drugs to affected children, using paramedical staff in rural and urban areas. Despite the usual promotional efforts of WHO/UNICEF/WB, mercifully, these programs failed right at the take-off stage.

The World Bank had joined WHO to launch yet another international initiative: the Safe Motherhood Initiative (86). Child survival programs were later dovetailed with this initiative. Apart from the question of cost-effectiveness, the success of this initiative, like all the preceding ones, depended on the capacity of the health service systems to undertake the task envisaged in the program.

Global Initiative in Launching "Essential National Health Research"

Some high-profile research administrators, who had earlier headed many key research organizations/committees, both nationally and internationally, in 1987 got together to set up a global Commission on Health Research and Development (87). The report of the Commission, and an account of the subsequent follow-up action and its impact, provide an interesting administrative case study on the intellectual make-up of the key decision-makers who have dominated the field worldwide for the past three or more decades. While the Commission had a self-imposed deadline for its automatic "liquidation" within one year, it could not present the report until 1991. Practice of Essential National Health Research (ENHR) was the centerpiece of the report. The Commission took some more time to hold well-publicized seminars in different parts of the world to promote the report. It received warm endorsement from government leaders and most of academia throughout the world, including the prestigious Nobel Symposium (88). The Swedish Agency for Research Cooperation with Developing Countries

(SAREC) (89) and the International Development Research Council of Canada (IDRC) (90) were among the foremost institutions to promote ENHR and the other recommendations. The then Executive Director of UNICEF proclaimed that "in future at least five per cent of UNICEF's budget will be devoted to research." This promise, incidentally, was never kept. SAREC and IDRC also agreed to provide funds for yet another proposal of the Commission to set up a two-year task force, with its office located in Geneva, to encourage developing countries to implement ENHR (88). The materials produced to document progress in the implementation of ENHR (88) leave little doubt that the initiatives could make little impact on the strengthening of health services in the countries of the world. The ENHR movement has not achieved anything more substantial than what was already done by WHO's Advisory Committees on Medical/Health Research at the global and regional levels.

SERIOUS INFIRMITIES IN THE GLOBAL INITIATIVES

It should come as no surprise that virtually every global initiative taken by WHO, UNICEF, and the World Bank since the promotion of Selective Primary Health Care by the rich countries suffered from serious infirmities. Remarkably, even when these infirmities were pointed out to the organizations, they failed even to enter into discussion on the issues raised, not to mention taken any corrective measures. That the infirmities were indeed serious is borne out by the fact that the programs consistently failed to yield the results expected of them. It is not necessary here to present a comprehensive critique of all the programs. Only three of the major ones—the EPI/UPI, GPA, and GPT—will be taken up, and only very briefly.

Even a very broad analysis of the process of policy and program formulation and implementation of EPI/UPI reveals that the apical organizations of international public health have shown scant regard for some of the fundamental principles of public health practice.

1. They have dared to launch a global/universal immunization program without caring to have reasonably reliable, global baseline epidemiological data (91). The specialty of epidemiology should have been the very soul of EPI/UPI. Its absence has made it "soul-less."

2. While using their patently unsubstantiated "estimates," they have tended to "homogenize" the situation even in the 100 or so poor countries, with their widely varying parameters affecting the incidence and prevalence of the six target diseases.

3. With no epidemiological baseline, how is it possible to assess the epidemiological impact of the program? It could well be argued, "from the other side," that the impact, if any, may have been due to the natural histories of the diseases over time.

4. No data have been produced to demonstrate the degree of effectiveness of the vaccines under the ecological/epidemiological conditions prevailing in the different countries.

5. No evidence has been produced to justify why the level of "herd immunity" has been fixed at 85 percent.

6. It is incredible that the program managers claimed that the programs could have been implemented "satisfactorily" in countries such as Chad and Niger, not to speak of Sudan, Somalia, and Sierra Leone, or Colombia, Ecuador or Guatemala. In Asia, Afghanistan, Nepal, Myanmar, Cambodia, and Laos provide the challenging examples. It requires stupendous logistical capabilities to ensure that an epidemiologically adequate proportion of infants receive potent doses of the vaccines in all the countries of the world.

Two academics, specializing in epidemiology, Vance Dietz from the Centers for Disease Control and Prevention and Felicity Cutts from the London School of Hygiene and Tropical Medicine, have recently produced an article in this Journal (76) on evaluation of mass immunization campaigns on the basis of a literature review. The fact that not one of the epidemiological issues raised in the foregoing discussion—which, incidentally, have been published in the Journal on more than one occasion—received any mention in their review gives a chilling picture of the depth to which the practice of public health principles has fallen during the past three decades. The authors explicitly mentioned that they "did not address the broader issue of comparing different approaches to the delivery of a strategy within the context of primary versus selective health care." Why? They did not even take up the broader epidemiological, sociological, and organizational and management issues raised, even when these issues fell within the severely limited range of the review. In their scheme of things, of course, issues concerning political economy and the less than academically acceptable role of international and other foreign agencies, including their own institutions, were considered "politically improper." Either they have become conditioned to follow the line laid down for them by the dominant intellectual group, or they did not dare deviate from this for fear of inviting retribution from them.

John Bland an John Clements (74) of the WHO/UNICEF/WB establishment, have not hesitated to repeat the wild claim, as recently as 1998 in the World Health Forum, that "Today 80% of the world's children receive this form of protection against childhood diseases during their first year of life," even though overwhelming data have clearly pointed to the contrary.

It is remarkable, and to a considerable extent frustrating, that neither academics such as Dietz and Cutts nor program managers and experts such as Bland and Clements cared to take cognizance of the well-designed and well-conducted evaluation studies carried out in some of the poor countries by "local" scholars. Dietz and Cutts claimed that these findings did not come within the parameters they had (arbitrarily) set for their literature search. Bland and Clements "blindly" accepted the government data, without caring to question their validity and

reliability. Indeed, Dietz and Cutts should have noticed that one of the "local" studies has more than once been discussed in some detail in the references cited by them. These two studies are briefly referred to below.

The EPI/UPI program of India, meant to last five years from 1985, was the largest in the world. WHO and UNICEF joined the Government of India to get the program systematically evaluated in 1989. The results were published in the form of a book, which was widely circulated (92). It showed that the immunization coverage was less than a fifth in the two-thirds of the population that account for most of the poor, as well as for most of the infant mortality in the country; the surveillance system was almost nonexistent. A similar situation existed for potency tests of the vaccines at the time of inoculation. The book described how reports of immunization coverage had been exaggerated by 100 percent or more to please the national and international officers responsible for administering the program. It also reported at least 56 recorded deaths due to the vaccination process itself. There was virtually no outcry, nationally or internationally, against this outrageous consequence of the program. Had even one such death taken place in a rich country, the entire program would have been halted. An in-depth study of the program in the State of West Bengal (93) has reinforced the findings of the national study.

All these startling findings made no impression; there was little follow-up action or correction of the records and reports. Another all-India study, the National Family Health Survey (94), was conducted with the involvement of the U.S. Agency for International Development (U.S. AID) and the East-West Centre at Honolulu in 1992-1993 (that is, well after "completion" of the time limit for the EPI/UPI). This study revealed that at the national level as few as 35.4 percent of eligible children were fully protected, with the coverage hovering around 9 to 22 percent among many of the highly populated states with the poorest records of infant mortality. In this survey, there was no study of the surveillance system, nor was there any check on the potency of the vaccines at the time of inoculation. Apparently, even these admittedly bare data, which called into question the effectiveness of EPI/UPI, did not receive the attention of Bland and Clements (74).

If the situation is so bad in the case of India, which has a fairly extensive network of health services at the grassroots level, the situation in Chad, Niger, and many countries mentioned earlier—as indeed, in all the world's least developed countries (44) and many more—will certainly not be any better. What then was the basis of the claims made by Bland and Clements?

That EPI/UPI was not a temporary aberration becomes clear when one subjects the other global initiatives to academic scrutiny. The "malady" seems to have pervaded the entire academic world of the ruling classes—as, for instance, was encountered by Navarro (1) when he ventured to study class issues in public health policy studies in the 1960s. The same trend was followed when WHO, along with a large number of U.N. agencies, set out to design the Global

Programme for AIDS, which was principally directed toward the poor countries. Incidentally, the first Union Budget (1992–1993) (13, 95, 96) after India submitted to the IMF conditionalities included a 20 percent slashing of the allocation to health services (including the tuberculosis program), without accounting for inflation. However, the World Bank and WHO "assisted" India in setting up the National AIDS Control Programme (NACP), which accounted for almost a fourth of the total allocation in the same financial year. Following the now familiar line, NACP was formulated under a veil of secrecy and no modification was permitted unless it got clearance from the World Bank Headquarters in Washington, D.C.

Despite the efforts by WHO/WB officials and their Indian camp followers to control information and extensively spread unsubstantiated information, it was possible as early as in 1992 to bring out the monograph *Combating AIDS as a Public Health Problem in India*, which questioned a number of critical assumptions in the formulation of GPA/NACP. Besides addressing matters of interdisciplinary methodology, the monograph raised issues of comparative epidemiology by taking up the history of syphilis. Interestingly, Steve Wing (97) has raised important issues in his article "Whose Epidemiology, Whose Health?" There is an interesting reference to a comparative analysis of the epidemiological behavior of AIDS and syphilis. Among the important issues raised were the profound implications of AIDS changing from a principally homosexual-associated disease in the rich countries to a heterosexual one in the poor countries; the key question of the natural history of the disease, as manifested in the differential incidence in different parts of the world, including among the countries of Sub-Saharan Africa; cultural, social, and economic parameters of the "risk groups" which determine the epidemiology of the disease; and the need for formulation of suitable strategies for different countries, based on these considerations (98-102). From the WHO/WB experts and program managers there was a stony silence on the issues raised in the monograph. Quite predictably, the objectives set before NACP in 1990 remain unfulfilled (103, 104), and very likely AIDS is set on a course broadly similar to that followed by syphilis as a public health problem in India over a period of time. A special category of sickness of mind appears to be afflicting the key decision-makers, who consciously hire an army of properly sanitized and brainwashed personnel to translate their "sick" ideas into action. For the oppressed classes and for all those who are prepared to take up their cause, it appears to be a re-enactment of a form of colonialism, with, as described by Navarro (1), fascistic overtones.

Justification given by WHO/WB for launching the Global Program for Tuberculosis is even more fantastic and incredibly contradictory. It is simply bizarre. Out of the blue, as it were, in the early 1990s, WHO/WB sounded the maximum-alert bell to proclaim that tuberculosis had become a "Global Emergency" and the GPT was the way to tackle that emergency (105, 106). How did a Global Emergency occur? What was WHO/WB doing when this emergency, was building up?

It is reflected in the Epidemiological Intelligence Reports these agencies are constitutionally bound to present? Then why did they cut back the staff of the Tuberculosis Unit at the Headquarters in the 1980s to barely one (45)? Why didn't they raise an alarm when the national tuberculosis program in the poor countries were being pushed onto the back burner to create "space" for high-priority program such as EPI/UPI or NACP, with the already crippled health services reeling under the impact of brutal cuts imposed by orders of the IMF? This would be a comical drama had it not been to tragic, costing the lives of hundreds of thousands of the poor, whose voices were stifled by the ruling classes.

A streak of steely determination on the part of WHO/WB in imposing the prefabricated, DOTS-driven agenda of the GPT is reflected in the leading presentation of a *World Health Forum* Round Table, which gives the pre-eminent position to DOTS (83). That even the conversion rates claimed for the new spectrum of drugs used in DOTS are nothing startling is exposed by comments made by the veteran tuberculosis worker of the old school, John Crofton, who was a participant in this Round Table Discussion (79, 83): He states "We demonstrated in Edinburgh in the 1950s that 100% cure of pulmonary tuberculosis, with no relapse, could be a reasonable aim (even with the drugs then available: streptomycin, isoniazid and para-amino salicylic acid)."

The GPT was particularly painful for tuberculosis workers in India, who have been instrumental in making such a mark in tuberculosis research and action worldwide over the past four decades. A meeting of key tuberculosis workers called by the Tuberculosis Association of India and the Government of India in 1992 to discuss the poor state of the country's National Tuberculosis Programme came out with well-argued and eminently implementable lines of action (107). Once again, a comprehensive document was prepared pointing out major epidemiological, sociological, economic, and administrative flaws in the GPT (108). To initiate dialogues, this too was extensively circulated to various agencies by the Voluntary Health Association of India, specifically including the chief executives of WHO, UNICEF, and the World Bank and aid missions of some of the major "donors." However, as in the previous cases, they remained unmoved; they refused to enter into discussion on scientific aspects of the program. A detailed account of the efforts made to bring them round to scientific discussions is also included in this document (107).

The cloak of secrecy shrouding the "selling" of the program to India has been a particularly unpleasant feature (108). The WHO/WB experts actively avoided entering into discussion with their counterparts at the National Tuberculosis Institute, Bangalore, and others actively involved in the conceptualization, formulation, and implementation of India's National Tuberculosis Programme. Instead, they interacted extensively with the then director-general of the Indian Council of Medical Research, who had been a tuberculosis microbiologist, and the then director-general of health services of the Government of India, who was

a specialist in orthopedics. Both these functionaries were later offered positions in the South-East Asian Regional Office of WHO.

CONCLUSIONS: A FRIGHTENING SPECTACLE OF DISTORTION OF THE PRINCIPLES AND PRACTICE OF INTERNATIONAL PUBLIC HEALTH BY WHO, UNICEF, AND THE WORLD BANK

A very large area has been covered in this report to demonstrate how imposition of an enormous, high-priority, prefabricated health service agenda by the rich countries on the poor ones has virtually decimated the somewhat promising growth of people-oriented health services in a country such as India. Poor people will have to struggle for their right to access to services that are specifically designed to conform to their epidemiological, sociological, cultural, and economic requirements. For this purpose, they will not only have to fight the misconceived and motivated interventions in the form of international initiatives; their struggle will also include restructuring of the entire health/health service system to be in tune with their requirements. This will be a long, grinding struggle.

It may also be mentioned in passing that the overriding priority assigned to a Malthusian family planning program for over four decades by the ruling classes, both national and international (109–116), has also had a devastating impact on the growth and development of health services in India (114). In his book *Birth Control and Foreign Policy* (117), Nicholas Demerath, Sr., has given a well-documented account of the various ways in which India's family planning program has been influenced by the U.S. Government (U.S.AID) and other U.S. agencies, such as the Population Council, the Ford Foundation, the Population Crisis Committee, the Council of Foreign Relations, and programs sponsored by numerous universities, church organizations, the International Planned Parenthood Federation, and other voluntary associations. So powerful has been the population lobby in the United States that it forced the publishers, Harper and Row, to hastily withdraw Demerath's book from bookstore shelves all over the world. It has now become a collector's item.

From the standpoint of sociology of knowledge, it is interesting to note that no other scientific specialty, not even the cousins of public health such as clinical medicine/surgery, microbiology, and health statistics, has undergone such a far-reaching distortion. What a macabre situation, reflecting the nature of international and national power plays of our time. This is indeed the darkest chapter in the history of public health. In conclusion, five major areas of such distortion are summarized.

1. The "public health" practiced by exponents of the international initiatives is starkly ahistorical (16, 17). They seem to consider themselves the inventors of the wheel. So carried away were they with the "new" thinking injected into their heads by the ruling class that they seemed to have no use for the pioneering work

in public health done in earlier years by many profound and dedicated scholars. C.E.A. Winslow's classic definition of public health way back in 1920 (118); Henry Sigerist's emphasis on the history of medicine (119–121) to develop a perspective for building health services, as in the report of India'a Bhore Committee (21); John Grant's efforts to promote regionalization of health services and take public health research and practice to rural field stations (40, 122); the pioneering works of Rene Sand (123), John Ryle (124), and Iago Galdston (125) in giving content to the important specialty of social medicine; John Gordon's pathbreaking field research at Khanna in India on the epidemiology of child mortality and morbidity (126); Hugh Leavell's insightful ideas on the development of strategies for intervention in the epidemiological behavior of a health problem based on analysis of its natural history of disease in an individual (127–129); Edward McGavran's exposé on an epidemiological approach to solving a public health problem (130); Milton Roemer's contributions to health manpower development (131); George Foster's pioneering work on medical anthropology (132); P. V. Benjamin and Halfdan Mahler's dedicated efforts to establish the National Tuberculosis Programme in India (35) and the latter's role in getting the Alma-Ata Declaration on Primary Health Care all over the world—these are but a few of the works of just some of the pioneers. The public health experts hired by WHO/WB/UNICEF have been selectively bred and properly programmed to be unaware, or at least to pretend to their paymasters that they are unaware, of the work of such pioneers.

2. The scientific term "epidemiology", which forms the foundation of public health practice, has been grossly misused by the new breed of experts. On the basis of the unrepresentative nature of the data used and their highly questionable reliability and validity, and the very limited data on causative relationship, validity and reliability of impact measurement, and the time trends, we can reject out of hand the scientific bases of almost all the international initiatives taken by the triad. Epidemiology, besides, includes the crucial areas of natural histories of diseases over time (133–139) and in the individual, as emphasized by Leavell (128). The experts have chosen simply to ignore other important areas, such as the social meaning of epidemiological data, the politics and political economy of health, and concepts of health administration elaborately developed in poor countries like India for over six decades (18, 129). In their zeal to sell their wares, they have also grossly distorted the concept of health economics, by confusing it with health financing (13). This amounts to practice of public health quackery. A similar fate was meted out to a well-established research tool—operational research (67, 68, 140–146). Developed in the course of World War II, it has very specific connotations and has enormous application to public health practice, as it seeks to optimize complex systems. These specifications too were simply ignored, and operational research has been grossly vulgarized (e.g., 69).

3. Suppression of information, use of doctored information, spread of misinformation and disinformation, and lack of effective evaluation/surveillance

evaluation/surveillance

are expected outcomes when programs are meant to serve power managers, required by their paymasters to satiate the ever increasing hunger of the marketplace.

4. Directors-general of two top public health institutions in India extended their support to the GPT, even though serious flaws in the program were repeatedly brought to their notice. After they endorsed the WHO/WB program, they found highly lucrative positions in WHO. It is not necessary to speculate here about other instances. This marks the rock-bottom of the moral and ethical standards of the practices of the parties concerned.

5. Those who are expected to be the conscience keepers of ethics and morality in public health practice—teachers in public health schools/institutes, key public health administrators in national and international institutions, nongovernmental organizations, and political leaders/activists responsible for safeguarding and promoting the health of the people—are perhaps the worst offenders in inflicting such humiliation on the peoples of the world. Apparently attracted by the financial rewards, many of these professionals actively associated themselves with the not so ethical and moral ventures. Many others looked the other way, fearing retribution for exclaiming that the emperor had no clothes. And there must have been a very substantial number of this "intelligentsia" who could not move themselves to find out what was happening. The situation certainly did not compare in depth with that in Hitler's Germany or even Franco's Spain, but the resemblance is uncanny. It shows how cheaply the leaders of the profession can be brought, to lend their support for patently unscientific, unethical, and immoral programs which have cost literally hundreds of thousands of lives of the world's poor.

The line of action for those few who still attach a high value to intellectual and moral integrity, and are prepared to pay the sort of price mentioned by Navarro (1), emerges from the analysis made in this report. The Indian subcontinent and China must take the responsibility for rediscovering their lost heritage, to set the tone for alternative, people-oriented health services for the long-exploited, deprived peoples of the world.

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The Information Age Challenges : Role of NGOs

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In today's world the most powerful resource used by people in government, business or any other system in life is **Information.** People have always relied on information for rational behaviour, be it physiological, environmental or that of more abstract higher realms of thinking and decision making. It is information on which is based the adaptive changes that one normally makes throughout one's life.

The Setting

Information is also used as a weapon today either to build or break a system. Be it a political campaign, news reporting (a la BBC!) or advertising a new product in the ever competitive commercial market, a scientific break though in biotechnology, it is information, which is moulded according to the interest of the provider that reaches the masses.

The new developments in electronics and telecommunications has enhanced this process. Every country tries to strengthen its knowledge base to have a firm hold on its resources and technology. At the same time, by using satellites and remote sensing facility they try to extract as much information as possible from other countries for their own benefit. As a result, each country tries to compete with one another to acquire the latest information technology and partake in the information age race. *Speed and variety is the order of the day in this age.*

We are witnessing a historic process of humankind, which will inevitably change man's psyche. Our inner images of reality, responding to the acceleration of change outside ourselves, are becoming shortlived and temporary. We are creating and using up ideas and images at a faster speed than ever before. **As a result, family life, market place and others are breaking into varied mini-markets.** They demand continuously expanding range of options, models, hypes, types and colours. Bell telephones which once hoped to put the same black telephone in every home, now manufactured thousands of combinations of telephone equipments in all the colours, shapes, styles etc. Now Cellular's have hit the market. The situation is the same with food, fashion designing and architecture. It is not what knowledge the country holds but the speed with which it is continually renewed, by passing on the know-how to those who need it and acquiring new techniques swiftly from all over the world. It is not the "stocks" but the "flows" that matter. The key infrastructure of the present and the 21st century is the electronic networks. For the national economic development building up this `information highway' across the continents has become the vital part of life.

The Deprived Millions

While the world is coming closer together at one level to form the 'global village', its is also breaking into fragments at another level. Development does not reach a massive portion of the population. While the information age benefits are few and its fruits are enjoyed by the power holders, the cleavage between the "well informed" or "Info-rich" and "Info-poor" deepens further. As a result, there is growing unrest which bursts out in the form of violence. Dissatisfaction and terrorism have become part and parcel of our social life. It is said that 'Tomorrow's terrorist may be able to do more damage with a key board than a bomb'. This is a good example to show that new technology could also be misused. It may be the 'suppressed information' or 'tailored information' by the authorities, which may be the cause of unrest or terrorism. Through violence they try to demonstrate that they are deprived of economic development or political mileage. A country which builds up massive super technology in the name of development, may ignore the basic needs and aspirations of the majority population. Due to this 'haphazard development' we see contrasts in every sphere of life. A country might have a sophisticated technology equivalent to the first world countries, while on the other hand, there might be incidences in day-to- day life, which would remind us of the medieval period. For the multitude of our people, 'development' is a distant dream !

The Striking Contrasts

At this juncture of history, each one of us has a role to play to bridge the gap between the 'Information-rich' (Info-overfed) and 'information-poor' (Info-starved) people. **Working in the NGO sector, we are constantly in the process of empowering people with information to change their present situation to a better tomorrow.** Paulo Friere said,

"Conscientizing people will facilitate people perceiving their needs". We use several methods to emphasise his statement through our awareness programmes, training, skill development campaigns and socio-economic initiatives and interventions. All these little acts go a long way to strengthen the individual and in turn, the whole society. Charles Jepson, Director of Office Marketing Hewlett Packard Co. says "Information is catalyst for effecting change at every level. That's what makes its power so awesome"

Gone are the days where oral culture was the only way to transmit information or communicate knowledge. At that time myths, legends, history and others were passed on from generation to generation through speech, songs, folklores, charts etc. All this knowledge was stored in the mind of the individual. The information was personalised and individualised. The next civilization moves this memory outside the individual. It smashed the memory barriers and spread mass literacy, build libraries and museums and learnt to store information outside the person. Today, we are about to take a quantum jump into a whole new world where information is the ultimate and infinite power. The mapping of earth by satellites, monitoring of patients by electronic sensors, computer (cyber) communications, etc. reaching the nooks and corners of the world, is a virtual reality. This civilization will have more finely organised information about itself than ever before,. Even more astonishing is the conversation between human and the intelligent environment around us.

It is this vast amount of information which explains that we are in the age of 'Information Explosion'. Though many more vistas need to be explored, further arming the information arsenal.

The Super Technology

Satellites have revolutionised the daily lives of people when it entered the drawing rooms of houses in cities, as well as in villages. Different types of information are bombarded into the minds of people from all over the world. As a result there is utter chaos in the minds of people. More questions. What is the truth ? How is this product better than the other one ? How to select from the hundreds of varieties ? Whom to believe ? What actually happened? So on and so forth. This gives rise to all kinds and shades of people : Sure shots, converts, sceptics, solipsists, sophists... leave apart, the info-starved.

At this information age, we should use the same technology to provide the correct information and to strengthen the deprived millions. There was a time when the sword was a powerful weapon, but when the sophisticated automatic weapon

came into the picture, war strategies changed. Oil lamps are replaced by electric bulbs in villages. Tractors are used in agriculture.

In the same way, *info-war* has to be fought with different strategies. By using the same technology, we could militantly criticise misinformation and reach the right information to people to empower themselves.

Alvin Toffler, the great futurist of our times, rightly said " the arrival of the computer is not only likely to bring in revolutionary changes in various walks of human endeavour. Even lifestyles will change. In such a highly complex society, information would be the most essential and highly valued property. Knowledge would be power in the real sense of the phrase".

The computer creates an historically unprecedented situation. It processes the data it stores and makes social memory extensive and active. The computer can be asked by us to think the unthinkable and the previously unthought. It make possible a flood of new theories, ideas, artistic insights,technical advances, economic and political innovations. In this way it can accelerate social change and thrust towards social diversity.

Francis Bacon predicted that **"knowledge itself is power"**. Our generation is witnessing this fact in all the realms of contemporary life. Knowledge turns out to be not only the source of the highest quality power, but also the most important ingredient of force and wealth. This explains why the battle for control

of knowledge is heating up all over the world. *The power, money and knowledge form a single interactive system. Information can be used to increase money or to multiply the force at your command.* **Unlike bullets or budgets knowledge does not get used up. This is the reason for its supermacy in the latest power game - the "Info-Wars".**

The Role of NGOs in the Information Age

The NGOs face an extremely difficult task in this information era. How to give a 'Democratic Development Plan' to the different strata of the society ? How to have a 'balanced strategy' to improve the social sector in line with the other important sectors like defence, economy ? How to include the peoples basic needs i he various policies ? How to appropriately use the super technology for the people ? These are some of the questions NGOs face in this information age.

Sam Pitroda correctly said that *"information is a major tool for social transformation in India"*. Social justice and freedom both now increasingly depend on how each society deals with three issues : Education, Information technology (including media), and Freedom of expression. To achieve this status, there is a need for the speedy universalisation of access to computers, information technology and advanced media. This requires a pulation as familiar with this i. mational infrastructure as it is with roads, trains, vehicles and other existing **infrastructure.**

Development strategies make no sense, unless they take full account of the new role of knowledge in wealth creation. Information is a major component for the success of a firm. It is imperative that the NGOs understand the need for managing information effectively, as it would ultimately lead to their successful performance.

NGO activities include field level action plans, research and analysis on wide range of development, social justice, environment, health and other issues. All the innovations, findings and success stories could be shared with others working in similar acreas around the globe. At the same time many new ideas, techniques, skills and strategies could be learnt from other parts of the world. Computer networks, E-Mail, On-line Databases, conferencing etc, go a long way in bridging the gaps between the 'information-rich' and 'information-starving' societies. A good example is the recently held international conferences. NGOs played a strong and well publicised role at the Earth Summit, ICPD, Social Development and the World Conference on Women held at Beijing. These are excellent examples to show the acceptance of NGOs as key partners in developing and implementing development policies.

Computer communications and networking can help build national and regional information resources that can be disseminated in Local Languages. At the same time international sources can also be tapped and thus bridge the geographical distances. NGOs could pass on our innovations to the first world and turn the flow from south to north. By this process, the monopoly over information in the hands of a few countries could be challenged.

They could also regulate the two way flow of information. This would be a major contribution of NGOs in this information age. This way, we could monitor and streamline several projects and natural resources and avoid problems of patenting etc.

The information highway welcomes the NGOs to share their innovations and experiences in exchange for the ideas and techniques from the rest of the world. The benefits are manifold:

- NGOs would have the ability to collect and send information, ideas from and to the remote corners of the world
- To access information in different forms, written material audio, visual (graphics) multi-media and many more
- Increased speed and accuracy in its retrieval and communication across national boundaries
- Quick reproduction of information
- Low cost link to exchange and share large volumes of data
- Saves time and resources
- Exchange into at any time and at any place
- Development of a global network of people with a common interest like health activists
- Opportunities for professional development
- To help fulfil the needs of people using the latest technology

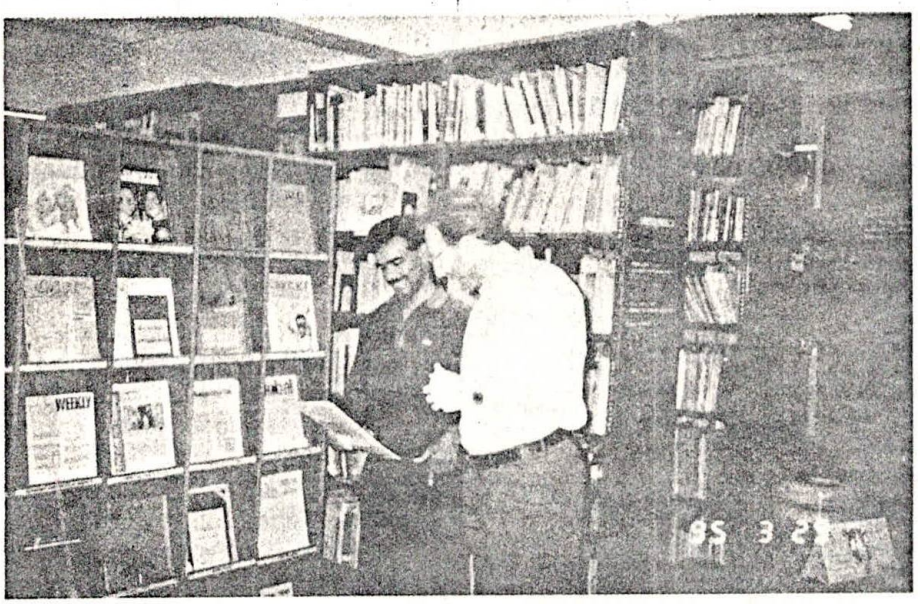
Our country is famous for its natural resources and time tested indigenous knowledge of herbal medicine. Since it is not 'scientifically' proved by us with regard to its efficacy, some of the technologically affluent countries are patenting our herbs which we used for generations, as their invention ! Time has come for us to strengthen our hold, ascertain our position, save our resources, and also get the credit internationally as the pioneering country in various fields, by using new strategies to face the technological threats.

NGOs have earned their name for their innovations, appropriateness and people centred initiatives. India is one of the leading countries in the Information race, both in hardware and software production. We have all the infrastructure available to be at par with any first world country. Here, the role of NGOs is unique. They should find ways and means of making this technology people oriented. It should be moulded

according to the local needs and make it appropriate to solve their day-to-day problems.

As NGOs, we should see whether the new information technology could answer the following questions:

Could we avert another Bhopal Gas tragedy ? Can we avoid Earthquakes like Latur ? Can we prevent Dhanbad mine disaster ? Could we control Malaria and TB deaths ? These are some of the challenges before NGOs in this information age.



NGOs should enter the information highway and act as a bridge between the international and local information resources. They would be the perfect judges to collect the relevant information from the massive international sources and pass it on to the regional or local centres and also transmit the innovations of the field level initiatives at the national and international levels. *NGOs could thus facilitate the two-way flow of information between north and south.*

VHAI's Share in the Information Age

For the past one and a half decades VHAI pioneered in Health Documentation and started conducting short term documentation and training programmes for the NGOs. VHAI also helped many NGOs to start their own documentation centre in varied fields like tribal development, traditional medicine, slum information centres, environment etc. VHAI entered the Information age through Computerisation including Computer Communications, E-mail and tapping International Databases like Medlars, Popline etc. for the use of its various activities, state VHAs and affiliate groups. At present VHAI is preparing itself to be a platform for exchange of information between International, National, State, District and Village Information Centres. We are aware that we have a long way to go, Selecting and Repackaging information from the grass-root level initiatives for the international plane. This is a herculian task. But we are confident and determined to achieve this feat.

Welcome the Information Highway

It is said that tomorrow's 'Development' strategies will com not from Washington or Paris or Geneva but from Africa, Asia and Latin America. They will be indigenious, matched to actual local needs. They will not over emphasise economics at the expense of culture, ecology, religion or family structure and psychological dimensions of existence. They will not initiate any outside model. They will rather create new ones. The information age provides the world's poorest as well as the richest nations with wholly new opportunities.

Let us join hands and reach out and humanise the distant tomorrows. As NGOs, we have a destiny to create in this challenging information age. ❐

Message to VHAI

Your strenuous efforts for pretty long period has brought a very nice set up in the country. It will be an asset in the long run for poor and needy patients in the country.

Go ahead and have brilliant success.

Gautam C. Mazumdar
Hony. Secretary
Indian Red Cross Society
C.S. Samariya Red Cross International Eye Bank
1, Atulya Bhavan, Near Consumer Centre, Sarkhej-Gandhinagar Highway, Thaltej, Ahmedabad-54.

PRIMARY HEALTH CARE - A CHRISTIAN MANDATE
February 26, 1996

BISHOP D C GORAI

President of CMAI, distinguished participants, members of the medical fraternity, our respected guests and partners from overseas churches and agencies - I greet and welcome you to a meaningful consultation on PRIMARY HEALTH CARE - A CHRISTIAN MANDATE organised by the Christian Medical Association of India.

We are all co-workers in the work of our Lord Jesus Christ. God has called us to initiate new ventures of love for restoring health and healing among all people in the various communities of our motherland India. Plurality of situation is a social reality and therefore diversity of approach is very essential in our deliberations and plans of action. At various grassroot levels different models have to be evolved to reach the poorest of the poor on a priority basis.

Jesus calls us to -

1. To spread the good news to the poor.
2. To restore sight to the blind.
3. To clearly demonstrate that the Lord is ever anxious to save everyone especially the poor (Gospel of Luke 4:18 - 19)

Our Lord hears the anguished cry of the poor and the dispossessed children of God who also have the right to wholeness. Therefore, let us obey the call of the greatest healer, our Lord Jesus Christ and stand beside the poor. It is necessary for us to identify ourselves as one of them and then jointly promote the healing process to restore health for all. All of us have our equal right on the wealth of the country so that a steady process of human enrichment may lead towards the holistic development of people everywhere. This calls for a well formulated health strategy which aims at creating health consciousness for a healthy community. We believe that all people are important therefore sick and malnourished people need greater attention and care to be made whole.

Healing is a Social Process with the following components:

1. Education & Training for health consciousness.
2. Care and Treatment: Preventive, curative, promotive and rehabilitative.
3. Balanced food and pure drinking water.
4. Ecological / environmental / cleanliness
5. Physical fitness - games / exercises and clean habits.
6. Value - based living standards.

7. Unity in the diversity of health-care alternatives in relation to the reality of Indian society.
8. Health and Healing as a process for empowering people to overcome social, mental and physical disabilities.
9. Control of population explosion, pollution and HIV/AIDS.

In India, ill-health is largely a consequence of poverty, ignorance, superstition and lack of education. On the matter of education for health the rich and the poor, the educated and the not-so educated people alike display great ignorance and therefore endanger their lives and the lives of others. All of them need proper health education so that each may play his/her role as health keepers for others.

Disease and ill-health have a close socio-economic nexus. Therefore it is not the exclusive prerogative of the health professionals. Society as a whole, must adopt a holistic approach in promoting healthy minds and healthy bodies through practical demonstration of sound living habits. Medical treatment is not merely curing the illness but it must aim at determining the causative factors of disease and eradicating them. This will strengthen the healing process for everyone in the community especially the marginalised people in our society. This work has to be continued in the socio-economic, medical, ecological, political, moral and spiritual dimensions which cover preventive, curative and rehabilitative thrusts. Primary health care is a long term commitment of a nation that wishes to be whole.

The Government of India is trying its best to foster the all round growth and development of its people. In this context let us remember that healthy people create a healthy community which, in turn produces a healthy nation. Therefore, appropriate Primary Health Care programmes are the prerequisites for strengthening our national aspiration to move forward into the 21st century.

The call of the World Health Organisation 'Health For All by 2000 ' is a prophetic challenge for everyone in the World and especially for India, where 40% of the people live below the poverty line. Health for All is a beautiful vision but perhaps for us in India in the present context, the attainable goal is '<u>Health Care For All Within A Decade.</u>'

The Christian Medical Association of India has to provide dynamic leadership in challenging the NGOs and government agencies for a more speedy and human approach to result oriented programmes for the people in the interior of rural India. They must enable the hospitals and health care units to resolve some of the disturbing health problems through systematic training, by enforcing discipline and by sound managerial skills. Poor management, a "status quo"

mentality, adhocism, absence of collective participatory leadership and a lack of social audit have greatly weakened the organisational capacity of the health care ministry. It is time that our institutions are sensitive to the new dimensions of human suffering and express by action the concern of the Church. The Church has to be a pioneer in empowering the victims of ill-health to have a new dream for a bright future.

Fortunately, most of our Christian Hospitals and health centres are in rural areas. This provides us wonderful opportunities to serve the rural poor with quality care. But let us not labour under the misconception that only the poor people need primary health care.

Low cost treatment must continue to be a high priority for Christian medical/health care institutions which are primarily not-for-profit service wings of the Church established in the name of Jesus Christ. It is imperative for us to undergo a process of re-orintation for a more prophetic health care agenda, for tomorrow.

The multidimensional health problems of our society have to be tackled with modern skills and competence. The poor who have very little money to pay for treatment, have to be welcomed to the Christian Hospitals and Health Care Centres, primarily because the doors of other private hospitals and nursing homes are closed to them due to prohibitive charges. Christians Mission Hospitals must become a 'Mission of Hope' to all and especially to the hopeless and helpless people of our land. This urgency imposes a divine imperative for a thorough overhauling of our health delivery facilities and systems.

a) By improving existing facilities. This would include diagnostic facilities which are generally lacking in the rural areas.

b) By starting new types of health care centres, especially in the woefully backward areas of our country.

c) By inducting more committed and skilled health workers and by bringing renewal and revival among the existing staff members and workers who are very often depressed, disheartened and demoralised due to various reasons, factors and forces. It is time to give due attention to restoring a work-culture and medical ethics in our own institutions and in all institutions all over India. The CMAI has to play the role of a catalyst in these circumstances.

d) By applying contemporary understandings of the socio-economic problems of the country where our people have been struggling for survival, it is time that efforts be made to

change the attitudes of health professionals so that all may dedicate themselves as catalysts of health for others.

But this will require:

i) Spiritual, moral and ethical re-orientation of all workers to inculcate in them a sense of vocation for service and sacrifice. This is indeed the universal quintessence of all Christian endeavors.

ii) The dilapidated infrastructure of the health centres and hospitals have to be infused with new life to meet the growing and varying needs of the community. The hospital authorities must be challenged to see things in their true perspective to ensure that the poor are not exploited by commercialization of medical care by the health industry.

iii) Facilities for appropriate care and treatment in hygienic conditions have to be provided, so that the health professionals may effectively deal with various health problems and related complexities. This does not necessarily mean super-specializations for each hospital/centre. But it does require minimum basic modernisation of the hospitals and primary health centres so that patient care can be conducted smoothly and competently at a time when 'CONSUMERS PROTECTION ACT' has come as a corrective and deterrent process for the public interest.

iv) If the health-care strategies for the poor are to be effective and sustainable they must reflect a systematic understanding of the perceptions of the poor who are normally not included in the corridors of power. Their voices are invariably absent from debate on policy reforms directed at improving their lives. The aspirations of the poor have to be articulated in all health care policies which are meant for them.

v) We are experiencing so many problems in maintaining and supporting our health workers. There is a great need for offering a suitable wage for a respectable living for all health care professionals in primary health care centres.

The situation demands justice in strengthening the qualitative service to the poor and the helpless. The question of a sustainable health care programme by NGOs needs special consideration in the context of free supply of some medicines by the govt. for certain illness such a tuberculosis, leprosy, malaria etc., Every organisation has to mobilize resources with the participation of the target group and business houses, where possible.

Today's patients are conscious about the skills, competence and ethics of cordiality of the hospital and primary health care programme workers. We reaffirm that poor people deserve

the best care and health education. Let us remember that cost effective considerations are very necessary but must not become the clinching factor in the mission strategy for primary health care delivery.

It is time that the NGOS/Churches reaffirm that primary health care programmes are a must in the context of privatazation and commercilalisation of medical care and increasing poverty. But primary health care does not mean merely treating dysentery, diarrhoea, night-blindness, scabies, etc,. The nature and scope of preventive treatment has assumed a new magnitude in the context of various fatal diseases of the modern day globalisation scenario which causes great suffering to the poor and the middle-income group. Primary health care is essentially caring for people so that they learn to survive and serve fellow human beings.

The charitable aspect of the compassionate ministry of Jesus must find a place not only in our hearts but also in our health care practice and this should be duly enforced by a Christian code of conduct. Without compassion, a nation cannot progress, nor can it achieve unity of all its peoples. This is especially relevant in India which has so great diversity and plurality of situations, which along with acute poverty creates a situation where the rich get richer and the poor poorer. The gap between them gets bigger and worsens at an alarming rate. It is high time that this deterioration is checked through social transformation.
While the Indian Church is poor, we are conscious of our heritage and partnership with the Church universal. Therefore we are not alone in our missionary journey.

As a caring community, we must promote a feeling of solidarity with those people who are deprived and suffering, enabling them to enjoy the fullness of life which Christ has offered. (John 10:10) This will demonstrate a new model for service and sacrifice, both of which are prerequisites for the development and prosperity of our country and indeed the world.

Recently, hundreds of people died of plague, malaria and gastroenteritis. Similarly, hundreds of people are dying of AIDS. Hundreds die of hunger, yet the world continues oblivious, on its selfish path, blind to the plight of others. It is high time that every educational, social, religious and medical institution promotes awareness programmes for the prevention of HIV/AIDS not only in our country, but also the whole world. Therefore our primary health-care programmes have to include these in their agendas.

The CMAI has provided leadership in popularising community health / primary health care concern all over India. It has become a facilitator, trainer and trend-setter and has displayed a great concern for the poor. It must continue to encourage health-activities to uphold the cause of the poor. I appeal to all our overseas partners, churches and various Christian agencies to strengthen the Healing Ministry undertaken by churches/social action groups in new areas. This will enable 'poor people' In India to have access to health care facilities in order to sustain national growth and development. Jesus said " when you do it to the least, you do it to me." Let us hope and pray that the CMAI emerges as a force to reckon with. May it continue fulfilling the Christian mandate- of celebrating life with its fullness for all. This must include those who have money and others who lack it. Let us give health a chance so that as Indians, we may become a healthy people, in the global village of tomorrow. A healthy India will make a better world. If health is wealth then we have a tremendous treasure trove just around the corner. Together, holding hands and with pooled resources, let us move towards these new riches by exploring new horizons in Christian Ministry as co-workers in His Healing Ministry.

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PRIMARY HEALTH CARE: BEYOND MATERNAL & CHILD HEALTH

Dr R.S.Arole

Dr. Cherian Thomas, esteemed colleagues and friends. Thank you for giving me this opportunity to address you this morning to share some of my views and experiences on Primary Health Care. The theme for discussion is Primary Health Care: beyond Maternal and Child Health Services.

Primary health care is an approach to health. It is a radical approach to health that goes beyond medicine. Its central theme is equity that leads to the goal health for all. It is about processes and concrete outcomes, be it medical, social, or political. It is a radical shift from a individual disease-based model that is dictated by the medical profession to one that views health from a broad perspective and where programmes and priorities are defined and articulated by the community. In the medical model the causes of ill-health are often looked at from a purely technical aspect with little or no attention being paid to the underlying or basic causes which may be deeply rooted in socio - political and economic structures. Primary health care in the ultimate analysis is directed towards equity and social justice which ultimately leads to a movement of empowering individuals and communities to be in control of their lives.

Many ideas on PHC were brought together at Alma Ata in 1978. It was in Alma Ata that governments from 134 Member States and representatives of 67 United Nations organizations, specialized agencies, and NGOs came together and agreed upon Health for All by the year 2000 The definition that was formed and is used is:

> *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 communities through their full participation and at a cost the community and the country can afford to maintain at every stage of their development in the spirit of self-reliance and self determination.*

In the Christian perspective it is bringing the Good News to the poor. Christ's clear proclamation that He came to establish the Kingdom of God on earth as He declared at Nazareth:

> *The Spirit if the Lord is upon me, because he hath anointed me to preach the Gospel to the poor; he hath sent me to heal the broken hearted, to preach deliverance to the captive, and recovering of sight to the blind, to set at liberty them that are bruised, to preach the acceptable year of the Lord.*

Primary Health care - a practice of Spirituality
John Grant - Peking Union Mission Med. Coll. 1920-30.
James Yen - France - 1923 Using Chinese how to read & write
Principle of equity ē comes from Christian faith

How was Primary Health Care envisaged at Alma Ata? It was based on a few successful experiences around the world in the early seventies. Jamkhed was one of them. These projects in turn drew upon the rich experiences of pioneers and stalwarts such as James Yen in China and who, later influenced the formation of community development blocks in India. Carl Taylor, David Morley and Maurice King, Sidney Kark, Kenneth Newell to name but a few, also led the way and influenced greatly the Alma Ata Declaration. Many of the projects studied were developed by dedicated Christian groups.

Drawing from the experiences of these projects, certain strategies were identified. Let me begin by recapitulating the main strategies of PHC. These include: commitment to equity; community participation (essentially empowerment); integration of promotive, preventive, curative, and rehabilitative services; intersectoral collaboration; and appropriate technology and services All these strategies are very much interrelated. These main strategies point to a much wider range of activities than Maternal and Child Health. However it was not by accident that in most instances PHC became synonymous with MCH services.

Primary Health Care (PHC) came into existence as a challenge to the medical paradigm of viewing health as only physical and owned by the providers. For the first time we were really putting people front and centre. But it was also about a devolution of power. Devolution of power of the medical profession and of all the so-called experts to the ordinary people. Hardly had the ink dried on the document at Alma Ata, that those in power, the medical profession started finding excuses. The donors and international agencies took the technological excuse route. They decided to change the terms and call it selective primary health care. The selection was done by them. Their reasons included that the PHC or the community based comprehensive approach was too idealistic - in short the message was that health, for all was not possible. They said the comprehensive package which addressed the real problems of inequity was too expensive. They also wanted measurable goals and quick solutions. The goal became more important than the process - essentially health statistics became more important than the people. The very essence of PHC namely people being in charge was prevented.

It was not easy to promote a shift in paradigm from doctor centered to people centered approaches. In our mission hospital setting where we are already struggling for financial resources, PHC meant a devolution of power and sharing of knowledge. It meant that those who had given their lives to hospital work, seeing their life work being superseded, it was difficult to let go. Therefore, this selective PHC became a welcome strategy - of staying in our ivory hospital towers and from time to time going into 'adopted' villages, (a very derogatory term), and providing immunization services and MCH services. Community participation was reduced to people availing themselves of these services. Perhaps providing a room to hold the clinic and a worker from the village to act as a promoter for the health services that we provide. Maternal and Child Health services to a large extent became synonymous with Primary Health Care.

The route taken was an easy one. A few common diseases with technologically known solutions were identified and packaged into maternal and child health services. In many instances a worker from the community was identified to work with the health professionals. However, the PHC movement was not dead. It was revived again at Riga when member states of WHO again reiterated and committed themselves to Primary Health Care . In the past few years the

importance of primary health care is being realized and has been hailed as the most relevant way to address health issues. Europe and other affluent countries have also recognized the need for primary health care in their own countries and in fact one of the best known PHC programmes exists in Scotland today. Community based comprehensive Primary Health Care is not second class medicine. It is not an interim or stop gap approach. It is based on sound scientific and moral principles.

As Christians are we not called upon to bring 'health and healing to the nations'? We are called upon to bring justice and equity among people. Because our God is about justice and equity. Are we true to what we believe in? If so, it is imperative that we go beyond maternal child health and address the basic causes leading to poor health. Going beyond maternal and child health is no more a political nicety, it is a necessity. In the words of Dr. Hafden Mahler *"it is a moral issue."* What can be done?
Drawing from experience at Jamkhed, I would like to discuss some of the basic principles of PHC and share how we can move beyond maternal and child health services. The overarching and the most important principle is equity.

Equity is about fairness of distribution. It is not the same as equality which is not always fair. In PHC we speak about health for all. In fact that was the main goal of the PHC movement. This does not denote that every person will have the same services, or, for that matter the same level of health. What it means is distribution of health services according to health needs. Needs not entirely determined by the health professionals but by the people. It is about addressing those in most need. If resources do not permit all being served, those most in need must have priority and what is done must be relevant to their situation. An equitable outcome and process is a central aspect of PHC. It is central because equity is about values such as respecting and caring and restoring dignity. It is essentially working towards an equitable, just, and peaceful society. Mary in her song to her cousin Elizabeth expressed equity in simple terms.

> *He hath shewed strength with his arm; He hath scattered the proud in the imagination of their hearts; He hath put down the mighty from their seats, and exalted them of low degree. He hath filled the hungry with good things and the rich He hath sent empty away,. Luke :1; 51-53.*

Equity in health care implies more than providing health services to the poor. It implies getting to the root of the problem - which is the socio-economic political and religious base of our society. It is only when these unjust structures are addressed that we can hope to achieve true equity.

In practical terms equity in health care implies meeting health needs according to people's basic needs. It does not merely denote ensuring provision of health services regardless of caste, class, and geographical location. Since communities have different health needs it is important to determine their respective needs rather than having a package of activities determined by us which we expect people to follow whether it is a priority to them or not. For example, it has always been felt that the maternal child health services are the most important components of a Primary Health Care programme because over sixty percent of the population are women and children. This is what we presumed when we first went to Jamkhed. We had already planned our programme as providing MCH services. From the medical point of view they are important services. We asked

the community leaders. They agreed with us. However, on sitting down and listening to the people, it became quite evident that poor people were more interested in food and water. They had no time for the luxary of health services or for that matter immunization. They were right. We were wrong. A deeper analysis of the situation revealed that over fifty percent of the health problems of women and children were related to lack of food and safe water. The impact of adequate and proper feeding practices and safe drinking water was far greater than immunisation services. This is already proven in the developed countries where measles is not necessarily a killer disease as it is here. This to a great extent can be explained by the higher nutritional status of the child. In Jamkhed too, the interventions addressed to nutrition and water brought down infant mortality long before we could afford to add measles immunization. Introduction of immunization, ante natal care and a few other services was not enough. It would have had a relatively small impact in the face of starvation and lack of clean safe water. With meager resources, we realized that reducing malnutrition and providing safe water was far more important than MCH service delivery.

In addition to determining their needs, another important aspect is that this process lets people themselves define their own needs and priorities in their own terms. PHC is not only providing services but enabling communities to be part of the decision making processes. Participation in the decision making process at the point of defining their own needs is a good beginning in the theory to practice process. This can be done using various epidemiological tools. Beginning with the simple step of having informal discussions with individuals to determine the workings of the village. This helps to understand who is who in the village: who are the decision makers, who would like to be the decision makers, what are the factions and their alignment or misalignment. This has a direct bearing on equity. Because, if equity is about fairness, then it is important to know and understand all facets of a community. If the commonality and differences are not fully understood one can make the mistake of aligning with or introducing programmes that are beneficial to one group at the expense of another. Also, one runs the risk of non-cooperation resulting in lack of ownership of programmes. To expand on this I again share my experience in Jamkhed.

After having understood the village structure, we arranged village meetings. It was important to ensure that all groups were represented and the place and time was accessible. Such meetings helped to broadly identify the areas of needs, concerns, and wishes. It was an opportunity for us to explain what PHC was about (though at that time it was not known as PHC) and listen to their reactions.

This was just the beginning of community participation, the next strategy of PHC. Community participation is a process where people are the key actors. Individuals and communities take active part in the decision making process which may change their lives. Since health is dependent on the village community as a whole, it involves interconnected aspects of life which the individual can only affect when there is cooperation among the members of the community for the benefit of all. Health is then a fundamental reason for community involvement and also provides a reason for community involvement and cooperation which everyone can easily see as valid.

One of the challenges in community participation is participation by those in need, i.e., the poor, and especially the poor women. The existing power structures in villages leaves little room to enter villages other than through them. As we moved about and gained the confidence of the poor people it became more and more evident that the needs of the leaders were not the same as those of the poor and marginalised. While the leaders were interested in having a hospital, diagnostic and surgical facilities, the majority of the people were preoccupied with basic survival. They sought medical help only for life threatening illnesses and injuries. They were not interested in having a hospital or fancy diagnostic machines. They knew better. They knew about survival. They identified water and food as their first need. This is the basics for prevention, a core goal of PHC. It became clear to us that preventive and curative services needed to be integrated with other development strategies. We also realized that while we wanted community participation, no such concept of community was inherent in the village. The lines drawn by caste, economics and the need for power have kept such a community from forming. We had to find ways to help people to step across the lines and begin to dissolve those lines before true participation can be achieved.

At Jamkhed we encouraged the men from the poorer sections of village to form Farmer's Clubs. Later women were also organized to form Mahila Mandals and along with the Village Health workers they form a team to address all issues. Their active involvement is critical to the success of the community-based PHC programme. This where we have a major role to play. Community based PHC programmes depend on people's action. Values of caring, sharing, respect for each other and the concept of equity has to be imparted. Undergirding all community processes are the values which lead to equity and justice. These ethical issues are important and need to be formulated and discussed. The objective is to form sharing and caring communities who will be empowered to take decisions in an empowered way.

Since community participation is going to be elaborated on in another session, I move onto the next strategy of PHC - the integration of curative, preventive, rehabilitative, and promotive services. Each of these areas are important in their own right. If the objectives of PHC is to meet the health needs of the poorest of the poor in the most effective and efficient manner, then it is only logical that all the services be integrated. People cannot be divided based on what type of services they need, their health needs must be treated in an holistic manner. The integration is also critical given that almost 80% of all diseases can be prevented. We cannot deny the need for curative and rehabilitative services, although emphasis on the prevention end would be more effective in the long run. Integration of curative, preventive aspects of health is important. I have seen many a health worker not being effective because of this compartmentalization. Once, I went with a public health nurse on her rounds in the village. She had her tool kit of health educational materials. She patiently went from house to house talking to mothers about preventive health care. We often came across children with acute illness and mothers would ask for treatment. The nurse would say that her job was to talk about prevention and that a another person would come later for treating the child. All the hard work of the public health nurse was lost because of lack of sensitivity to the needs of the people. We must be prepared to respond within reasonable limits in a holistic manner.

At the primary level, the integration of all services is not only possible, it is essential. The diseases in the village are simple, repetitive and for most guidelines have been developed to treat diseases that are common. For example the mother can be taught home remedies and oral dehydration based on home-based fluids. Mothers need to be taught all about acute respiratory diseases. A well-integrated referral system to health facilities will greatly enhance the acceptance of PHC by the people. This is more so in areas such as antenatal care. Unless there is facility for referral and emergency obstetric services, antenatal care is of little use as credibility will be lost if there is no place for referral for obstetric emergencies.

Our experience at Jamkhed has shown that it is possible to integrate the so-called vertical programmes into primary health care. For example leprosy control programme was integrated from the very beginning. It was found that when we started treating leprosy in the context of PHC, most of the problems were quickly solved. Once village people understood that leprosy was not as contagious as they thought it to be and that deformities could be prevented, people themselves made eradication of leprosy one of their objectives. The detection of leprosy is included in the general health surveys. The village health worker is also trained in leprosy follow up. It is she who ensures that the treatment is complied with. Since the village health worker is concerned with many other activities, her visit to a leprosy patient's house is not specifically pointed out as having leprosy. Leprosy patients can lead a normal life fully accepted by the community. Once the village people understood the cause of deformities they helped to encourage the patient to act responsibly and encouraged him to wear shoes. Village people also helped in the rehabilitation process and ensured that the families were also taken care of. This integration has dispelled the stigma attached to leprosy in Jamkhed villages. Often, it is fear that prevents leprosy patients from seeking treatment early. Over the years over 4000 leprosy patients have been treated in the villages. Through the village communities these leprosy patients have been well rehabilitated and are leading normal lives, fully supported by the village communities. This approach has also been financially cost effective as far as leprosy is concerned. Leprosy paramedical workers are multipurpose workers having multiple skills.

Similarly the PHC approach has effectively reduced the prevalence of tuberculosis in the villages. Village people see this as a priority and ensure both compliance and also rehabilitation of the family. Community support is important specially when women get tuberculosis. She has the fear that she will be kicked out by the husband. Community support ensures her well being.

As part of the integration of services there is a need for intersectoral collaboration, because health is more than medical care. Primary health care seeks to get at the root of the problem and most of the medical problems in this part of the world are linked to socio-cultural, economic, environmental, and political issues. Thus, intersectoral collaboration is necessary to improve the health of the population. Over 50% of the low birth weight babies are born in India today despite the large infrastructure of health services and emphasis on antenatal care. Maternal services, in the form of antenatal care alone cannot solve the problem. The problem is rooted in the social structure of the society which relegates women to a secondary status. Low birth weight with its consequences is inevitable, as women are denied the very basics of adequate food and rest so essential during pregnancy. It is not only poverty that has to be addressed, the deep-rooted social evils of women as objects and not subjects and caste barriers have to be rooted out. It is only

people themselves who can change these social structures. This means going far beyond the domain of the health system. Collaboration with other sectors of development is essential for the achievement of PHC.

Another important aspect of the PHC approach is demystification of knowledge. Health knowledge has to be shared in such a way that people are empowered to act. It is not just giving them a few messages on what to do. This concept is based on the fact that people can understand complex facts if they are simplified and shared in a way that they can understand. In health it means understanding not only the cause of desiease or its prevention, but also learning to assess the situation in one's own village and working out what is the basic cause which may be embedded in the social structure, beliefs, attitudes and then working out how solve the problem. This type of learning enhances the skills and encourages people to become more self reliant.

Recognition of intersectoral collaboration by health workers is very important if primary health care is to go beyond maternal and child care. They need to be aware that the root causes of many diseases is more socio-cultural, economic, and political in nature, in order to be more effective in ensuring health for all. Working in collaboration with other sectors is obviously an essential strategy. This also includes a knowledge of other development programmes and agencies. Though we did not directly employ any agriculturist, veterinary doctor or other experts, we were able to bring about intersectoral collaboration by acting as catalysts and working in partnership with government.

As people were organized into viable community groups, they expressed their needs. Landless people were more interested in having farm animals such as goats, chickens and cows. They were interested in having village veterinary workers rather than human health workers. We were able to get the local veterinary doctor and extension workers to provide the necessary training and follow-up. Intersectoral collaboration is not inherent in the government hierarchy. However this PHC approach which has strengthened the community organizations has helped to bring the various departments together for seminars held for village people. Departments of agriculture, soil conservation, minor irrigation, animal husbandry, social forestry, block development officer and banks and cooperatives come together for the seminar. Each explains his or her development programme and how the people can avail themselves of the services. Poverty, improvement in food production, income generation are all aspects which ultimately affect health. We can play an important catalytic role in converging services at the block level.

These seminars are popular because people get knowledge and awareness on many development issues. Legal problems are discussed with government officials. Particularly status of women. Women have been able to get property rights and many women have become joint owners of property with their husbands.

Another strategy of PHC is ensuring appropriate technology and services. To be true to the spirit of PHC, of its commitment to equity, the introduction and use of certain technologies and services must maintain the respect and dignity of individuals. Women have multiple health needs, yet the services to meet their health needs, focuses only on their reproductive role. It would appear that women are only cared for by the health system only when they are pregnant. For

example 85% of women are anemic; however this problem is not addressed until the woman is pregnant. Women's health is more than maternal care and family planning. Yet, we continue through our health services to take a narrow and inequitable view of women's health. It is necessary to emphasize women's health at all ages in her life.

One of the aspects of PHC is that technology should be accessible, affordable, and culturally sensitive. It means the use of technology which is based on scientifically sound principles. It ranges from low cost, simple techniques such as the use of home-based fluids for diarrhea to high technology which may be quite expensive initially. For example the use of two-way radio for continuing education of health care of grassroots worker is technology that is useful and relevant where their a limited mechanisms for communication and where geographic access makes it difficult. For the efficient use of scarce professional human resources a vehicle (jeep) is important as time should not be spent in long and exhausting hours of travel. The use of women from the village as village health workers can be considered as appropriate as expensive professionals are not only scarce, but are as effective as a person from the village. The examples of appropriate technology are numerous and I will not elaborate on it accept to list a few such as the growth monitoring chart, delivery pack

PHC also includes appropriate rehabilitation of those who are handicapped in any form. Often rehabilitation is thought to be expensive and beyond the scope of PHC. However with the main thus being equity, rehabilitation plays an important role. When all those needing rehabilitation are aggregated at the level of a state or country, the sheer number of people to be rehabilitated makes one feel it is an impossible task. However if we reduce the problem to the lowest level, that of the community or village, it is only a few that have to be rehabilitated.

In Jamkhed, village artisans such as carpenters and blacksmiths, have been trained to make the Jaipur foot which is an artificial limb designed specifically for the local culture of sitting on the ground, squatting, and working on the farm. The development of the Jaipur foot required taking local resources and with some guidance they were able to create something that is appropriate to the needs of the people. Essentially, we took a technology and got the community involved to address a need in their own community. It was appropriate because, the technology was tested.
Going beyond Maternal and child health is not only because of the more comprehensive approach to health, it also occurs as health of mothers and children undergo change.

Primary Health Care is a dynamic process and if successful the communities' priorities change in due course of time. Over the years the priorities in Jamkhed have also changed. In the beginning in the 1970s the health priorities were mainly malnutrition. Children had not been immunized and tetanus was frequently seen in the hospital. As people become more aware and knowledgeable, health priorities started changing. Immunizing children became a social norm. A small family social norm occurred as more and more women started deciding on small families. In the early seventies close to fifty percent of the outpatient clinic was children under five being brought with common childhood diseases. By 1980 the hardly two percent of the our patient attendance was children. Instead of health workers going out and urging mothers to immunize their children, people started demanding immunization. Wasting, stunting and low birth weight

were the predominant problems in the early seventies. Through the community based programmes these problems were addressed. The disease pattern slowly changed.

At Jamkhed the health education and sharing knowledge with village health worker and people has been a dynamic one. The continuous training every fortnight has helped to enhance the health

workers knowledge and skills. Therefore, within antnatal care for instance, the detail of antenatal care continues to increase. In the beginning no mention is made of problems such as Rh incomparability. However with each round of training more and more knowledge is imparted and so community knowledge is eventually built up. This enables people to demand more and more services.

People's priorities changed. They demanded more on women's health. There was a demand for regular screening for hypertension, diabetes, cancer. Responding to the people's demand Village Health Workers were trained to monitor blood pressure, test urine for sugar and take cervical smears and do pelvic examination. New programmes have been instituted concentrating on adolescent girls, a hitherto neglected age group. Anemia is a major problem and supplementary iron during this period would help combat anemia. Attention is also being paid to her nutrition.

In the context of PHC, the whole question of HIV/AIDS is being addressed. The Mahila Mandals have discussed the issue of AIDS and how it is transmitted. Through the health worker they receive regular up dates. A an organized group they have identified the high risk women. Such women include the wives of men who have to stay outside such as truck drivers, bus conductors and drivers and those working in the cities. The Mahila Mandal supports her as she tries to protect herself by insisting that her husband uses condom. This is a relatively new programme and will be monitored to see its effects. Some villages have decided to do routine screening for STD and if it is high also test for HIV/AIDS.
In addition to change in priorities in health, as the development process proceeds take on more activities relating to environment. Through the PHC programme environmental issues such as social forestry with large scale planting of trees are carried out. In villages there is acute shortage of fuel. Hence women are interested in tree plantations. Environmental sanitation and construction of drainage pits for waste water and building toilets are also areas where people show interest.

The evolution of community based primary health care is that it moves from first addressing common childhood illness and maternal health to looking at health as a whole. Once the common infectious diseases are taken care of, the next priority is addressing more chronic diseases associated with the aging process and affluence. They are mainly diseases of life style. This includes high blood pressure and diabetes and cancer. And eventually the programme programmes attempt to address more complex problems such as HIV/AIDS and environmental issues. I especially mention AIDS as the epidemic is assuming large proportions and soon the devastating effects will become evident. Addressing HIV/AIDS in the context of community based initiatives will be important and this is the challenge we as Christians will have in the years to come.

Today as never before we as Christians are being challenged. The market forces are closing in on the poor. The social sector programmes are rapidly being replaced by private enterprise. And during this period of transition both in terms of economy and interms of epidemiological transition, it is the poor that will suffer. We are called to respond to the needs of the poor. Christ has given us His Peace- Shaloa Freely we have received freely we must share what we have received. :"My peace I leave with you " Peace; Shaloam in Hebrew means more than peace. It means health in all its wholeness. It denotes harmony within oneself, harmony with other human beings, harmony with all God's creation and harmony with the Creator. It is this Shaloam that we must strive to bring about in the areas where we work. May God give us Grace to respond to the needs of our people. **Shaloam.**

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THE RISE AND FALL OF PRIMARY HEALTH CARE

Prem and Hari John

In the Beginning:

Alma Ata visualised PHC as an approach aimed at not merely eliminating disease but as "a complex of strategies that determined people's livelihood and Quality of Life"(1). Social, political and economic ***equity,*** fulfilment of the basic needs of the *majority* and above all, people's ***participation in decision making*** became the key words of this approach. Sociological and qualitative solutions were placed above technological and quantitative gains. This approach did not arise in a vacuum. It was historically rooted in the concept of the barefoot doctors of China deployed in large numbers during the Cultural Revolution of 1968(2) as well as experiences gleaned by its various mutants in Guatemala 1970 *(Beherhorst)*, India 1973 *(Arole, John)* and Indonesia 1976 *(Gunawan)*. It was also rooted in the failure of the so-called public health services to touch and heal the vast majority of people, i.e. the disadvantaged of the Third World. Also, by then, more in hindsight than by systematic analysis, it was recognised that lack of people's participation was a major bottleneck to successful change at the community level(3). Community participation was therefore identified as the *"key"* to PHC. It was also recognised that the reasons for poor health are due in large part, to the unequal distribution of existing resources and that a more equitable situation can be brought about only by structural changes(4). As Mahler says *"Health is politics on a social scale"* and therefore the 'PHC approach' started addressing health improvements in the political context. The expectation was that community participation in health programs will act as a catalyst for social change by *empowering* local populations to become involved in the political process(5). Having affixed their seals and signatures to the declaration on PHC, most of the rulers of the world found that this approach was intensely political, if carried out in the spirit in which it was conceived and that it would alter power equations, first locally and eventually on a wider scale (as was demonstrated in Peru(6) and Indonesia(7)) in favour of the powerless . Against this background began the deliberate efforts of WHO to water down PHC through the promotion of the concept of vertical interventions and Selective Primary Health Care(8). Properly understood and implemented the key to the comprehensive PHC approach was the ***processes*** that the community went through whereas verticalisation focused on the ***program*** of intervention(9). Also in spite of declared intentions, governments never really put any pressure on the class in power, the paradox of political democracy imposed on an undemocratic social structure(10). Therefore, there was a deliberate shift - from wide coverage to intensive care, from societal goals to achievable, technological goals, from qualitative objectives to quantitative ones. The interests of the powerful, then as now, continue to direct the development of the rest of the globe. The result is , less than four years before the magical mark of 2000 A.D., Primary Health Care as a *paradigm* has been lost on the way and "Health for All" remains a distant mirage.

The Problem:

Much has been written about the "health" of India (or rather the lack of it) , the health status of its people, its systems and structures, almost all of it documented by the Ministry of Health itself, (and published in the *Pocket Book of Health Statistics)*. Briefly it can be stated that:

I. at Independence, a completely inappropriate system based on western models, was chosen.

ii. this system, not by oversight but by design, (as a result of urban, upper class, upper caste *decision making* for the largely rural, lower caste, lower class population), failed to address the needs of the majority i.e. the rural poor, the Dalits, the indigenous people and among them, women.

iii. successive five- year plans allocated less and less (in terms of percentage of total budget) and out of that, allocation to rural health continued to show a marked decline.

Table-1:

Five Year Plans	I	II	Annual Plans	IV	V	Annual Plans	VI
% of health budget to total budget	3.30	3.00	2.60	2.10	1.90	1.82	1.86

Table-2:

Five Year Plan	I	II	III	IV	V	VI
Outlay on Primary Health Centres & Rural Health as % of total health budget	17.8	10.2	18.05	6.6	5.4	8.54

iv. meanwhile disease patterns were showing a significant divergence - i.e. the diseases of the urban and rural rich on the Euro-American pattern and on the other hand, *diseases of poverty*, a distinctly different pattern affecting only the *disadvanaged.*

v. Systems and structures were built up mainly to service the better off (Cancer Hospitals, Institutes of Post Graduate Education, Medical Schools, CAT Scans etc.) And when the poor were taken into consideration at all, investment was made on hardware (PHC buildings, vehicles, again medical schools to produce doctors for the PHCs etc.).

vi. More medical schools were opened not nursing schools, Valium, Zocor and Nifetipidine catering to the richer classes were easily available, but drugs for the treatment of Tuberculosis or Leprosy were not.

vii. There is an ever widening gap between the advantaged and the disadvantaged.

In summary, the end result was quite predictable and reflected a state in which the planners were comfortable with (and confirmed by data provided by the government itself) as seen below.

The Great Divide:

Two distinct types of health status have been in evidence. Consider IMR alone, which, rather erroneously, is considered as an index of development:

Table 3.

Year	Rural	Urban	Combined
1971	138	82	110
1981	119	72	905
1986	115	62	885
1996	120	48	79(12)

The above shows the ***rural-urban*** divide. There is also the ***rich-poor*** divide, the ***educated - uneducated*** divide, the ***upper caste - lower caste*** divide and so on. The point is that the majority of people, especially the disadvantaged, had and continue to have, no *meaningful* access to the health care delivery system be it government, private or even "Christian"(13). (For an in-depth look at the PHC system, refer Banerji. The result is a morbidity pattern for the poor which is not very different from what prevailed in 1947.

The same disparity is exhibited in the economic sphere also:

Table 4:(14)

Country	Per Capita GNP in US $. For total population (1990)	Estimated GNP in US $. for poorest 20% of population
Bangladesh	210	69
India	360	90
Nepal	180	28
Pakistan	400	138
Sri Lanka	470	139

Class divisions are nowhere as well seen as here. After five decades of Indepence, the per capita income of the lowest 20% of the population of India has not increased more than one dollar(15).

In sum, India failed to achieve a mode of life in which a *statistically significant majority* of its citizens have been able to fulfill their material and spiritual human needs(16). The unbridgeable gap that exists between the North and the South, also exists between the advantaged (in terms of class, caste, ethnicity, gender, urbanised) and the disadvantaged in India and nowhere is this more explicitly seen than in the field of health.

What Now:

Into this already bleak scenario, new, and vicious, players have stepped in. These are the international financial institutions, specifically the World Bank and IMF. Their domination of the lives of the Third World has been insidious, inevitable and now, total. Their Structural Adjustment Programs (SAP) which impoverished and bankrupted several Latin American and African nations have now subjugated the economies of South Asia. Parliaments can no longer pass laws based solely on the needs of their citizens. In more ways then one, India is not a sovereign nation any more. The economic, social and therefore, the political agenda of the nation is set in Washington. Even the health goals are no longer the concern of the WHO, let alone the Ministry of Health in New Delhi. They are now set by the World Bank, just as in the early eighties when it was the World Bank that opted for selective PHC with achievable and quantifiable goals as opposed to comprehensive PHC(17) and forced WHO to accept it as a policy.

Structural Adjustment Programs:

The 20th century is drawing to a close but unfortunately the World Bank and the International Monetary Fund are imposing a set of policies on developing countries which are, directly contradictory to their own policy position stated by Robert McNamara in 1976. WB/IMF have proposed certain structural adjustment programs (SAP) as a precondition for loans. Developing countries need these loans urgently to maintain their fragile economic, service outstanding debts and to import essential items such as food, fuel and pharmaceuticals. These countries are caught in a vice and seem to have no other alternative. The main policies demanded by WB/IMF under the SAP include the **following**:

* reduce or remove government subsidies on food, education and health.

* devalue currency - (prices of imported basic items such as food and pharmaceuticals will be increased.)

* remove trade and exchange controls and liberalise trade - (limited foreign exchange will be used by the rich to import luxury items; low priced generic drugs may disappear from the market.)

* privatise public sector enterprises - health care services is one sector targeted - (health

costs will escalate)

* charge user fees for public sector health care services - (the poor will drop out of the safety net provided by free health services.) (18)

The absolutely negative impact of SAP as a long term solution to poverty has been well documented (19). A noticeable increase in maternal mortality in Latin America, infant mortality in sub-Saharan Africa and incidence of malnutrition in rural Orissa in India among other places has been extensively documented (20). *(For a fuller discussion on this see Balasubramaniam, C.R. Bijoy and Martin Khor on this topic in LINK Vol.13.No.2 Sept.1995).*

The inescapable fact emerges that the powers that be have deliberately abandoned the poor to their own devices, including a paring down of the public health services, often the only "safety net" that the poor have, inefficient as they have so far been.

What of Us?

It is well to pause and ask ourselves, while all this has been happening what has been the response of the NGO sector? Specifically what has been the response of the so-called Christian Health System? The Christian Medical Establishment? I submit that our response has been negligible, in fact non-existent mainly because the shakers and movers in the establiushment are ignorant or choose to be ignorant of this rising challenge. We have been on a "business-as-usual" approach, going on as if nothing has changed. Nor is the track record of the NGO sector likely to give hope to the disadvantaged. The point that they raise in their defence is that "what can we do against global forces? What can we do against the World Bank?" The problem seems too big and therefore unsolvable. It is well, therefore to pause again and take stock of ourselves:

* Are we able to visualise the problem clearly? (Including the historical roots of the problem, of which wittingly or unwittingly we have been a part, the current scenario and the likely situation in the future, say in 2050 A.D.).

* Are our programs and activities, our systems and structures adequate in handling the problem now? (Not to speak of 2050 A.D.)

* Are our *resources* - our organisational base, our resource base and our human potential base *sensitive* and "informed"? Are they adequate in working towards solving the problem?(Not to speak of 2050 A.D.)

We better recognise what a dispassionate analysis will tell us: That (i) we are utterly incapable of participating in the transformatory processes of the people given our present decision making procedures, our systems and structures and that (ii) whatever we can achieve can only be done in partnership with the people with whom we have in the past had an unequal and often uneasy partnership

A People's Movement?

The title given to me for this presentation is **"PHC - A People's Movement"** - the underlying

premise being twofold: One is that *people's health should be in people's hands* (it has not been so till now, it has been in the hands of the professionals and that is why things *have not* worked) and secondly, *people power* should be harnessed, potentiated and maximised. *Movement* is defined as "consciously propagated, organised action on a mass scale focused around a central issue". We should recognise that any movement, be it political (like the Jharkhand Movement), or ecological (like the Narmada Movement) or social (like the Dalit Movement or the women's movement) needs three operative factors: (i) a clear and ***"just"*** issue, (ii) an informed, sensistive and dynamic leadership capable of visualising the future, nurturing and facilitating the movement and finally (iii) methods that would raise people's enthusiasm, build people's power, and channel people's resources in a sustained manner in achieving the objectives of the movement.

The political capacity to reform the social order and to achieve social goals can either come *from above* i.e. through a people - responsive government, that would have:

I) a *coherent and stable national, political leadership* that allows for the clarification of goals, their prioritisation and then sustained pressure from above for goal completion.

ii) a *clear pro-lower-class ideology* that gives the government legitimate authority to pursue goals beneficial to the rural poor. (The failure to translate "socialist" ideological commitments into a strong left-of-center regime capable of redistributive intervention is India's greatest political failure).

iii) *an organisational ability to go to the people* and penetrate the countryside without being captured by propertied groups(22).

Unfortunately we are well aware that successive governments since independence, have opted for clear, upper class and often upper caste goals (*always with pro-poor rhetoric*), what Myrdal calls as the *soft-state* nature of governance and the conflict between the promises made and the actions undertaken by the state(23). The less said about the present political climate, modes of governance and the capacity of the ruling classes to respond to the legitimate needs of the disadvantaged, the **better**.

In a situation such as this, we, the voluntary sector, can play several roles: (i) we should stop playing the usual *silent majority* role and play a more active *"political"* role individually and organisationally and (ii) recognizing that the present problem is *class-based* and the existing problem solving by the ruling classes is also *"class-based"*, we go to the people direct and start building *people-power*. It is not as difficult, hopeless or as far fetched it may appear - the recent history of the World is replete with instances of people-power over-throwing structures thought to be invincible. The precedents therefore are there and are hope-giving ones. Whichever movement has been successful, the bedrock on which they were built, have been "*people*" and their inherent capacity to break off their shackles. In a process such as this, the role of NGOs is only facilitatory but nevertheless a crucial role. The only way in which we can even halfway fulfill this role is by setting our own house in order. This requires, on the one hand enormous humility on our part to accept that we have been less than adequate so far and on the other, the capacity to *refashion our systems and structures* in a manner that would potentiate people power. Specifically, organisational strategic planning that would result in:

i) appropriate organisational development and ii) motivating, enthusing, training, developing and nurturing human potantial, specifically "informed", young people, with the knowledge, skills and capacity to facilitate people's transformatory processes. As we move into the Third millennium, if we do not take up this challenge we will stand indicted by posterity as accomplices in creating and maintaining sick societies.

Note: In order to understand this presentation in its entirety it is necessary to read the enclosed background papers fully. These are:

1. *Privatisation of Health. Its Impact in South Asia - K. Balasubramaniam.*
2. *Mismanaging Health - Privatisation and Politics of Economy - C.R. Bijoy.*
3. *Shift in Global Health Strategy - Martin Khor.*
   (All from LINK, Madras, Vol.13. No.2. Sept.1995)
4. *Towards the Third Millennium, Community Development in India, Health and Healing - Hari & Prem John.*
5. *The Christian Health Care Systems and the poor of Asia - Hari John.*

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16. John, Hari et.al. *Towards The Third Millennium* , Tubingen, 1995
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19. Cornia G.A. et.al. *Adjustment with Human Face*, Oxford, 1988
20. *LINK* , op.cit.
21. John, Hari, *The Christian Health Care System & The Poor of Asia,* Moshi, Tanzania, June 1995.
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THE STRATGEY FOR HEALTH & HEALING

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1. INTRODUCTION:

We are going through a crisis in civilization. Old concepts and ideas are submerging and newer insights are surfacing before us. There may be many under pinning issues such as nuclear economic, ecological, food, human aggression or new morality and ethics. At the core of most of these are also health issues. The modern medicine seems to be evolving,

from the whole to the part
from the person to the product
from belonging together to a state of isolation
from total approach to fragmented approach

II. HEALTH:

Let us have a look at the very concept of health. WHO defined health as a state of complete physical and mental well being. They have recently added another dimension - the dimension of spirituality. To expand further, health is a state of vital and harmonious well being, which reflects all these qualities - a state of dynamic wholness. Wholenss need not be confined to physical perfection as many of the physically disabled also could be truly healthy. Concept of harmony should extend beyond the person to include relationship to his environment, his neighbour and his creator. So health is a function, a quality of life, unfolding a personhood which is dynamic, comprehensive, coporate and forward looking. It has moral and ethical values aiming for a purposeful living.

III. HEALING:

Apart from curing any illness healing is concerned with any aspect of a person's life which falls short of wholeness. It is also restoring a person to harmonious relationship to fulfill the purpose for which he is created. It is a reconciling and a renewing process. It may be concerned with remedies that are physical, psychological, spiritual, socio-economic or environmental to restore a broken body, broken mind, broken life or broken society. Healing is the gospel which Jesus Christ preached and practised.

IV. THE HEALING SCENARIO IN INDIA:

In spite of the great strides made recently in science and technology, India still remains as one of the backward countries of the world. Our longivity is 58.6 years. Following is the morbidity in **India:-**

Malaria	2.1 million
Leprosy	2.8 million
Gastroenteritis	9.2 million
Goiter	8.8 million
Tuberculosis	12.7 million

Filariasis	18	million
Waterborne diseases	50	million

A good many of these are preventable. Infant mortality is said to be an index of the health of a nation. India's IMR is 80 per 1000. Following is the comparative figures for IMR for 1992-93:-

Bangladesh	119
Pakistan	108
India	80
Philippines	45
China	35
U.S.A	9.1
U.K	9
Sweeden	5
Japan	5

V. RELATED FACTORS IN HEALTH:

Several developmental factors, even within the western health care system have led to a broader comprehension and integreated appraisal of the determinants of health and causes of illness. Health disorders are multifactorial and interactive. It is increasingly recognised now that the life styles and environment plays a large role.

In his recent key note address at Medical Anthropology Conference in Suraj Kund near Delhi Dr. Reddy, Chief Cardiologist of AIMS, New Delhi said nearly half of the cardiac problems that he sees could be avoided if physical exercises, proper diet and proper life style were followed. The recent epidemic of plague in Gujarat is an illustration showing environmental factor play a key role in epidemics. Let us look at some of the major factors in the Indian context.

a) Poverty

About 40% of our people live below the poverty line. India's GNP is Rs.5,529/-. We are about sixth from the bottom. Poverty is described as the starting point of the vicious circle of mal-nutrition, illhealth, population explosion, unemployment, backwardness etc. Health is the prerequisite for increased production.

b) Malnutrition

One of the basic needs of a person is food. A third of our people go to their bed with a hungry stomach. Staple food should be made available at subsidised rates like Rs.2/- per kilo for rice as in Andhra Pradesh. Appropriate food habits, high protein and vitamin rich food such as raggie, green leaves should be encouraged. Breast feeding instead of costly baby food should be implemented.

c) Water

Safe drinking water is a major factor influencing health. WHO reports that 25 to 30% of hospital beds are occupied by patients whose illness is related to polluted water. Only less than third of the villages have water supply scheme.

d) Population Explosion

Today we are 900 million in India - we will cross a billion at the turn of the century. Our population doubles in every 27 to 30 years. Rapid population growth curbs our capacity even to perpetuate the present inadequate facilities and services as we have to stretch thin our fragile economy to cover our ever growing population. Population control should become a peoples movement. China has demonstrated that by improving the quality of life of people population can be controlled.

e) Social Factors

Housing, literacy, emancipation of women, employement (3.7 crores unemployed) and such other social factors play a vital role in health. Shelter is an essential requirement in human life. A recent survey in the city of madras and Bombay revealed that 25 to 30% of the city population dwell in slums and pavements. 46.6 million need housing. A new technology of low cost building with locally available materials is the only solution. Our literacy rate though gradually rising up but is still low. A study in Hyderabad showed the infant mortality of literate mothers is far less than that of illerate mothers.

f) Environmental Hazards

Environment plays a crucial role in prevention of illness. There is a complex interdependence of geological factors, flora and fona. Toxic wastes are accumulating, breaking the protective ozone layer. Rapid deforestation is affecting rainfall and weather conditions. Pollution is caused by excessive use of pesticides. The Coimbatore study revealed that 70% of mothers milk contained pesticides.

VI. ALTERNATE STRATEGY FOR BETTER HEALTH:

a) Primary Health Care: 80% of health care need is primary. Social awareness and self reliance are key factors in human development. So also is health. Individualls and communities should resume responsibilities for their own health and strive for self reliance. The prevailing health care system is largely allopathic western model. This is highly centralised, capital intensive, hospital based and in-accessible to the masses. It is dualistic, reductionist and mechanistic with over technologisation and consequent impersonalisation in both diagnosis and therapy, especially in rural areas. 75% of the nations health budget is for the benefit of 25% of people in urban areas mostly spent for the upkeep of sophisticated high tech medical institutions. Modern technology and treatment has a place in managing acute and complicated illness but the benefit goes to less than 5% people.

b) Traditional System of Healing: A few days ago I was participating in an international conference at Suraj Kund near Delhi. Participants from various Asia Pacific and European countries demonstrated how effective are some of the traditional healing methods - Ayurveda, Unany, Yoga, Accupuncture of China, Pranic healing of Philippines, Sora of Japan etc. These are less expensive least toxic or non-toxic as some healing methods are non invassive.

c) Health Personnel & Training Programme: Present pattern of training in health is the western. With the commercialisation of medical training there seems to be an over production of doctors through the mushrooming of substandard private medical colleges producing about 13,000 doctors a year. The present curriculam and system of training needs to be restructured to meet the needs and demands of the community, inculcating, ethical and moral values for a wholistic healing. What we really need is an adequate number of health workers who will spread themselves into the community to meet the primary health needs of people in dealing with preventive and promotive health and health teaching programme.

d) Networking: The Government should identify all the existing healing services, private, mission, corporate etc and also all the system of healing. These should be coordinated in the larger frame work of service. There should be a net working of all healing services from primary health care to secondary, tertiary and very specialised care which will be accessible to all. There should be a gradual referral system developed from primary to tertiary care.

e) Role of Drugs in Health Care: The recent Wineberg study in USA reveal the following factors in healing:-

20% of healing is by drugs and modern techniques
30% by OBECALP (ie, placebo effect)
25% by HAVITHORN effect (let off steam technique)
25% by FACTOR X. said to be spiritual and related factors

This unknown X factor is now recognised as the pnemo neuro psycho immunology phenomenon. Eminent medical people give testimony of spiritual healing seen in their practice.

f) Holistic Healing: The scientific method is based on the knowledge of biological process as verifiable, quantifiable and reproducible entities. The Indian system of traditional medicine emphasises life styles, morality, hygiene, nutrition, positve emotions and spiritual values as important enablers in fastering health. These two approaches can come together in holistic healing. Holistic means attention not only to the biological factors in an illness but also to psychological, social, emotional and spiritual factors which may contribute to the illness or wellness. Every ailment is a complex disorder of the whole person in all its different dimensions. A wholistic and enabling approach to healing not dominated by the biomedical paradigm, is an essential premise of whole person medicine. We have to grapple with this evolving redical change in our understanding of medicine from its mechanistic orthodoxy to a more crative metamorphosis.

g) Rational Drug Policy: 80% of todays health expenses are for drugs. WHO recommends only about 160 drugs as essential drugs. But there are about 50,000 to 100,000 formulation in the market. Some of them are spurious (Glycerol tragedy in Bombay, I.V. Fluids and sura deaths in Delhi are examples).

We need to appoint a drug authority to list the essential drugs with its generic names, and control the prices. Essential drugs should be supplied at subsidised rates and accessible to all. All products should be tested and standardised. All spurious and substandard preparation should be banned. Unethical marketing practices should be discouraged, and an ethical marketing code on the model of the WHO should be followed.

VII. TRAINING OF HEALTH WORKERS:

What is needed today urgently is not training of doctors but health workers, specially village level health workers to deal with 75 to 80% of common illness at the primary level. Just as China had succeded in achieving health through bare foot doctors India also should try to produce village level health workers. This experiment has been successfully tried in Tamilnadu and other places. These village level health workers are able to identify common ailments like malaria, tuberculosis, diarrhoea, filariasis, leprosy etc. and deal with it or refer them to appropriate centres for treatment. Voluntary organisation like CMAI should encourage such training programes.

VIII. CONCLUSION:

As we look forward to stepping into the new century inspite of several handicaps and negative factors, I visualise a bright future for India. We have the third biggest scientific manpower in the world. We have plenty of talented and motivated personnel. We have an abundance of raw materials, natural resources, energy potentials and a rich cultural heritage. Let us mobilise all our resource potential and work hard with a firm determination upholding the ethical and moral values to make our mother land, a leading nation of the world, to brigh prosperity, health, harmony and peace.

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Resources: Health Information India '93,
H& F Welfare '94, UNICEF '95
World Children '95

CMAI CONSULTATION ON
" PRIMARY HEALTH CARE - A CHRISTIAN MANDATE"
New Delhi - 26th - 28th February 1996

Bible Study :

I. Primary Health Care and Healing Ministry of the Church today

John 2 : 13 - 22 (see also Mathew 21 : 12-14, Mk 11:15 - 17 & Lk 19: 45-46

Introduction : Cleansing of the temple is reported in all the gospels. But John's word has some special marks.

1. Timing : To John this is the beginning of the Mission of Christ : as if Jesus is demonstrating in action what the whole of His mission is all about. To others it is the final action that disturbed his enemies and led them to act to arrest him and to kill him. Did he do it twice - both at the beginning and at the end ?

2. Significance : John alone relates this event to the inauguration of his mission of the kingdom " Destroy..... I will rebuild" Corruption and power-politics eating away the very heart of faith is destroying the structures from inside. His rebuilding is what Jesus gives in answer to the demand for a sign to prove his credentials as Messaiah.

3. Message : True to the nature of this 4th gospel, there is a rearrangement of the source material so as the reveal is a subtle way the deeper and inner meaning of the word in action. The essential message is that Faith - and Healing - cannot be institutionalised. It is a dynamic movement. Not lake but a stream.

The text:

1. Use of violence : Jesus never a pious lotus eating Buddha, He was a man of action. But he was a scourge on systems, inhuman institutions and economic power-never on human beings as such.

2. Father's house and Den of thieves : distance in effect is not very far at any time in history - There is a very good rational in secularizing, commercialising and institutionalising worship and Faith and mistaking means for end.

3. The zeal of thy house : Ps 69:9. The prophetic fervor that brought about changes begins with zeal eating us up: what `eats us up' today ?

4. Sign : Jesus rightly related this action to the Messianic Mission and asked for a corroborating proof- Mission has to be proved in action.

5. Destroy : Charge against Jesus that he was destroying - but systems itself leads to destruction.

6. Rebuild : A new start, not white-washing the old-renewal both personal and collective in the work of the risen Lord even today.

7. From Institutions to Movement : that is what the Healing ministry of Jesus always is .

Conclusion :

1. Institutionalism, commercialisation and secularism is destroying the ministry of Healing.
2. need a new zeal that should eat the whole of us.
3. Let the Lord rebuild.

Bible Study II

Lk - 10:1-10 and 16-24

2. Mandate and Motivation

Introduction:

1. Healing the side was the central part of the Ministry of Jesus. He sends his desciples with authority. Here the 30 are sent. See also ch - 9:1

2. He sends them two by two : The life together is essential for the power of healing to be released for the service of others.

3. They report back to Jesus - like others of sucess, of failure, of statistics but Jesus puts his finger on something else.

Text:

1. Satan falling from heaven : striking as the heart of the evil power of the world, of power by, of poverty, sickness and superstitions is what restoring people for the purpose for which God created them means.

2. Names written in heaven : Made workers together with God. Participation is the kingdom making process in the real motive.

3. Revelation : ability to see beyond the particular to the universal, from part to the whole, from curing to making whole is the revelation :

4. Eyes that see there things : The opportunities that are open to us - Discoveries in Medical Sciences, the Communications explosions, the infrastructures that share the resources God has given are subjects for Joy.

Message :

1. PHC is not an end in itself but a necessary condition for people to enjoying the fullness of life that the Lord offers.

2. The mandate is both to heal and to bring the message of the kingdom. This is a single mandate - separating the two will only make us fail to obey the call.

3. Ultimately we look for evaluations not on the success of failures of the health standards but on the extent to which we are in obedience to His call. It is this mandate that gives meaning and significance to our life and mission - not merely the agenda that the world sets .

Rev A C Oommen.

CONCLUSIONS OF THE CONSULTATION ON
'PRIMARY HEALTH CARE - A CHRISTIAN MANDATE'
CMAI, NEW DELHI, FEBRUARY 1996

The Church has a mandate to work towards a just and healthy society. We believe that Primary Health Care in it's widest sense would be instrumental in this work. We are conscious that as of now, the poor remain marginalised and exploited, and that we as a Church have a clear bias or preferential option for them. We realise that with the change of direction in India's economic development policies with globalisation, structural reforms and marketisation of society, the poor are being sidelined and jeopardised even more. We are committed to increasing the understanding of the contextual realities of the country, within the Church, it's institutions, amongst health professionals and the public at large, and of the urgent roles we need to take on, especially on the side of the poor.

In this scenario, we feel that there is an urgent need to

a) Sensitise the Church it's congregations, and it's institutions to the wider understanding of the Healing Ministry that Jesus calls us to, and the emerging health scenario to which it needs to respond.

b) Study and analyse the existing health context with it's social, economic and political ramifications, especially with relation to it's implications on the health and life of the poorest of the poor; and to respond by taking sides with these persons through advocacy and through solidarity in the pursuit of justice.

c) Promote the concept of Primary Health Care in it's widest sense, through all the channels available, in ways that will empower people and make health a people's movement. The Church with it's congregations, Christian Health Professionals and Training Institutions need to be geared for this movement.

Many suggestions on what specifically needs to be done have been raised. These will need to be looked at in detail and taken up subsequently. Overall, however, some sort of an action plan has emerged, with the following possible outcomes.

1. We recommend to the CMAI to foster regional/local, issue-based networks of people and organisations interested in Primary Health Care. These should ideally use minimum resources, linking up in solidarity and fellowship with congregations, organisations and people's movements. The reality of the concentration of need in the BIMAROU states would call likewise for a

concentration of response in such areas. This effort would hope to sensitise the Church to wake up to it's great role in working towards a healthy society.

We recommend to the CMAI that it set up the mechanism for follow-up of this dream, maybe through a small core-group. They would need to study the existing situation, other responses and networks currently in place, and help develop this forum, making local, national and international linkages as needed.

2. There has been a strong expression of the need to invest on Human Resource Development, and the need to develop mechanisms for nurture of and expressing solidarity with persons stepping out in roles in Primary Health Care. Many specific suggestions have come up, and we recommend that CMAI respond to them as appropriate.

3. There is a dire need for a pooling of information on the health of the country, from the various institutions and organisations in the network. This would create an alternative source of health information at a national scale; this is greatly needed to make up for the deficiencies and gaps in the governmental health information system. We recommend to CMAI that it set up the mechanism for this, linking up with other organisations as needed.

Three levels of follow-up were suggested :

1. Individual: We as individuals, commit ourselves to the philosophy and practice of Primary Health Care, through our own individual and institutional linkages.

2. Organisations: We recommend that CMAI work with other interested groups and people to effect follow-up of these ideas.

3. Information Sharing : We request the CMAI to keep us informed of the follow-up and progress in this work. We would also continue to share our experiences and responses with the rest of the network.

Compiled by

28.2.96

Dr Thelma Narayan
Dr John Oommen

CONSULTATION ON "PRIMARY HEALTH CARE - A CHRISTIAN MANDATE"
26TH - 28TH FEBRUARY 1996
New Delhi

PROGRAMME

Monday 26th February 1996

02.00 pm. - 04.00 pm	Registration - YMCA CCL Conference Centre
04.00 pm. - 05.00 pm	Tea
05.00 pm - 07.00 pm	Inaugural Function
Opening Prayer :	The Rt. Rev. Bishop S.R Thomas
Welcome:	Dr. P.S.S Sundar Rao, President, CMAI
Introduction:	Dr. Cherian Thomas, General Secretary, CMAI
Remarks:	The Rt. Rev. Bishop Lawrence Mar Ephraem
Inaugural Address:	The Rt. Rev. Bishop D.C Gorai
07.30 pm. - 09.30 pm.	Welcome Dinner - YWCA Blue Triangle, Ashoka Road

Tuesday 27th February 1996

07.30 am. - 08.30 am.	Breakfast
09.00 am. - 09.30 am.	Devotions - Rev A C Oommen
09.30 am. - 10.30 am.	Keynote Address - Dr R S Arole `PHC - Beyond MCH' Chairperson: Dr. C.M Francis
10.30 am. - 11.30 am.	Keynote Address - Dr Abraham Joseph `PHC - A priority for Hospitals' Chairperson: Dr. Thelma Narayan
11.30 am. - 11.45 am.	Tea
11.45 am. - 12.45 pm.	Keynote Address - Dr Prem C John `PHC - A people's movement' Chairperson: Fr. John Vattamattom
01.00 pm. - 02.00 pm.	Lunch
02.00 pm. - 3.00pm.	Keynote Address - Dr (Mrs) M Arole `PHC - A need for Empowerment' Chairperson: Dr A K Tharien

Gp Discn

03.00 pm. - 04.30 pm.	Group Discussions
04.30 pm. - 05.00 pm.	Tea
05.00 pm. - 06.00 pm.	Presentations by groups & Plenary discussions
07.30 pm. - 09.30 pm.	Fellowship dinner

Wednesday 28th February 1996

07.30 am. - 08.30 am.	Breakfast
09.00 am. - 09.30 am.	Devotions - Rev A C Oommen
09.30 am. - 10.30 am.	Plenary + Recom. Keynote Address - Dr Cherian Thomas `PHC - A need for networking' Chairperson: Dr. V. Benjamin
10.30 am. - 11.30 am.	Presentations by Overseas Partners
11.30 am. - 11.45 am.	Tea
11.45 am. - 12.30 pm.	Presentations by Overseas Partners (continued)
12.30 pm. - 01.30 pm.	Discussion
01.30 pm. - 02.30 pm.	Lunch
02.30 pm. - 04.00 pm.	Plenary and Recommendations
04.00 pm.	Closing Function

? Statement - Committee of 2-3

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50. United Mission to Nepal - Dr Bill Gould
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51. DIFAM - Dr Rainward Bastian
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52. E Z E - Erika Marke
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53. I C C O - Ms Maria Verhoevan
54. Ms Christina de Vries
The Netherlands

55. Lutheran World Relief - Rev Eugene Thiemann
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56. World Council of Churches - Dr Daleep S Mukarji
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57. Bread For the World - Ms Ingrid Ostermann
Germany

58. CEBEMO - Dr Jan Vorisek
The Netherlands

CASA

Questions for discussion

FIRST SESSION 2:00 to 4:00 pm

Yellow I

What is happening today in the national scene and in the Christian health network regarding Primary Health Care ?

Yellow II

What can concerned and sensitive Christian health professionals/workers do regarding Primary Health Care ?

Pink I

What are the implications of the emerging social, political and economic developments in India for Primary Health Care ?

Pink II

What can, and must, congregations, parishes, and fellowship groups do about Primary Health Care ?

Green I

What can, and must, Christian/mission hospitals do regarding Primary Health Care? What is their Christian responsibility ?

Green II

What is the responsibility/mandate of the Church for Primary Health Care ?

(Questions for Session II overleaf)

SECOND SESSION: 4:30 to 6:30 PM

Yellow I

Spell out a strategy for reorientating the direction of the country's health care towards Primary Health Care. What can be CMAI's role in this reorientation ?

Yellow II

Spell out a strategy for attracting, equipping and sustaining Christian health professionals/workers in the role you have identified for them in Primary Health Care ? How can the CMAI facilitate this ?

Pink I

Spell out a strategy, for reorienting the Christian/mission hospitals (especially the larger ones) towards their legitimate role in Primary Health Care. What can CMAI do to reorient its member institutions in this way ?

Pink II

Spell out a strategy, or line of action for getting Christian congregations, parishes and fellowship groups involved in the kind of role you have identified for them in Primary Health Care. What can be CMAI's role in this congregational involvement ?

Green I

Spell out a strategy of line of action for getting the Christian/mission hospitals (especially the more numerous middle level ones) actively involved in the kind of Primary Health Care that you have identified for them. What can the CMAI do to reorient its member institutions in this way ?

Green II

Spell out a strategy or line of action for getting the Church to accept and become committed to the role you have identified for the Church in Primary Health Care. What should CMAI do in this regard, as the Church's arm in the healing ministry?

Extracts from

Health For All : An Alternative Strategy

Issues & Conclusions

We are optimistic about the possibilities of bringing better health to the people of India. A new partnership between the health system and the people can release their tremendous c capacity to solve their own problems. The remarkable scientific advances of recent years can be adapted specifically to meet the needs of the poor and deprived rather than being focussed mainly on sophisticated care for the elite. Abundant demonstrations have shown what needs to be done to produce d ramatic changes in the health and w elfare of those in greatest need, especially women and children. We are, therefore, convinced that the goal of health for all by 2000 AD is realistic and practicable. The plan we have presented here is expected to help the country to achieve this goal through vigorous and sustained action. Its principal message is that this goal cannot be achieved by a linear expansion of the existing system and even by tinkering with it through minor reforms. Nothing short of a radical change is called for; and for this it is necessary to develop a comprehensive national policy on helath and to create an alternative model of health care services.

The basic challenges presented in this plan are to initiate an integrated plan of health, development and family planning, based on a hopeful vision of what can be achieved by the year 2000. It necessarily implies the adoption of several alternative policies which have been broadly outlined in this Report. No twenty year perspective should try to provide detailed prescriptions for implementation. That is essentially a task for the five year and annual plans; and in a vast and plural country like India, for each State Government and district authority to decide in the light of the national policies laid down by the Government of India. What this plan provides - and that is all what a plan of this type can ever hope to provide - is a frank analysis of the existing health situation, highlighting the gap between even minimal aspirations and the actuality, a comprehensive conceptualisation of where the country might be at the end of this century if this challenge is taken seriously, critical analysis of constraints and major policy options, a discussion of interlinkages and priorities, and an indication of the best strategy available to realise our objectives, with some idea of its administrative and financial implications. These are presented here in a format designed to be used by all those who will be most concerned with these issues, including leaders of public opinion. The various Chapters of this Report present the rationale and justification for the new directions proposed in the different health sectors and a fairly detailed indication

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Report of a study Group set up jointly by The Indian Council of Social Science Research and the Indian Council of Medical Research, New Delhi, 1980.

of the changes needed in programmes and strategies. In this concluding Chapter, we shall bring together our major conclusions and recommendations to facilitate the consideration of this document and to expedite action thereon.

Health for All by 2000 A.D.

Targets

What does this goal of health for all by 2000 AD mean in precise terms? We have suggested that this should mean the provision of good and adequate health care for all citizens - and especially for the poor and under privileged groups. In our opinion, this will imply a tremendous reduction in morbidity and mortality resulting in a fall of the total death rate from 15 to 9 and in the birth rate, from 33 to 21. This will also imply that the Net Reproduction Rate (which is now 1.67) will be reduced to one, that infant mortality would be reduced from 120 to 60, that the average family size from 4.3 children to 2.3 children, and that the total population of India may stabilize at about 1200 million by about 2050. This would indeed be a great break-through, not only in health, but also in development and family planning. We consider these targets as realistic and practicable.

If this goal is to be realised, a major programme for the development of health care services if course necessary, but it is not sufficient. Health is a function, not only of medical care, but of the overall integrated development of society - cultural, economic, educational, social and political. In fact, as we said earlier, good health and good societies go together. Health also depends on a number of supportive services - nutrition, improvement in the environment and education; and the influence of these services on health status is far greater than that of medical care. The major programmes which will improve health are thus outside the realm of health care proper. These were comparatively neglected in the last 30 years and that is one of the major reasons why the country has obtained such meagre results for its large investments in health. This error should not be repeated; and during the next two decades, the three programmes of (1) integrated overall development, (2) improvement in nutrition, environment and health education, and (3) the provision of adequate health care services for all and especially for the poor and underprivileged, will have to be pursued side-by-side.

Integrated Development

Poverty, inequality and ignorance are the greatest illness of the Indian society. The status of its women and children is low; they are both cheap and expendable. Health for all is an essentially agalitarian goal and it cannot be achieved in a society of this type. The integrated programme of development to be pursued over the next 20 years should therefore be basically aimed at reducing poverty and inequality, spreading education, and improving the status of women and children, as well as of the poor and deprived social groups. This will include the following:

1) Rapid economic growth with the object of doubling the national income per capita (at constant prices) by 2000 AD.

2) Full-scale employment, including a guarantee of work on reasonable wages to every adult who offers to work for 8 hours a day.

Creation of adequate opportunities of gainful employment to women, with an emphasis on equity of remuneration and reservations to make up for past neglect, so that women become 'visible' assets to their families.

3) Improvement in the status of women with a determination to check the adverse sex-ratio and to make it rise substantially upwards, say to 972, the level it was in 1901.

4) Adult education with emphasis on health education and vocational skills, the targets being to cover the entire illiterate population in the age-group 15-35 by 1991 and liquidation of illiteracy by 2000 AD.

5) Universal elementary education for all children (age group 6-14) to be provided by 1991.

6) Welfare of Scheduled Castes and Scheduled Tribes.

7) Development of an intensive and integrated programme of family planning.

8) Creation of a democratic, decentralised and participating form of government.

9) Rural electrification; and

10) Improvement in housing, with emphasis on the provision of houses for the landless and slum clearance.

We have recommended that the details of these programmes should be worked out and that they be implemented fully over the next 20 years.

Family Planning

Family planning should become a people's movement. This process would be facilitated by the efforts at integrated development and the education and organization of the poor and underprivileged groups. It is desirable that there should be a National Population Commission set up by an Act of Parliament to formulate and implement an overall population policy. The objective should be to reduce the net reproduction rate from 1.67 to 1.00 and the birth rate from 33 to 21. This will imply effective protection of 60% of eligible couples (against 22% at present). While the emphasis on terminal methods should continue, there should be far greater use of other methods as well. The accent should be on education and motivation, especially through inter-personal communication and group action. Incentives, especially those of a compensatory character, should be used. There should be concentrated effort to work with women as well as men. While the health care services have a role to play in motivation also, their main responsibility is to supply the needed services, and to undertake follow-up care. The alternative model of health care services has been designed to meet these challenges fully and squarely.

Nutrition

Among other supportive programmes, nutrition deserves priority because it is a major foundation of health. For this purpose, it is necessary to grow adequate food, to reduce post-harvest losses, to create an adequate system of storage and distribution, and to increase the purchasing power of the people by creating employment for men, and especially for women. It will also be necessary to give special attention to improving the nutritional status of women and children. Breast feeding should be encouraged and women trained and assisted to take better care of children through weaning at the right time and through a more efficient management of the child's diet in the immediate post-weaning period. Pregnant and lactating mothers should be given the special protection they need. Special Programmes should be developed for specific nutritional disorders like iron-deficiency anemia, or vitamin - A and iodine deficiencies. In addition, supplementary feeding programme may have to be organized for carefully identified target groups at risk.

Improvement of the Environment

The second supportive service is improvement of the environment. It will reduce infection and make programmes of nutrition itself more effective. Several programmes will have to be developed from this point of view. Safe drinking water supply should be provided to all urban and rural areas at an average annual estimated cost of Rs.7,500 million. In urban areas, the sewage disposal system will have to be improved by eliminating the basket service system in ten years, providing water seal latrines to all households who have no facilities at present, during the same period, and ultimately, installing good sewage disposal systems with essential purification works in all urban areas by 2000 AD. The estimated costs of this programme will work out to Rs.1,125 million per year. A massive programme of proper collection and disposal of solid wastes and their conversion into compost will have to be developed in all areas, the estimated cost being Rs.4,000 million a year on an average. In rural areas, an intensive programme of improving sanitation, with special emphasis on proper disposal of night soil, will have to be developed at an estimated cost of Rs.5,000 million a year. Greater attention will have to be paid to town and village planning (with special emphasis on removing the segregation of the Scheduled Castes), and large-scale programmes of housing for the rural poor and clearance of urban slums will have to be undertaken, with emphasis on the development of low-cost building technology. Urgent steps have to be taken to prevent water and air pollution, to control the ill-effects of industrialization and to provide better work-place.

Health Education

The third supportive service is health education. It gives information, teaches skills and cultivates attitudes and values which help an individual to be healthy. Health education is not also a one-shot affair: an individual will need it throughout his life. The best way to universalize health education and therefore is to make it an integral part of general education which, in its turn, will have to be life-long. In early childhood (0-5 years),

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turn, will have to be life-long. In early childhood (0-5 years), it is primarily the responsibility of the mother to give to to her child and she must be trained to do so. For older children (6-14 years), health education should be an integral part of general elementary education which should be universal. Health education suited to adolescents and youths should be an integral part of secondary and university education also. What is extremely important, health education should be an integral part of adult education.

The health personnel have three major responsibilities for health education. They should assist the general education system to provide health education by devising suitable programmes, training of teachers, production of materials and conduct of experiments. They have also an educational role with regard to every patient because all proper medical treatment often includes an element of health education. Finally, they have a very important role in which they try to give health education to the poor and under privileged groups who need it most. The Central and State Health Bureau should be reorganized and strengthened to help the health personnel to discharge these responsibilities. The mass media should be harnessed fully for purposes of health education.

The Alternative Model of Health Services

This brings us finally to the central problem of the action required within the health field itself to reach the goal of health for all by 2000 AD. As stated earlier, no meaningful results can be obtained by a linear expansion of the existing health services or by tinkering with them through minor reforms. We have, therefore, proposed that this model should be totally abandoned and a new alternative model should be created in its place.

This new model differs from the existing model in several important respects. It abandons the top-down and elite oriented approach of the existing services and is based or rooted in the community (which means a population of 1,00,000 which will have a Community Health Centre, a sub-centre for every 5,000 population and a village-neighbourhood centre for every 1,000 population) and then rises to specialised referral services at the district and regional levels. It gives up the over-emphasis which the present system places on large, urban hospitals and creates a small community hospital of about 30 beds in each community to meet the vast bulk of its referral needs. It moves away from the predominantly curative orientation of the existing services and integrates promotive, preventive and curative aspects at all levels. It redefines the role of drugs and doctors so that they remain the best agents of health care and do not develop a vested interest in ill-health. It gives up the centralized and bureaucratic character of the present system and adopts a decentralized, democratic and participatory approach which will involve the community intimately in planning, providing and maintaining the health services it needs. It strives to integrate the valuable elements in our culture and trudition (e.g. the ashrama concept of stages in life, nonconsumerist attitudes, sense of individual and

community responsibility, yoga and simplicity and self-discipline as the core of a life-style). It also strives to create a national system of medicine by giving support to and synthesizing the indigenous system. Finally, it abandons the over-expensive model of the health care systems in the developed countries and creates an economic model which will be within the reach of the country. It is our considered view that health should have the same priority as education and that both should receive about 6% of the national income by 2000 AD. This would provide all the funds needed to implement this model and to develop its essential support services. It is our recommendation that this model should be fully created, in a phased and planned manner, by 2000 AD.

MCH Services

In this new model, special efforts will have to be made to expand and improve MCH services which are now patchy and rudimentary. There should be an attempt to cover all women and children with basic services with special attention to those at risk. The dais should be trained and fully utilized, along with CHVs, at the village centre level with strong referral support from the MPWs. These services will be largely domiciliary. A detailed programme should be drawn up of the different services that will be provided at the village, sub-centre and community levels, and priorities in MCH activities should be clearly laid down. The MCH staff at each level should be adequate and should receive job specific training. Health education of the mothers should be an important component of MCG services and care should be taken to see that these services retain their essential character as services for women and children even while laying adequate emphasis on family planning.

The Communicable Diseases

The communicable diseases still form the largest cause of morbidity and mortality and the fight against them will have to be continued with still greater vigour in the years ahead. The existing programmes against malaria, tuberculosis, leprosy, filariasis, polio myelitis and Japanese Encephalitis will have to be strengthened, broadly on the lines indicated. Diarrhoeal diseases, especially those of children, need special emphasis. To develop these programmes on proper lines, it is necessary to develop a good surveillance system and a coordinated effort of all research institutes and the administration. By 2000 AD our object should be to eradicate (or at least effectively control) diarrhoeal diseases, tetanus, diptheria, hydrophobia, polimyelitis, tuberculosis, guinea-worm, malaria, filariasis and leprosy.

Rehabilitation Services

There are an estimated 60 million physically handicapped in the country. Every year, 5 million more are added. Despite this the rehabilitation services are poor and inadequate. Rehabilitation services should be integrated with other community health services. Rehabilitation workers should also be drawn from the community and health education will include rehabilitation education. New technologies suited to our life should be evolved using local materials and artisans

Personnel and Training

Under the new alternative model, the organization of the health services will be radically different from that in the existing system. A new personnel and training policy will, therefore, have to be adopted on the broad lines indicated. A new category of personnel, the CHVs, will be introduced and will be the main bridge between the community and the services. The middle level personnel will increase very substantially. This will include health assistants, MPWs, nursing personnel whose numbers will be much larger and whose status will need considerable improvement, and paramedicals. Very important questions about doctors will have to be sorted out; these relate to their numbers, training, remuneration and social conditions, value system and proper development of post-graduate course. The training and utilization of specialists and super-specialists will have to be reorganized from the point of view of effective utilization. Facilities for training in public health should be increased. There should be adequate arrangements for the continuous in-service education of all categories of health personnel. The Government of India should establish, under an Act of Parliament, a Medical and Health Education Commission, with comprehensive terms of reference. A continuing study of personnel and training and taking effective action thereon should be a major responsibility of this Commission.

Drugs and Pharmaceuticals

There is need for a clear-cut drug policy and a National Drug Agency to implement it properly. The pattern of drug production in the country should be modified to suit the disease pattern. The drugs required by the poor people should be produced in adequate quantities and made available at the cheapest prices possible. This applies specially to the few simple drugs required at the community level. It is also necessary compile a list of other essential drugs. The quantities needed of all essential drugs should be calculated and steps taken to see that they are produced. The production of high price and useless drugs needs to be controlled, the tendency of the profession to over-prescribe should be curbed. The production of basic drugs has to be made more selfsufficient and in this, the small scale sector needs to be encouraged subject to strict quality control. The dominance of the foreign sector should be reduced still further. Price control should be more effective; the cost on packaging and overheads should be reduced; the introduction of new drugs should be strictly controlled and proliferation of drugs by minor variations should not be allowed; the prices of essential drugs should be kept to the minimum, a higher mark-up being allowed, if necessary, in other drugs; and all essential drugs should be sold only under generic names. There should be adequate arrangements for quality control of all drugs, including indigenous medicines and R and D in drugs needs to be greatly encouraged. There is considerable imbalance in the consumption of drugs in urban and rural sectors of the health system which needs to be corrected and it may be desirable to move towards a system when the patient pays for the cost of drugs.

Research

The main problems in research are selection of priority areas, quality and utilization of research, improvement in research capability, and attainment of indigenous self-reliance. The priority areas obviously are: primary health care, epidemiology, communicable diseases (with special emphasis on diarrhoeas), environmental research, and research on drugs and problems of rural water supply and sanitation. It is also necessary to promote research on social aspects of medicine jointly under the ICMR and ICSSR, especially on the economics of health and financing of health services. Other important areas are indigenous medicine, health implications of industrial development, and family planning. Considerable attention has to be given to the development of appropriate technology. Side by side, there should be an emphasis on the development of clinical and basic research, particularly in the field of biology, and a determined bid to build up high level indigenous research capability with a view to attaining self-reliance.

Administration, Finance and Implementation

The introduction of the alternative model has large administrative and financial implications. From the administrative point of view, it is necessary to redefine the roles of the Central and State Governments in view of the large powers delegated to the local bodies at the district level and below. Voluntary agencies will have to function within the overall policylaid down by the State. But they should receive encouragement and aid, especially when fighting at the frontiers and doing pioneer work. There will be considerable tensions within the new health care services and need for redefinition of roles and mutual adjustment. This is the responsibility of the administration to secure through good leadership and proper training. The referral services should be strengthened and streamlined; a new and efficient national information system should be created; and adequate arrangements made for more effective coordination at all levels.

On the financial front, the total investment in health services will have to be substantially stepped up and the health expenditure will have to rise by about 7 to 9% per year (at constant prices). The existing priorities will have to be radically altered and the bulk of the additional resources will have to go into promotive and preventive activities, in rural areas, in the development of supportive services like nutrition, sanitation, water supply and education, and underprivileged groups. This will need taking of both positive and negative decisions. There should be adequate grants to local bodies and communities to enable them to discharge their responsibilities; and while the basic responsibility of financing health will continue to rest with the Centre and States, an effort should be made to tap local taxes and individual payments to cover drug costs.

The alternative model proposed here is a large step in the creation of a national health service, but it does not create it. In our opinion, the time is not ripe for the purpose and the issue may be examined in due course, say, ten years from now. There is, however, need to control private practice and it should not be allowed to employees in the public health care system.

Conditions Essential for Success

This, in brief, is the plan we have proposed, for realising the goal of health for all by 2000 AD. There can be no two opinions about its desirability, and what we have outlined is enough to show that the goal is realistic and feasible.

As we said at the opening of our Report, the country dedicated itself, when it adopted the Constitution in 1950, to create a new social order based on equality, freedom, justice and dignity of the individual and to eliminate poverty, ignorance and ill-health. This 'mid-term' review after three decades shows that, in so far as health is concerned, the country is still far short of its objective inspite of major advances in several areas. It also shows that an attempt to eradicate ill-health will not succeed in isolation and that it can be pursued side by side with the other two interdependent and mutually supportive objectives of eliminating poverty, inequality and ignorance, and against the backdrop of a socio-economic transformation which will give effective political power to the poor and deprived social groups. It is, therefore, necessary that the country rededicates itself to this task and strives to achieve its goals by 2000 AD. Succeeding generations will never forgive us if we fail to do so.

The attainment of this goal depends, above all, on three things: (1) the extent to which it is possible to reduce poverty and inequality and to spread education; (2) the extent to which it will be possible to organize the poor and underprivileged groups so that they are able to fight for their basic rights; and (3) the extent to which we are able to move away from the counter-productive, consumerist Western model of health care and to replace it by the alternative model based in the community which is proposed here. These are our tasks and it needs millions of young men and women, both within and without the health sector, to work for them. If a mass movement for this purpose can be organized and the people rededicate themselves to the realisation of their national goals, the country will be able to keep its trust with destiny at least by 2000 AD, if not earlier.
