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Com

BEING HEALTHY

(or)

HEALTH FOR ALL - NOW

INTRODUCTION :

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

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

WHAT IS HEALTH ?

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

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

HUNGER :

people who die of hunger are seen as dying of some disease or the other. A body weakened by hunger is a prey to every passi illness. A mild diarrhoea, an attack of measles, a chest infe a fever - which in a normal healthy person would be only a few inconvenience that would go away by itself, is enough to kill malnourished person especially children. Thus it is that the commonest cause of death of children are conditions like respi (chest) infection, diarrhoeas, measles, all of which need neve caused death at all but for the malnourishment.

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

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

A BALANCED DIET:

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

Grains like rice or jowar or wheat is the main food. It i chief supplier of energy for the body. The fats and oils are a rich source of energy and especially in children they are

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

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

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

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

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

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

COMBATTING HUNGER:

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

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

NUTRITION EDUCATION:

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

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

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

FOOD SUPPLEMENTATION SCHEMES:

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

SAFE DRINKING WATER:

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

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

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

There are however many areas in the country where availabi of any water is a great problem. In such areas enginnering wor minor or major will have to be taken up or new technologies lik desalination of salt water adopted.

ENVIRONMENT :

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

BIOLOGICAL ENVIRONMENT :

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

SHELTER :

However by environment we need also include the social environment. The provision of good shelter and clothing is o major aspect of this. A person with adequate clothing living in a well ventilated house which is not over crowded within the house or located in an over crowded area is far less like

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

EMPLOYMENT :

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

HEALTH EDUCATION :

To nearly all people much of this is common knowledge. Medical science has only helped establish that most disease result from a lack of these essential requirements. Medical

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

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

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

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

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

EDUCATION :

Obviously a literate person has far greater access to su knowledge than an illiterate person. Literary is an essentia component of health. But mere literacy is not enough. The l of general education is important. General education increas the 'health' literacy' of the people. It enables them to und stand their health problems and how to identify, prevent and

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

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

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

MATERNAL HEALTH CARE :

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

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

CHILD ¾ CARE :

The newborn child fed on breast milk from a healthy mother is likely to be healthy. Immunication pretects us against a

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

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

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

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

THE FAMILY PLANNING PROGRAMME :

India is one of first countries in the world to have a maj national family planning programme. Enormous resources have be spent on it - in the last five years plan period alone - more than 3000 crores have been spent on it. Nearly half the budget allocation for health care goes to family planning - yet the programme has not succesded. The crude birth rate over the last 1' years has remained static at about 31/1000 as against a 22/1000 that it was supposed to reach. Or in simpler words despite 3000 crores spent there has been almost no change at all in birth rate. The measage of family planning has been

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

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

PREVENTION OF ENDEMIC DISEASES :

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

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

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

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

OF DOCTORS:-

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

HEALTH POLICIES :-

If many doctors today to not do this it is also because

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

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

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SCIENTIFIC AWARENESS FOR PEOPLES BENEFIT - CHAI'S CONTRIBUTI

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

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

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

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

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

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

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

Our awareness building programmes are aimed at raising a critical consciousness level of the community so that

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

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

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

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

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

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

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

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

There are attempts to study and campaign against unnecessa surgical procedures such as Caesarean, Appendicectomy and

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

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

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

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

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BACKGROUND PAPER ON HEALTH AND PSM'S

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

BY DELHI SCIENCE FORUM.

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

POST-INDEPENDENCE EXPANSION IN HEALTH SERVICES

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

Table - 1

IMPROVEMENT IN HEALTH FACILITIES/CONDITIONS SINCE INDEPENDENCE

Year	Life expe tancy at	Infantmort ality rate	No. of hosptials	Population per bed	No. of PHCs	Doct per pop
1951	32.1	180	2694	3199	725	16
1961	41.2	165	3094	1930	2800	1

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

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

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

BALANCE SHEET OF HEALTH

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

- Only 20% of our people have access to modern medicine.
- 84% of health care costs is paid for privately.
- 40% of our child suffer from malnutrition. Even when the foodgrain oroduction in India increased from 82 million tonnes in 1961 to 124 million tonnes in 1983, the per capita intake decreased from 400gms. of cereals and 69 gms. of pulses to 392gms. and 38 gms. respectiv Due to increasing economic burden on a majority of the people, they just cannot buy the food that is theoreti- cally "available".
- Of the 23 million children born every year, 2.5 million die within the first year. Of the rest, one out of nin dies before the age of five and four out of ten suffer

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-- 50% of children and 65% women suffer from iron defi-
ficiency, anaemia.

-- Only 25% of children are covered by the immunizatio
programme. 1,3 million children die of diseases whi
could have been prevented by immunization.

-- 1/3 of the total population of India is exposed to
Malaria, Filaria and Kalazar every year.

-- 550,000 people die of TB every year. About 900,000
people get infected by Tuberculosis every year.

--nAbout half a million people are affected with lepso
which is 1/3 of the total number of leprosy patient
in the world.

-- 70% of children are affected by some intestinal worm
infestation.

-- 1.5 million children die due to diarrhoea every year

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

TABLE - 2

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

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

TABLE - 3

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

Source: GOI, Health Statistics of India, 1984.

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

TABLE - 4

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

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

Moreover, even these meager resources are not equitably distributed, 80% of the resources is spent on big hospitals an research institutions which are situated in metropolitan citie

TABLE - 5

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

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

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

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

Here another disturbing trend needs to be mentioned. In last few years there has been large scale investment by thepri sector on curative services. With encouragement from the gover for the first time in India big businesshouses are entering the of health care. In addition to the fact that they areexclusive meant for the elite, the trend is also an indicator of a certai of Philosophy within Goct. circles regafding health care. It kind of thinking which draws inspiration from a World Bank repo which says "present health financing policies in most developi countries need to be substantially reoriented. Strategies favo public provision of services at little or no fee to users and w little encouragement of risk-sharing have been widely unsuccess (de Ferranti, 1985). This, in other words, is a prescription f

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

LACK OF HOLISTIC APPROACH

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

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

out of four slums are the extremely insanitary environmental a hygeinic conditions in which the slum population is living". Further, while India accounts for more than 35% (3000 deaths ev day) of all deaths taking place in developing coun ries due to vaccine-preventable diseases, less than 25% of our children are covered by the Expanded Programme of Immunization. How prevent measures can alter the course of diseases is typified by Tuber- culosis. Drugs for treating Tuberculosis were discovered after Yet, 20 years earlier, the disease had been almost totally erad from Britain due to improvement in conditions of living. But e today, when numerous drugs have been discovered for treatment o disease, more thanhalf a miilion die of its every year in India

We have seen earlier that resource allocation is heavily b in favour of urban areas. Similarly the emphasis on curative se vices also reflects a bias in our planning process in favour of services vis-a-vis preventive and promotive services. As in oth walks of life, health services are a function of the political s of a community. They reflect the needs of the ruling sections, terms of resource and manpower allocation andin regard to the ch of technology. A holistic approach towards health care, taking to account the socio-economic factors influencing health, demand a level of conciousness which is lacking in our planning process

PRIMARY HEALTH CARE SYSTEM

The Alma Ata Conference defined Primary Health Care as "essential health care made universally accessible to individual and acceptable to them through their full participation and at a cost the community and country can affort". This concept was mooted as an alternative to the existing concept of comprehensive health care, which vieweed the people as mere receivers of curati services through doctors, health centres, dispensaries and hospit It based itself on four broad principles:

1. equitable distribution of health services.
2. community involvement
3. multi-sectoral approach
4. appropriate technology

3. Primary Health Centre Level-has a staff of 3 doctors (one female and two male) and other auxiliary staff. PHCs have facilities for laboratory tests, minor surgical procedures etc They are also responsible for training of health workers, maintenance of rec rds and for liaising with various National Heal Programmes.

While this 3 tier system is supposed to provide basic health care, there are a number of "national health programmes". The cover areas requiring special attention and include areas like Immunisation. Family Planning, Tuberculosis, Malaria, Leprosy Blindness, Child helath (ICDS)programme) etc. Thes programmes also known as "Vertical Programmes" are technically not part o the Rural Health Scheme but areorganised along independent lin with centrally administered control.

It is widely recognised that both the Rural Health Scheme and the vertical progra,,es are plagued with problems of inade facilities and resources. The annual report of the Ministry o Health and Family Welfare (1987-88) very candidly states "beca pf the resource constraints only 50% of the Community Health C would be established by the year 1990". In other words the targetted coverage of the PHC system by 1990 is just 50% Simil is the state of various vertical programmes. The Nutrition Fou ation of India in a study of the Integrated Child Development Service (ICDS) says " Though ICDS has been extended to cover mo blocks form time to time, the support it has received has been gruding and halting" and often "extracted after much struggle". The CAG report for the year ending March 31, 1987, has criticis the functioning of three major programmes viz. Blindness Contr Programme, Tuberculosis control programme and Leprosy eradicati programme. These programmes have been pulled up for improper non utilisation of funds, non release of sanctioned funds and l of planning andmonitoring of these programmes. The principal p problem with all the health programmes in operation has been a total lack of community participation and the consequent absens of accountability of theseprogrammes to the local community, which runs counter to the guiding principles of Primary Health

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

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

It needs also to understood that entry into medical college is by and large limited to those coming from a higher socio-eco stratea, predominantly from urban areas, who consequently find it difficult to conceive of working in rural areas. Even when uneploument among doctors is not uncommonm doctors are unwilling to take up jobs in PHCs. A two pronged strategy is required to tackle the situation. Medical curriculum has to be reoriented and entry into medical colleges needs to be regulated in a manner which ensures amorebalanced "mix" of students. Side by s incentives have to beworked out to attract doctors to the rural health schemes. After all its is impractical to believe that doctors ~~to the rural health schemes~~, are natutally fired by altruistic motives and with feeling of "service to the poor". At the same time, within the medical fraternity, there is a str resitance in changingehthe age old concept of health as function of doctors and drugs. Implementation of recent concept of prima health care requi es a certain degree of demystification of Medical Science. But within the established medical bureaucracy

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

COMMUNITY PARTICIPATION

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

1) They should be permanent residents of the local community,

Candidates after selection are trained for a period of a 3 months. After completion of their training the CHWs are given an honorarium of Rs.50 and simple medicines worth Rs.50 per month. They are free to continue in their earlier vocation, but expected to devote 2-3 hours every day to community health work.

As the CHWs scheme constitutes the Government's principal effort in implementing the slogan of "Peoples" health in peoples hands" it merits a closer look. Under this scheme around 4 lak CHWs have been trained. However the implementation and impact o the scheme raises a number of questions related to the whole con cept of community participation.

The CHWs scheme presupposes a degree of volunteerism in the selected candidates. Otherwise a stipend of Rs.50 per month this is far short of an adequate remuneration for the CHWs whose functions include - health education regarding preventive and promotive measures; encouraging participation of community in public health tasks; curative measures for treating simple diso and referrals to the next level (sub-centre). In other words th CHWs is also required to play a leadership role in the community However the methodology required to identify such personsis yer worked out. In practice the contradiction between inadequate re neration and high expectations is often resolved in one of two Either, after a short period of CHW stops performing the requir functions or dropts out of the scheme altogether. Or he sets h up as a private practicioner in the village. (In should be rea that the training imparted to them is often more than what a la section of unqualified practitioners/quacks in villages have received).

Moreover, while the CHWs main functions are related to pro motive andpreventive aspects, the village community almost invariably is more inter sted in his curative abilities. Thus the CHW ends up as another practitioner in the village, albeit partial Government support. The training programmes of CHWs ar also not flexible enough to take into account regional and cast community based differences in perceptions towards health. Thu a dichotomy exists between the CHWs own perceptions (with are

The tendency is to solicit support for any health programme from the village 'sarpanch" or other infleuntial members of the village which mostsareas means the "high" caste and landed sections. A similar modus operandi is applied whle choosing the CHW "acceptab to all sections" from the village community. This almost invaria means excluding the landless and poor peasants, who form a bulk of the population and are most in need of health services, from t decision making process.

The dificiencies enumerated above in CHW scheme are question which require to be faced squarely if community participation is to be the desired goal. Central to theprobelem is the question of acceptance by our village comm nities of the concept of preventive medicine. Today attempts at intoruducing this concept are carried out by initially gaining entry through curative servi In other words curative services are offered as the "carrot" to esnure to be acceptability of the programme, while preventive services are sought to be introduced through the "back door". Such subterfuge, which starts by not taking the local community i confidence, cannot bring about any significant deg ee of communit participation.

It needs to be recognised that communities are primarily interested in curative services because of theutter inadequacy of these services. As result this is pe ceived, and rightly, so the immediate necessity;. Can the people befaulted for such a ception when majority of them are denied access to even very rud tary curative services. Moreover the functioning of programmes atproviding p reventive carehasnot shown to thepeople the advant ges of preventive medicine. It is only whe, from their own expe people realise the advantages of preventive servicesthat one can expect a shift in perception.

Thus to sum up, for any tangible changes to takeplace in th field of health, radical redemarcation of priorities in the whol health care delivery system ha e to be initiated. Hard politica decisionsto greatly increase spending on health care have to be taken. For the Primary Health Care system to function adequa it has to be made answerable t local bodies. This in turn woul

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

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

CRISIS IN PHARMACEUTICAL INDUSTRY:

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

turnover of the Pharmaceutical Industry has increased by leaps and bounds and today, globally, it stands next only to the Armaments Industry. The growth of the Industry has been phenomenal in India too. From a turnover of Rs.10 crores in 194 it rose to Rs.1050 crores in 1975-76 and today stands at Rs.2350 crores.

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

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

Further, drugs differe from other consumer goods, in that while the consumers have a direct say in the purchase of consume goofd, such is not case for drugs. Drugs are purchased on the

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

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

INCORRECT PRIORITIES OF GOVERNMENT

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

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

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

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

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

There have been persistant demands that the Multinational companies should be nationalised. In fact this was one of the recommendations of the Hathi Committee set up in 1974 to go int the problems of the Pharmaceutical Industry. MNCs are still be allowed to operate in this country on the plea that they bring new technology. Yettheir record in the last decade shows that contribution in this field has been less than the Small Scale S

TABLE-7

COMPARATIVE CONTRIBUTION OF MNCs AND NATIONAL Cos

(Top 85 Cos.)

(Rs.in Crores)

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

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

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

ROLE OF VOLUNTARY AGENCIES

Probably the single largest contingent of Voluntary agencies are involved in work in thehealth sector. Unfortunately thenet ou

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

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

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

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

ROLE OF AIPSN

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

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

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

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

-- Models ofor Primary Health Care: Initially in a few selected

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

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Com H

A P&M APPROACH TO PRIMARY HEALTH CARE

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

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

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

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

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

Unfortunately despite the brilliant polemic and sweep of t declaration, its implementation lags far behind, and now 22 yea since its adoption in practical terms, at least in India, this great slogan has had little impact. Unfortunately the World Health Organization who gave this call, has its contacts limite to the health ministries and to medical and allied professional and it is to these sections that the task of implementing this programme went. One critic ruefully comments 'Handing over the implementation of PHC to the medical establishment was similar to handing over the implementation of land reforms to landlords One outcome was to attach 'health for all by 2000 AD' as a slog

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

It is possible today to campaign extensively for ensurin provision of the 25 essential drugs within 1 km of any habitat and for banning hazardous drugs. In select areas it may be ev possible to launch health education combined with collective a against diseases like guineaworm infestations which are poten tially easy to eradicate and even against di eases like leprosy & measles which are potentially eradicable even within the pres system with existing medical knowledge.

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

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

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

Even theoretical work, based on analysis of published data has a significant role to play. The drug policy is one area where health activists in India can take pride as being the sole force to have oppossed the government's consistent pro-industry and anti-health policies. And most of this inter-vention is based on study done by various health activists themselves. Similarly on patent law and on iodisation of salt,

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

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

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

When building such models one needs remember the past PSM experience, that successful campaigns need a critical size for

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

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

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

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

One major new area of contribution of PSMs is in adult

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

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

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

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

Health for All by 2000 A.D.

Resources

Dr. C.M. Francis
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Co

Resources for "Health for All by 2000 AD"

If "Health for All by 2000 AD" is not to become another slogan like the large number of "International Years" and "International Decades", we will have to mobilise all our resources towards that objective. Our greatest resource in this regard is our National Commitment to attain "Health for All by 2000 AD". That commitment should

(1) make each individual, family and community become their own agents for health

(2) enable us develop the needed health manpower and provide the needed financial and material resources.

The Government has to mobilise all resources to these ends, with the full participation and active involvement of the community. All sectors must contribute towards health, as it is a goal and a means for developme There are sectors in agriculture, industry, public works, education, etc, which have important contributions to mak towards health. Our providing resources will depend on whether we consider health as a consumer item or as a means of increasing the productive capacity of the factors of production--labour, land and capital - that ma result in health care? If health care merely restores or maintains the well-being of the people but does not add to their productive capacity it has to be considered as consumer goods, however it is clear that health care is an investment; by improving the quality of life, persons become more productive and hence adds to the economy of t country.

"Health for All" should basically provide primary health care for all. There should be a minimum programme involving

(1) promotion of health
(2) prevention of disease
(3) care of the sick and cure where possible, and
(4) rehabilitation

These have to be achieved by

(1) health education : This would involve all attempts at making the individual, family and community assume responsible roles for promotion of health, with greater self-reliance - both formal and non-formal education can be used. The mass media could be utilized, with a little more imagination and not much more financial inputs.

Excluding the age group 0 - 4, India has 307 million

During the school years, it is easy to inculcate th principles and practices of good health. Well-planned steps have to be taken at all levels of school and University education. This would not only help the school goers but also help in creating better health awareness in their families and the social groups in which they live. The National Council of Educational Research and Training has made some efforts in bringing about some behavioural changes but not enough. The concept of healthful living has to be included in the different disciplines and with the use of all types of educational materials. These do not involve any additional expenditure over and above what is spent in the educational sector.

(2) Nutrition: Activities have to be directed towards t production and supply of food and to improve the nutriti status. We have seen that even though India has achieve self-sufficiency in food production, the distribution ha not been such that all can benefit; the purchasing powe of large numbers of people, especially the marginalised people, is very low. The expenditure on food and drinks in India is about 63% of the income; this is one of the highest in the world, next only to Sri Lanka, among the 43 countries surveyed this year by the World Bank. Ther is no prospect of increasing this amount. In spite of s a proportionately enormous segment of the income, nutri- tional anaemia is common especially among pregnant women and young children. Many women die during pregnancy or childbirth because of anaemia; it is also responsible for premature or still births. Measures have to be undertaken for greater distributive justice with respect to availability of nutritious food and supplements to vulnerable groups.

(3) Immunization programmes: We have still with us many infectious diseases, which can be prevented by immuniza- tion programmes. The new expanded programme of immuni- zation should reduce the prevalence of these diseases. The cost for this programme has been worked out by World Health Organization and the materials are being made available.

(4) Eradication and control programmes: The programmes o eradication and control for the major diseases have to be followed up vigorously. This would include attacks on malaria, tuberculosis, blindness, leprosy and filariasis. Measures will have to taken to reduce the incidence of parasitic infestation, which takes a big toll as far as morbidity is concerned.

(5) Water supply and sanitation:

The Ministry of Works and Housing have drawn up a Water Supply and Sanitation Plan for 1980 - 90 in line w

The requirements of funds for fulfilling the targets set for 1990 are (in crores of rupees)

Urban water supply	- 3044 (100% coverage)
Urban sewerage	- 2432 (80% coverage)
Rural water supply	- 7057 (100% coverage)
Rural sanitation	- 3301 (25% coverage)

This has been studied again in an effort to reduce cost; with low unit costs and use of local community resources, the central Public Health and Environment Engineering Organisation has worked out the cost as

	Rupees in crores
Urban water supply	- 2,475
Urban sewerage & Sanitation	- 2,590
Rural water supply	- 4,288
Rural sanitation	- 1,584
Total	- 10,877

The draft VI Plan provides about Rs. 2700 crores for water supply and sanitation cover. The present annual le of investment is, on an average, Rs. 540 crores. It has t be increased to about Rs. 1,088 crores p.a. during the dec if the targets are to be achieved.

Many underdeveloped countries are making efforts to provide drinking water to all and sanitary disposal of was Bangla Desh is scheduled to achieve the target of protecte drinking water supply in every village within 200 metres o any household, within the next 2 years, with massive aid from World Bank.

4. Primary Health Centre

The sheet anchor of our primary health care is the primary health centre with the subcentres. While we start well, our progress has been tardy. There ought to be at least one primary health centre for 50,000 population (20,000 in hilly areas) and one subcentre for 5000 populat (one subcentre for 3000 population in tribal and hilly are But we have a backlog in establishing primary health centr and subcentres. We have at present 5471 PHCs; we will hav to have an additional 9000 PHCs by 2000 AD. It has also been decided to upgrade 1 in 4 PHCs as the first point of referrals; about 3700 PHCs will have to be upgraded. A these require enormous inputs by way of finances and mate-

mate-

and utilise locally available material and cheaper methods of construction, we should be able to reach our targets.

These primary health centres and subcentres must provide primary health care which should be comprehensive to the extent possible. The priorities must be for promotion of health and prevention of disease. In whatever way the Health Administrators may see the needs, the immediate needs for the people are cure where possible and care of all illness.

The Primary Health Care should address itself to the cure and care of the commoner diseases.

Among these are

1. Respiratory diseases, including tuberculosis
2. Parasitic infections
3. Injuries and accidents
4. Infections of various kinds, fever, influenza
5. Gastro-enteritis/diarrhoeal diseases
6. Abdominal pain; back pain
7. Insect bites and stings

5. Laboratory Service at Primary Health Care Level.

A Laboratory Service usually exists only at the Hospit with only rudiments of such a service at the Primary Healt Centre and none at all at the subcentre. Provision of a reasonably competent Laboratory at the Primary Health Leve is a necessity. This can be managed with a trained technician. Many of the underdeveloped countries like Indonesia, Malaysia, Sudan and United Republic of Cameroon, have Laboratory Services at their Health Centres. Without simp reliable laboratory services at the primary level, health cannot be improved. The techniques must be adapted to the local possibilities and resources. These could be supervised by periodical visits by senior laboratory staff from the referal centres. Quality control is necessary to ensure that the results of the investigations are reliable

6. Community participation

Community consists of all the families living in the area without any reference to their occupation or social o economic status. Community involvement would contribute to a significant reduction in the costs of projects and al ensure better management. It is also prudent to charge a small charge to the beneficiaries (perhaps for every house hold), as the services will be better appreciated and prop erly utilized

7. Legislation: In a country like ours, sensible legislative measures are needed to improve the health of the people. This is particularly so with respect to legislative protection of the people at work (both inside the factory and outside the factory) and pollution control With increasing industrialization, measures should be take ahead of the establishment of the industry to avoid pollut and, if there are health hazards, legislation must provide to reduce their effects. In Great Britain based on the report of the Committee appointed by the Ministry of Housing and Local Government (under the chairmanship of Sir Hugh Beaver) to go into the question of pollution whi resulted in about 4,000 deaths attributed to smog in December 1952, the Clean Air Acts were enacted. There was a further report on the environmental pollution (1971-73) which preceded the Composite Control of pollutio Act of 1974. The appointment of such commissions and the legislations following them depend to a very large extent on the public opinion, created by pressure groups, lobbies or individual enthusiasts. A report "A Blueprint for Survival" by E. Goldsmith (1972) created a lot of interest in the public and led to Governmental action. The public opinion may be expressed through meetings, press, radio, television or other mass media.

Legislation is also necessary to protect the developm of industries including the pharmaceutical industries. Capital intensive machinery is being imported displacing the local labour intensive ones and adding to pollution. economic deprivation which follows leads to poorer health of the marginalised people. Legislation must be aimed at protecting the small scale industries and also the labour intensive industries, if India is to provide employment to the large numbers of people and lead to economic growt and better distribution of wealth.

Not all companies based in developed countries which go to developing countries to set up factories show the same civic-mindedness which they show in the developed countries. They usually have high standards of safety and occupational health in the parent countries; this may be either by choice or by compulsion. When they set up factories in the developing countries these high standards are not often observed. These industrialists sometimes try to take deliberate and undue advantage of the less knowledgeable Governments and people in the developing countries, resulting in pollution and health hazards. Legislation should be brought out such that these transnationals have the same standards in India as they have in the country of origin. In India there a many Acts like the Factories Act, Mines Act, Tea Planter Act, Dock Labourers Act and so on, which have provisions health cover, but in the majority of instances such coverage is not adequate quantitatively or qualitatively

Very often the legislations which are already prese

in Mines and Quarries by the Department of Industries, Occupational Health by the Department of Employment or the Department of Agriculture, Hygiene in Food Handling Institutions by the Department of Health and so on. Such fragmentation and the multitude of departments will not be dondusive to the effective control of the problem which are allied and intertwined.

Health Man Power

In the resources for health care the most important critical will be the human resources. It is necessary t we make all efforts to develop their skills, knowledge, and capacity for the betterment of health. Health manpo development could be thought of in terms of the demand f the health personnel and the need for them. It is necessary to make a judicious decision as regards the number and types of health personnel necessary for delivering primary health care. Once such a decision is we can proceed to the training of these personnel. Such persons could be manning the hospitals, rural health complexes including the peripheral centres, laboratories and activities such as health education.

I shall not deal with man-power resources developmen and the cost of such development. Today, India has enou information on the cost of the training programmes and deployment of personnel of different categories. We also know the availability of manpower; various targets and projections have also been made to meet the needs of health care. The cost-benefits and cost-effectiveness have also been analysed. But till we know our options a our readiness for substitution, if necessary, it will be meaningless to forecast our requirements.

Financing

There is little accurate information available on the extent and kinds of sources of health care finance, except for the direct sources such as that provided by the Government, Centre or State. In India where there is a mixed economy, the biggest single source for health care financing has come from the general tax revenues. In view of the low gross national product in India the allocation from State revenues is limited. The per capita income is very low (India being one of the poorest countries) and the amount available after meeting the immediate direct necessities is small. A recent study by Earthscan has shown that the mean expenditure on food in India is 63% of the income. Under the circumstances increase in taxation and increase in allocation are both difficult to achieve. With a low priority for health the budget allocations for health are usually small, and unfortunately has been showing a tendency to be reduced. Budget projections usually involve overestimates of tax collections and underestimates of expenditures. When unforseen expenditures become necessary like increase in pay of Government employees etc., the funds actually available for disbursement for all sectors fall short of expectations. The immediate priorities have to be met. The health sector which often lacks strong political support and direct demand by the people may then receive proportionately lower disbursements than had been projected in the national budget allocation: net result in this particular source of finance is stagnant or even receding.

The levels of resource allocation varies from State to State, both with respect to the amount per capita and the percentage of the State revenue. It has produced disparities in the health care available in different parts of the country and therefore in the quality of life of the people concemod.

Deficit Financing: This may be either a part of the entire budget allocation or specifically for health care. It is done by borrowing both domestically and internationally. The borrowing may be for specific projects which directly or indirectly bring about health benefits like water supply, sewage and drainage systems or irrigation systems. Domestic borrowing has an advantage in that it mops up domestic savings. International borrowing could be from bi-lateral or multi-lateral foreign aid in the form of long term, low interest loans. These loans are very often limited to the cost of imports required for developing the projects. Much of the aid provided by the donors requires that purchases be made in those countries. This is disadvantageous for a number of reasons. The most important is that it limits the flexibility of the recipient country to look for the more suitable imports. It also costs the recipient country to purchase relatively higher cost goods and services which could have been procured at a cheaper price elsewhere. It also produces dependence on the aid giving country for the technology and service and maintenance later. Aid loans usually

advantage is that it makes immediate progress possible at the exis ting costs and prices.

Social Insurance Finances: Social Insurance Finance may cover health care invalidity and old age of employed workers (and often of their families) by imposing mandatory insurance payments as a percentage of their wages and by imposing on their employers a similar payment; in some cases the Government is a contributor to the scheme. The best example in India of such financing is the Employees State Insurance Schem It is a major source of finance for health care and looks after the persons who are involved in production in Industry. Its principal shortcoming is its limited coverage. The large majority of labour forces, artisans, petty traders etc., are not covered; whatever coverage exists is for the better paid and better organised sections of the society. One of the forecasts when Employees State Insurance Scheme was started was that it could ultimately evolve itself into a national health insurance system with universal coverage. This hope has not materialised.

Government Workers and public sector workers derive many medical and health care benefits apart from the Employees State Insurance Scheme: so also private sector industries give coverage for their employees who are not covered by the Employees State Insurance Scheme. These are hospital-based, doctor-centred programmes and their impact on the health of the people is not very large. Recently efforts are being made to take care of the health of the workers and not merely attend to them when they are sick. One such effort is that of the Ross Institute Unit of Occupational Health of St. John's Medical College. There are complete

(1) pre-employment check-up

(2) periodical check-up and

(3) monitoring of the environment.

Advice is given to the management such that steps can be taken at tho the earliest.

Lotteries: Some State Governments run lotteries for various purposes; some of these may be earmarked for health and other social services. The amount which is available through lotteries is however not an important component of the total health sector finances. A major p-art of the amoun collected has necessarily to go as prize money to winners. The expenditure is large proportionate to the receipt such that the net income is low. Further, lotteries are particularly burdensome on the earnings of the lowest income segment of the population, who are attracted to try to get a windfall even though the chances of winning are extremely small.

Private Sources: Private sources of financing health care in our country are not yet fully developed.

Direct Employee Financing: Many sectors have worked out private health care for their employees. This is particularly so in the larger industries and enterprises. It is especially important in remote geographical areas where accessability is difficult. One example of this will be KHDP & Company which provides health care to their em-

these and other agencies in monitoring the health conditions, identifying factors which function contrary to positive health and take measures to provide healthy living.

Private Health Insurance: Private Health Insurance has been carried out only to a slight extent in India, unlike countries like the United States of America; it usually covers only medical care of the sick. The premiums are acturially determined and there could be individual or group insurance.

Charitable Contributions: The amount that is made available for health care by charitable contributions is not fully known; these can be by contributions in the country and contributions from abroad. It may be by wealthy individuals, families, business enterprises, trusts or religious bodies. These contributions often enjoy tax deductions which work as incentives to give large amounts as contributions. One of the difficulties in these charitable contributions is that the donors might have priorities which do not coincide with the most pressing health needs of the population involved. Very often these donors prefer to provide physical facilities aand large equipments as visible evidence of their charity. Funds are provided for construction of buildings for hospitals and donation of sophisticated equipments. Other sources have to be found to provide for operating budgets; often it is very difficult to find funds to meet the recurring expenditure.

In many parts of India religious organisations have been the first to introduce modern medicine. Very often these health centres have been models of excellence in the quality of service provided because of their dedication to service. Some of the largest charitable contributions come from foreign organisations in the form of grant aid. In 1978, 4,700 organisations in India received 297 crores in foreign exchange from donors abroad, mainly for social services. A large chunk of these foreign donations has gone into health related activities. One of the defects in these large foreign aids is a dependency for funds, material and technology and a tendency not to use sufficient care in the utilization of funds.

Direct Household Expenditure: A major part of expenditure on health care is a direct expenditure by the persons who wish to have the health care. Payments are made directly to the provider as fee for services and as price for the product purchased. Very large amounts are spent in this way and we can have only very crude estimates of amounts thus available.

Community Help: With the awakening of different sections of society more and more are coming forward with self-help programmes. This is still in an infant stage but there are numerous examples. One such is the Mallur Health Co-operative, in which the members of the co-operative have a self-sustaining programme. If such programmes can be multiplied wherever feasible, considerable finances can be mobilised to take up local projects which improve the environmental sanitation. It can also take up specific disease eradication programmes.

The consumer demand for health care varies from place to place.

Pharmaceuticals for Primary Health Care

One of the recommendations of the Alma Ata Conference has been with respect to the production, import, distribution and utilization of drugs and pharmaceuticals to ensure the availability of essential drugs at feasible costs.

Though some advances have been made by the Pharmaceutical industry in the country, India is lagging far behind in the provision of pharmaceuticals for the people. The amount that is utilised for the purchase of drugs and pharmaceuticals by a person in India is extremely small compared to what is used in the developed countries and even in some of the developing countries. While increase in expenditure of drugs is not an indicator of health it is necessary that a certain minimum amount is available for the purchase of drugs and pharmaceuticals to care for the sick. A look at the amounts spent by some countries is revealing.

Estimated purchase of human pharmaceuticals (1975)

	Per capita Average
West Germany	US$ 53.35
Japan	38.45
U.S.A.	35.05
U.K.	19.50
India	0.75

Not only is the consumption of pharmaceuticals low in India but even for the low consumption, the production of pharmaceuticals is not enough. The financial requirements for the manufacture of bulk drugs have been estimated to be Rs.720 crores for 1983-84, with a production of formulation of Rs.2,160 crores. The investment in the public and private sectors is of the order of Rs.150 crores and Rs.400 crores, leaving a gap of Rs.1,610 crores. We are still dependent almost entirely on other developed countries for these products. In the International trade in medicinal products there is a wide disparity between the developed countries and the developing countries.

International trade in medicinal products 1969-1974

	Imports		Exports	
	1969	1974	1969	1974

Ten countries in the world accounted for 86.8% of all the exports in 1969 and 84.4% in 1974. These countries are therefore in a position to control the production of drugs as regards the nature of the products, the priorities and the final prices. Modern drugs are mostly chemical substances derived from petro-chemical or fermentation industries. The German chemical industry was the only major international supplier before World War I. Later other developed countries joined them, especially when it was found that the Germans withdrew their supply of some of the more important drugs from the international market; the countries involved also put large duties on the imports discouraging the imports of these drugs and thereby helping the indigenous production of the drugs. The State acted as a facilitator in the growth of the pharmaceutical industries in the countries and was mediator between interests of the industry , the medical profession and the consuming public.

Large capitals, modern technology, expertise and extensive promotion activities are necessary in the highly sophisticated pharmaceutical trade and there is a concentration of these industries in the developed world. The Pharmaceutical industries are often a part of the activities of the firm which is mainly a chemical industry. Hoechst which ranked 2nd in world wide drugs was one of the 8 largest companies in the world of overall net sales in 1976. Bayers which was among the top 15 transnational companies in total drug sales was one of the most successful firms in the world, in regard to the overall net sales in 1976. Most of the leading transnational companies dealing with pharmaceuticals have widely diversified interests. A country like India has little chance to compete.

Research and Development: Research and Development are often geared to the needs of the more developed countries (because of the greater purchasing power) and carried out in the technologically forward countries. The developed countries have different prevalent disease patterns from those in the under-developed countries. There is a change from communicable and parasitical illnesses to chronic and degenerative such as heart disease, cancer and various stress-related diseases. This would mean that lines of research which could have yielded beneficial results in tackling health problems of countries like India by development of cheaper andefficacious drugs may not be followed up.

There is a possibility of a geographic redistribution of industry based research. This is evident in some of the countries like Mexico and Hongkong. It is because (1) certain development costs particularly for research personnel are lower in developed countries, (2) the requirements for testing human subjects are less formidable and (3) delays in registration of new products are shorter. Nevertheless this change in allocation of part of production and development of drugs has not affected the industrialised countries' disease orientation of the Transnationals.

Patent: The great majority of patents registered in the developed countries are in the chemical sector and among them a great majority concern drug products, but the nationals within the group of developing countries own only 6% of the total number of patents; a ll the remainder were by other countries. Very few of the patents registered by foreigners are actually worked in the developed countries. The Patent holders very often decide not to use them and therefore do not develop them and also prevent others from developing the product; the patent has worked adversely in providing the

Promotion: Many of these drugs are given intense promotion by various advertising means when doctors become used to recommending the drug by its brand name, and not by the generic name. One drug may be known by a very large number of different brand names and depending upon the capacity to advertise and exploit, the same drug marketed by different firms may be sold at different levels in different countries. There are certain countri which are now insisting on purchases being made by generic names. Some of the developed countries like Norway have national formularies and purchases had to be restricted to the drugs found in the formulary. The total number of drugs in the Norwegian formulary comes to about two thousand whereas in India there are over 15,000 products in the market, most of them being duplicate products. It has been estimated that marketing expenses were equivalent to 15 - 35% of the sales and represent roughly 3 times the expenditure on research and development.

Pricing and Profitability: Only a small proportion of the selling price of the drugs represents direct cost of production. Even where the substance has been produced by the same manufacturer, costs vary greatly between the various distributors. The firms often get monopolies by various methods and therefore are able to fix the price. The US Trade Commission found that the first company to patent Tetracycline, Messrs. Pfizer, was directly responsible for "procurement by misrepresentation" of monopoly control over tetracycline. It was found that Pfizer and Cynamid had concluded a secret agreement by which Cynamid withdrew its application for patent for tetracycline after accepting an offer from Pfizer to divide up the market for the drug.

Pricing pattern is often higher in the developing countries. For 100 tablets of 10 mg librium the cost was

U.K.	-	0.83 US$
Mexico	-	4.42
Costa Rica	-	7.03

The transnational companies have charged whatever the national market would bear.

One of the ways in which the prices are manipulated is by transfer pricing. The prices of intermediate chemicals which are produced only by a few firms are fixed at different levels and supplied at different costs t imports by subsidaries or joint operations in developing countries.

U.K. has a system of negotiating profits with pharmaceutical firms. Hoffman La-Roche, the biggest manufacturer of drugs in the world, included the costs of active ingredient of Librium at £437/- per kilogram. When operations and overhead costs in the United Kingdom were computed the

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WORLD HEALTH ORGANISATION

REGIONAL OFFICE FOR SOUTH EAST ASIA

ROLE OF INTERNATIONAL AGENCIES IN PRIMARY HEALTH CARE

by
DR. RO KO

1. Introduction

Of late, we have been talking and hearing a lot on Primary Health Care and I believe, the word 'PHC' is quite well known/and quite familier to most people. Though the practice and approach of PHC will vary from situation to situation and country to country, there are certain basic principles which can be applicable anywhere. The two most striking features in PHC are the utilisation of some form of volunteer workers and the predominant role placed on the community. Since the PHC programme is conceived as an inter sectorial programme which is to be shaped around the life pattern of the people, in many countries, PHC is understood or misunderstood as a simple and cheap health care of the people which can be organised successfully by lay people ignoring the importance of professional leadership. I like to stress the important role of the medical profession underlinin its leadership role in Primary Health Care, without of course, meaning to undermine or challenge the overriding importance of community participation. I feel that at the same time I should reiterate the vital role of team approach, where, the professionals, the para-professionals and the auxiliaries participate in their respective part.

2. Definition

There are a number of ways of defining primary health care, but for the purpose of this discussion 'Primary Health care is taken to mean a health approach which integrates at the community level all the elements necessary to make an impact upon the health status of the people. Such an approach should be an integral part of the national health care system. It is an expression or response to the fundamental human needs of how can a person know of, and be assisted

in the actions required to live a healthy life and where can a person go if he/she needs relief from pain or suffering. A response to such needs must be a series of simple and effective measures in terms of cost, technique and organization, which are easily accessible to the people in need and which assist in improving the living conditions of individuals, families and communities. These include preventive, promotive, curative and rehabilitative health measures and community development activities'.

3. Principles in Primary Health Care Approach

This approach can be summarized by the following general principles which should be adhered to if primary health care efforts are to be successful:

i) Primary health care should be shaped around the life patterns of the population it should serve and should meet the needs of the community.

ii) Primary health care should be an integral part of the national health system, and other echelons of services should be designed in support of the needs of the peripheral level, especially as this pertains to technical supply, supervisory and referral support.

iii) Primary health care activities should be fully integrated with the activities of the other sectors involved in community development (agriculture, education, public works, housing and communications).

iv) The local population should be actively involved in the formulation and implementation of health care activities so that health care can be brought into line with local .. needs and priorities. Decisions upon what are the community needs requiring solution should be based upon a continuing dialogue between the people and the services.

v) Health care offered should place a maximum reliance on available community resources, especially those which have

stringent cost limitations that are present in each country.

vi) Primary health care should use an integrated approach of preventive, promotive, curative and rehabilitative services for the individual, family and community. The balance between these services should vary according to community needs and may well change over time.

vii) The majority of health interventions should be undertaken at the most peripheral practicable level of health services by workers most suitably trained for performing these activities.

4. Role of International Agencies

In conformity with the principles of primary health care , primary health care approach is essentially a self-help approach relying on the resources and efforts of the community itself. However, the programme needs a strong political commitment by the Government with its full technical and administrative support. UN and bilateral agencies, which are always coordinating and assisting Member Governments also have their role to play in the planning and implementation of primary health care programme. The respective role and area of interest for individual agencies is given as follows:-

1. UNDP: From general development point of view. PHC as a part of general development
2. WHO: PHC as a part of general development as well as integral part of health delivery system.
3. UNICEF: PHC with relation to basic services of the children.
4. UNFPA: PHC as an instrument in delivery of family planning.
5. IBRD: Socio-economic development as a basis of health development and health as an important contribution to general socio-economic development.

....4/-

6. ADB: In recent trend of moving into field of population, family planning and health, PHC found to be a feasible area of support.

7. ESCAP: Interested in PHC in the context of the integrated programme on rural development.

8. Bilateral Agencies:

   1) USAID
   2) SIDA/SAREC
   3) IDRC/CIDA
   4) NORAD

9. OTHERS

   1) League of Red Cross Societies
   2) International Union Against Tuberculosis
   3) World Federation of Public Health Associations
   4) International Union of Nutritional Sciences etc. ~~etc.~~

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BANERJI/
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COMMUNITY HEALT
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BANGALORE - 56

NATIONAL SEMINAR ON PRIMARY HEALTH CARE
7TH & 8TH NOVEMBER 1977. NEW DELHI.

1. AGENDA & PROGRAMME

1. Inaugural Meeting.
2. Alternate Approach on Primary Health Care (Countries Experience).
   Dr. V.N.Rao.
3. Role of International Agencies in primary health care- Dr. U. Ko
4. Health Planning Specially in relation to Primary Health Care –
   – Shri C.R.Krishnamurthy.
5. Proposed Rural Health Scheme, concept of primary health care as an integral part of the National Health Service. –
   – Dr. B.C. Ghoshal,
6. Feasibility of utilizing indigenous system of medicine in primary health care delivery – Dr. P.V. Kurup.
7. Principles and Practice of Primary Health Care – Dr. P. Diesh.

MONDAY THE 7TH NOVEMBER 1977

2. P R O G R A M M E

9.00 – 10.00 Hrs.	–	Registration.
10.00 Hrs.	1.	Invocation – R.A.K.College Students
	2.	Welcome Speech – Shri C.R.Krishmanurth
	3.	Inaugural Address – Shri Rajeshwar Pra
	4.	President's Address – Dr. P.P.Goel.
	5.	Vote of Thanks – Dr. B.C.Ghoshal.
11.00 Hrs.	–	Coffee Break.
11.30-13.30 Hrs.	–	Plenary Session

Chairman – Shri K.P.Singh, Addl. Secretary(

Presentation of the following papers:

1. Alternate approach on Primary Health Car (Country's experience) – Dr. V.N.Rau, D.D.G.(I.C.M.R
2. Health Planning specially in relation to Primary Health Care –
   Shri C.R.Krishnamurthy, JS(
3. Proposed Rural Health Scheme, concept of primary health care as an integral part of the National Health Services –
   Dr. B.C.Ghoshal, ADG(HA)

4. Feasibility of utilising indigenous system of medicine in primary health care delivery -

Dr. P.V. Kurup, Adv. (ISM).

Discussion of the above papers presented .

- Formation of groups.

13.30-14.30 Hrs. - Lunch Break.

14.30-17.00 Hrs. - Group Discussions.

Divide into discussion group as follows:

Group I Service Priorities within Primary Health Care.

Group II Role of Primary Health Worker.

Group III Relationship between Primary Health Workers and other health workers in the Block.

Group IV Community Participation and Multi-sectoral Approach.

Group V Guidance/Supervision of Primary Health Work

(Coffee will be served in the meeting)

TUESDAY THE 8TH NOVEMBER 1977

Plenary Session

9.30-10.00 Hrs. Review of Previcus day's Group Discussions.

- Open Discussion.

Chairman - Dr. R.M.Varma, D.D.G.(RH).

10.00-11.00 Hrs. 1. Role of International Agencies in Primary Health Care - Dr. U. Ko Ko, Asstt. Director, W.H.O.

2. Principles & Practice of Primary Health Care -

- Dr. P. Diesh.

11.00-11.15 Hrs. Coffee Break.

11.15-13.00 Hrs. Divide into group as follows:

Group ~~II~~ ~~Assessment of requirements of Primary Health Workers~~ - Critera for Selection for training.

Group ~~II~~ ~~Range of activities~~ and Training of the Primary Health Worker.

Group ~~IV~~ Training and utilisation of workers in ~~existing~~ indigenous systems.

..../3/-

Group IV — Development of training materials.

Group V — Reorientation training for existing Health Personnel.

13.00-14.00 Hrs. - Lunch Break.

14.00-15.00 Hrs. - Plenary Session.

Discussions on Group Reports.

Chairman - Shri C.R.Krishnamurthy, JS(K).

Group Rapporteurs to prepare their reports with conclusions and recommendations.

15.00-15.30 Hrs. - Coffee Break.

15.30-17.00 Hrs. - Plenary Session

Adoption of conclusions and recommendations by Workshop - Rapporteurs.

Vote of Thanks - A representative of the Participants.

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PRIMARY HEALTH CARE

A WHO STUDY

PRIMARY Health Care is essential health care made accessible to everyone in the country ; care given in a way acceptable to individuals, families, and the community, since it requires their full participation ; health care provided at a cost the community and the country can afford.

The Primary Health Care approach forms an integral part of the country's health care system, of which it is the keystone, and of the overall social and economic development of the nation and the community. Primary Health Care attacks the main health problems facing the community. and does so through promotive, preventive, curative and rehabilitative actions as they are needed. Since these actions grow out of the real-life conditions and social values of each country, they vary from country to country. Since underdevelopment and poverty are major factors in causing ill-health, national development can contribute greatly to better health ; specially those components that raise the incomes of the poor, such as rural development, agrarian reform, and the promotion of employment.

Actions taken to improve health will accelerate economic development by building community self-reliance, overcoming apathy, improving the quality of labour, reducing the burden of ill-health, and expanding labour-intensive services. The Primary Health Care approach draws largely on community resources that otherwise would remain untapped. At the same time, Primary Health Care raises the standard of living of the mass of the population by adding a component of "health income", thus contributing directly to economic development goals.

Though no single model is applicable everywhere, Primary Health Care should include the following :

- ★ Promotion of proper nutrition
- ★ An adequate supply of safe water
- ★ Basic sanitation
- ★ Maternal and child care, including family planning
- ★ Appropriate treatment for common diseases and injuries
- ★ Immunization against major infectious diseases
- ★ Prevention and control of locally endemic diseases
- ★ Education about common health problems and what can be done to prevent and control them

Primary Health Care : How it works

Primary Health Care seeks to bring about the overall promotion of health :

- ★ by giving the individual, the family and the community responsibility for Primary Health Care, with support from the national health care system ;
- ★ by the active participation of the community in defining its needs and finding ways to satisfy them ;
- ★ by using community as well as national resources ;
- ★ by using simpler and less costly technology ;
- ★ by mobilizing other sectors, such as education, agriculture, housing, public works, information and communications and industry.

Primary Health Care recognizes that in order to achieve good health people must have the *basic necessities of life* : e.g. enough food to eat and plenty of safe water. It emphasizes the need for a safe environment and for people to understand the role they themselves can play in improving health and in promoting socio-economic development. This approach has evolved as a result of the hard experience of countries in the promotion of the health of their people.

Self-reliance and community participation

There is much that an active and self-reliant people can do to improve their health. Indeed, better health is not simply a commodity that can be delivered to the people. Its attainment requires their enlightened participation, as individuals, families and communities, in measures to prevent, to control and to treat disease.

The necessity for community participation has often been overlooked in national development and health programmes. Communities have important resources comprising human intelligence and ingenuity, labour, materials and money. The creative use of these resources opens up dramatic new possibilities for the improvement of health.

Individuals and families cannot become real agents of their own development unless they are given the opportunity to identify their true health needs, to assess the existing situation and to suggest how problems may be solved, using all available resources. Within a national strategy of Primary Health Care, individuals and their communities can help plan health care activities. and participate in the process of providing services. Individuals should accept a high degree of responsibility for their own health care, recognizing how the health of each person and each family contributes to the development of the community. This

includes adopting a healthy life style, ensuring good nutrition and hygiene, and proper use of immunization services. Mothers deserve particular attention as they carry a major responsibility for the health of infants and children, the most vulnerable members of society. Within the community, actions to improve health should provide visible results and fulfil expectations in a short time. This may range from building an irrigation ditch or constructing a school, with community participation, to promoting immunization and improved nutrition.

In many countries, the process of community participation may lead to the selection by the community of one of their own people to serve as a Primary Health Care work. After appropriate training and with continuing support from the national health service, the Primary Health Care work, who may be a volunteer or part-time, will become the main agent for preventive and curative action in the community, with the support of conventional health services.

Just as a part-time Primary Health Care worker cannot go it alone, the community too needs continuous help in many forms. The health system must provide education and information about the causes and prevention of illnesses. about the implications of the solutions being proposed and their costs. An adequate and continuing supply of basic drugs, and adequate

equipment for Primary Health Care workers is also required.

Training of primary health workers

Training of primary health workers and the retraining of existing workers should be undertaken at the nearest point to their communities, and should address itself to the most urgent local problems. Practical and non-formal approaches can be used in continuing education, including learning by doing, in-service training during visits by supervisors and frequent short courses. This is essential because the demands on primary health workers will increase and because the health situation will be changing. The training of primary health care workers is a formidable task because of the large numbers and because of the variety of education techniques involved. Hence, special preparation of trainers, who will also participate in supervision, is a prerequisite.

New challenges to the existing health system

Introducing Primary Health Care into all communities will greatly increase the demands on existing services in terms of training, supervision, logistical support and referral care. The redistribution of functions involved in the new approach will also make for a more efficient use of health personnel and health facilities. Professional personnel and hospitals will no longer be dealing with minor ailments and problems but will direct their resources to more complicated problems beyond the competence of primary health workers.

To assure the success of this approach to Primary Health Care, all categories of existing health personnel—professional and auxiliary—will need to be reoriented so as to gain their understanding and support. They will need to realize that community level Primary Health Care is not reducing their status and responsibilities; it is enhancing them. In some situations, they will need additional training in their supportive and referral functions. The basic training of all health personnel will also need to be reviewed and adapted so as to fit them for different functions at various levels of the health systems.

Appropriate technology

Primary Health Care needs scientifically sound techniques that are acceptable to the community and within economic reach. Attempts to bring health care and protection to people in need are still hampered in many places by the absence of simple, low-cost materials, and techniques that are designed for local conditions.

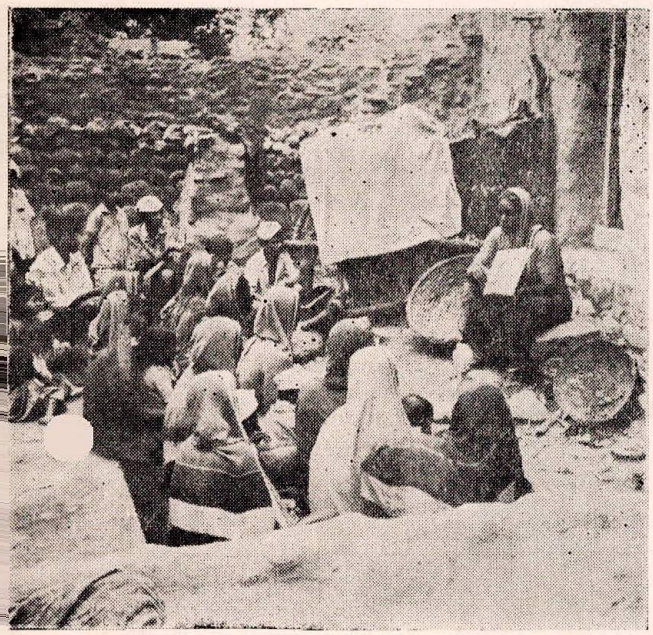
This technology must be in keeping with local customs and traditions. It should be easily understood and applied by community health workers and be capable of adaptation or development as conditions change. The identification of such technology must be considered when formulating a national strategy for Primary Health Care. Such technologies now are available, for instance, to ensure safe cold storage of vaccines, to sterilize medical equipment in the field and diagnose anaemia in villages. Medicinal drugs are an important element in health technology. A model lists of some 200 essential drugs now is available, and can be used to select those drugs required locally to deal with specific conditions. It is an advantage if both drugs and equipment can be manufactured locally.

No community need wait for basic improvements in such things as environmental sanitation until large-scale, expensive means are brought to bear. Work on water supply and waste disposal, for example, is already underway. Sophisticated technology may not be the most suitable, and it is often the most expensive; the cost is high, even for industrialized countries. The important thing to discover is what can do the job and what the community can afford.

More equitable and more efficient use of resources

In many countries today, 80 per cent of the health budget is still spent on 20 per cent of the population. As a result, rural people and the urban poor are neglected and still have little contact with conventional health systems. Only through active community participation, and equitable reallocation of growing national resources can maximum impact on the health of the total population be achieved.

Scarcity of resources can no longer serve as an excuse for not providing better health care for all. Better use of existing resources, fairer distribution of what is available and the use of untapped resources within the community can go a long way to improving the situation. But community, non-government and local governmental resources



must all be used, following an overall plan, for any rapid advance can be made.

More rational use of the national resources will also contribute to narrowing the resource gap. More rational use means providing better referral services, and the supplies and equipment the community is unable to obtain for itself. If countries are to develop Primary Health Care on a self reliant basis, most of the resources must come from within; and along with the growth of national resources, a process of reallocation and equi-

le sharing becomes essential.

It has already been pointed out that community participation brings significant new resources into improving health. Although the resources of communities are limited, experience shows that many communities are willing and able to pay some part of the costs of basic health care, besides contributing labour and materials. These community resources will go directly to the support of Primary Health Care.

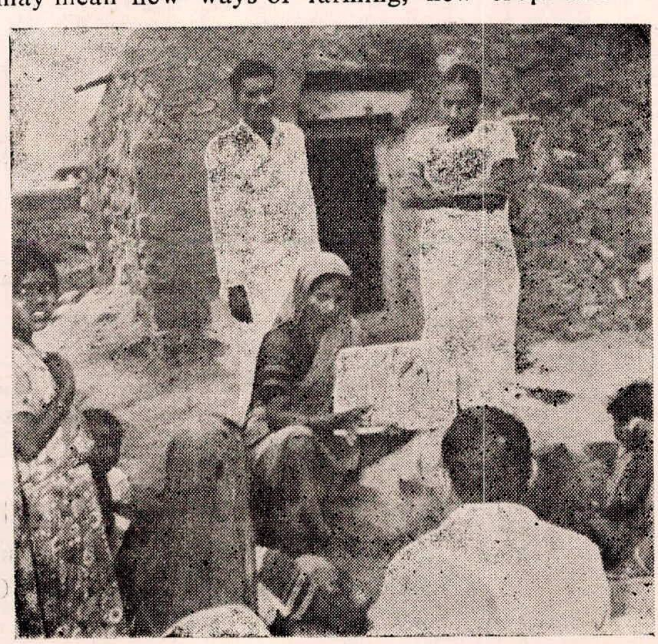
But community resources are not sufficient. Government aid is required for training, supervision, referral services and logistical support. In most countries this means increasing the amount and the proportion of funds in the national budget supporting Primary Health Care. As the national health budget gradually increases, the new money will go to extending health to unserved communities rather than, for example, constructing hospitals in cities.

In this new ordering of the health system, the nation will be getting more for its money. For one thing, there will be a reduction in preventable diseases ; and this in itself will result in substantial savings in supplies and staff time. Concurrently, common illnesses which now take up so much of the time and facilities of the health services will be dealt with effectively and at much less cost in the communities. Sophisticated and expensive health resources will be used in more selective and appropriate ways.

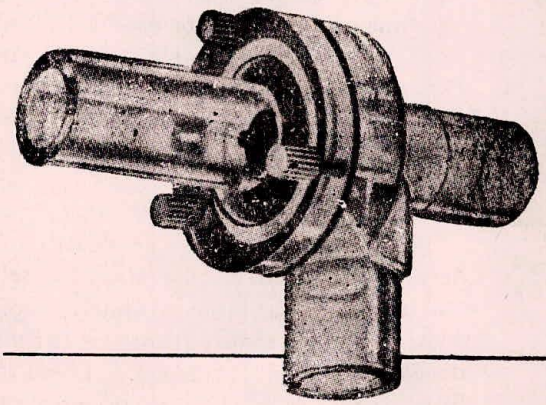
Food for health

More than half of the deaths of children in developing countries are directly related to poor nutrition and a large proportion of those who survive are physically stunted ; for many, mental development is retarded. Thousands become blind from an early age because of vitamin A deficiency. Lack of food and iron-deficiency limits the work capacity of the labour force. Furthermore, these nutritional deficiencies increase the risk at childbirth both for mother and baby, and contribute to high maternal mortality and the delivery of small, weak babies who are susceptible to diseases and early death.

The first step in dealing with nutrition is seeing that people get enough of the right food. Food must be made more abundant and more accessible to the millions who need it and cannot afford to buy enough to keep their families healthy. This may mean new ways of farming, new crops and



SANJEEVANI

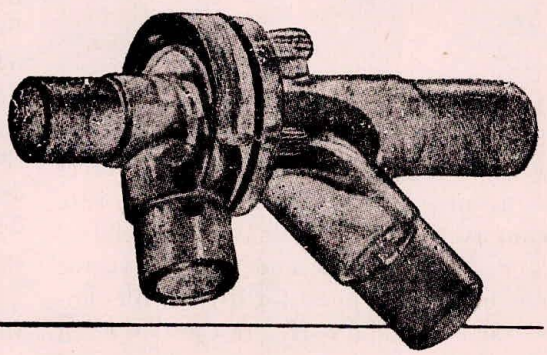


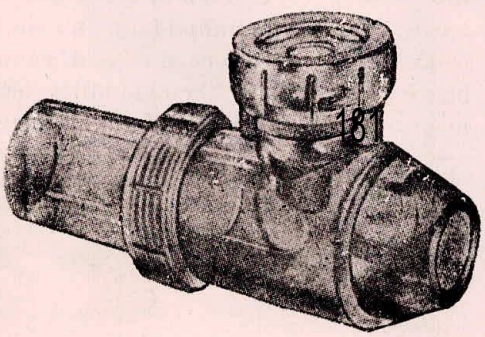
SANJEEVANI POLYVALVE

It automatically operates by the pressure variations occuring during spontaneous and controlled respiration.

SANJEEVANI REVIVALVE

Same as Sanjeevani Polyvalve except that it has an inlet for fresh air and extra oxygen can be added to the inspired air, both in spontaneous and artificial respiration.





SANJEEVANI POSITIVE PRESSURE VALVE

It permits one handed operation squeezing the breathing bag automatically closes the exhalation opening. Functions as conventional non-rebreathing valve when positive pressure is not applied.

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changes in land tenure. In addition to an increase in quantity, sound education is needed to encourage people to make better use of locally available foods. A handful of green vegetables a weak can prevent vitamin A blindness. A little iodine added to salt can prevent goitre. By careful mixed feeding and giving young children enough solid food, serious nutritional diseases such as marasmus and kwashiorkor can be avoided. The danger of malnutrition in pregnancy can be prevented by giving mothers a litte more of their accustomed diet.

Just as food is needed, so are good eating h[illegible]its. Mother's milk, for example, is the best a[illegible] safest food for babies everywhere and breast feeding should be encouraged. Young children's foods can be prepared from locally available resources. Cleanliness in the preparation and storage of food goes a long way in preventing infection.

It is essential that early in life children receive a diet that will ensure a healthy growth and an effective immune response. Without the latter immunization programmes will be less effective.

The environment as an ally : Enough safe water and a safe environment

The importance of improving the environment so that it promotes rather than undermines the health of the individual is fundamental to the Primary Health Care approach. Formal health [illegible]tivities and medical care cover only a very small [illegible]t of a person's life, even for someone who is repeatedly ill; most of one's life is spent working and living far from the walls of a clinic. Therefore the way in which people lead their lives, and the setting in which they do it affects their health and that of others around them to a vast extent.

Water, for example, can help a community to health in many ways or on the other hand it can menace its well-being. Where water is abundant and safe, a number of diseases will be greatly reduced or eliminated. Where water is scarce and polluted, nothing can prevent high infant mortality and constant attacks by gastro-intestinal disease on all members of the community. Malnutration can result from infestations and worms and frequent diarrhoea.

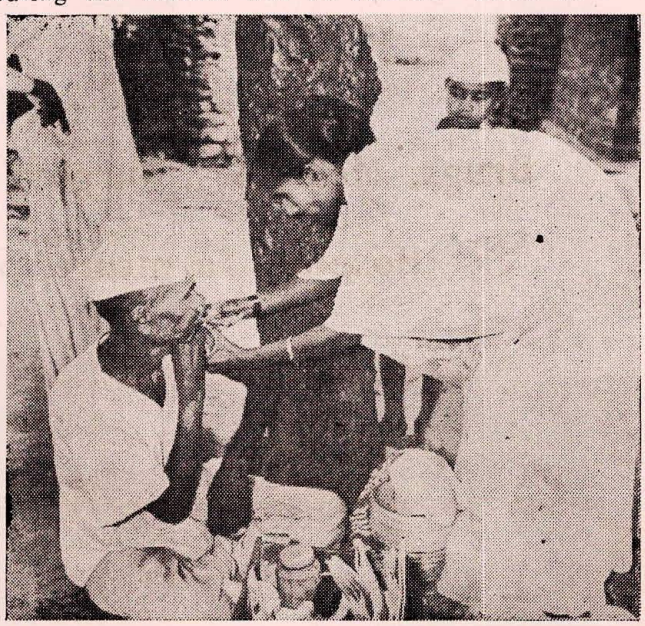
More is needed than greater quantities of water. It is important to avoid polluting water and its surroundings. The proper disposal of human waste is crucial. This waste can become valuable compost or a focal point for contamination and a breeding place for insects that carry disease. The water in drains, rubbish, and the excreta of man and animals can either be used as a resource or pose a dangerous threat to health.

Prevention of disease

The Primary Health Care approach lays stress on prevention, which is the first line of defence against disease and ill-health. Most of the measures required can be carried out within the community itself, using local people and local resources, backed by support from the national health service and other agencies of government.

Improvements in the environment, provision of adequate water and proper nutrition, as outlined above, will go a long way in the prevention of diseases that are currently causing ill health and death in the world.

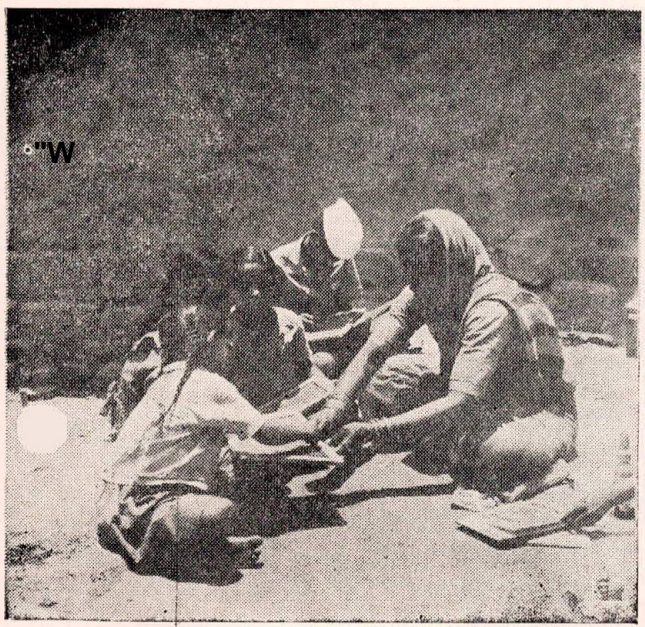
Other programmes such as family health, family planning and immunization against several of the major killing diseases, can also reduce illness and suffering, particularly among mothers and children. To make any real difference, immunization must reach everyone who needs it. Steps in this direction include simplified immunization techniques, firm administrative procedures and enlisting the help of the community, to see that those who need protection receive it. In many cases, better ways of producing and distributing the vaccine will be needed. These have



been worked out in many countries, using imagination, local cooperation and hard work.

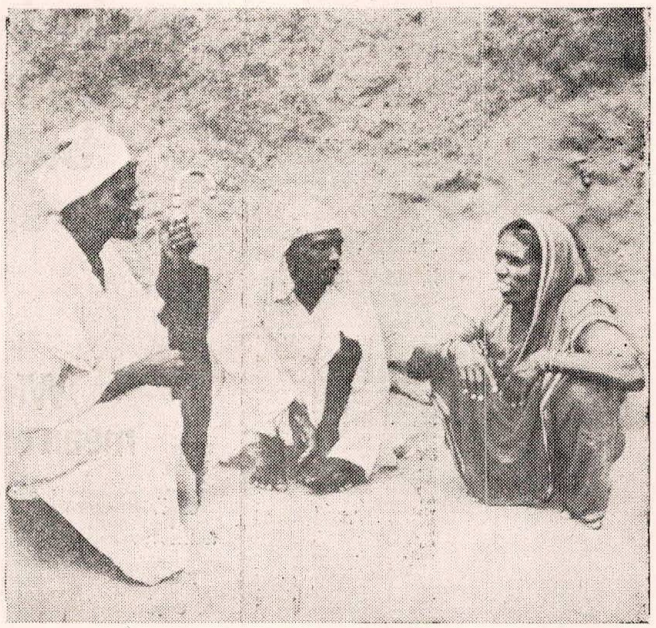
A national policy : Coordinated support at all levels

Although no single model of Primary Health Care can be applicable everywhere, in all cases there must be a national policy and political will. Furthermore, this approach should encourage the community to become actively involved from the very first stages. Primary Health Care means a close partnership between community and government in the development of resources and health care, and involves a continuous dialogue between n. The community must identify itself with the purposes and activities that are called for. Planning, shaping of specific activities, evaluation and modification should all be carried out with the participation of the people.



Government activities should be oriented in order to encourage and support community actions. These should include intersectoral planning and coordination, and the identification and reallocation of resources to provide the personnel, material and finances needed to support the community.

Solutions to national and local health and development problems can only be found through mutual support and collaboration. All levels of government—district, provincial and national—must commit themselves to coordinating and reallocating their resources to meet the real needs of the people. This requires decentralization of operational responsibilities and the coordination of sectorial activities so that the overall goal of health through development can be achieved. Implicit in this partnership is the involvement of members of the community in identifying what thay feel are the most pressing problems they face and in determining priorities and solutions they feel will work in their local setting.



Health is not a separate entity. This is why Primary Health Care has to be unequivocally supported at the national level as part of the government's overall national plan for total development.

A matter of will

The Primary Health Care involves a political commitment to reorient national development, to direct increase resources to the under-served majority and often to increase health budgets substantially.

For industrialized countries, a Primary Health Care approach means rationalizing their health systems and controlling and redirecting soaring expenditures from hospital-based, high-cost technology towards basic care for all. It also means a commitment to assist the developing countries, and particularly the least developed, in carrying out the Primary Health Care approach, as an integral part of rural and urban development.

The world has the resources and know-how to

(*Continued on page 31*)

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ESSENTIAL ELEMENTS FOR HEALTH

You may ask what, within any range of elements, are those that are essential to the attainment of health for all. I suggest that they include adequate food and housing, with protection of houses against insects and rodents; water adequate to permit cleanliness and safe drinking; suitable waste disposal; services for the provision of ante-natal and post-natal care, including family planning; infant and childhood care, including nutritional support; immunization against the major infectious diseases of childhood; prevention and control of locally endemic diseases; elementary care of all age groups for injury and diseases; and easy access to sound and useful information on prevailing health problems and the methods of preventing and controlling them.

A BROADER HEALTH SYSTEM

If we could succeed in providing primary health care to all, we should be well on the way to ensuring health for all. Primary health care, however, cannot be effective alone; it has to form part of a broader health system, and the other components of that system must be organized in such a way as to support its needs. This is another dimension of the filter-inwards process to which I referred earlier whereby problems of the periphery should determine the content and organization of the more central levels of the health system - whereas I am sure you will admit it is usually just the opposite.

IMMUNIZATION OF ALL CHILDREN BY 1990

Immunization against the common diseases of childhood is another high priority programme. Again, the Thirtieth World Health Assembly set the direction when it adopted a resolution aimed at ensuring that by 1990 all the children of the world will be provided with such immunization. Experience has shown that episodic mass campaigns have not been effective; programmes have to be established on a permanent basis and for this it is again necessary to have recourse to the primary health care services. But in most countries these services will only be able to provide immunizations if a government decision is taken to this effect,

LEARNING TO LIVE WITH FEWER DRUGS

Drugs - and I am not referring to narcotics-are inseperable from health technology, which has become unduly drug-dependent. We must learn to live with fewer drugs if we are to master the health situation, and I think we have shown convincingly that we can. A recent scientific consultation in WHO, based on country visits, came to the conclusion that some 150 essential drugs could meet the vast majority of health care needs. If you want to free yourselves from drug colonialism, let us work together to make sure that these essential drugs become available to all who need them. To do so will mean formulating new national policies concerning the manufacture, quality and price control, import, and export of these drugs. You will appreciate the need for inter-country collaboration within the Region, as well as with other Regions, to ensure the orderly application of this new policy of progressive national and regional self-reliance in drug matters.

NUTRITION ACTIVITIES - A CORNERSTONE OFPRIMARY HEALTH CARE

Malnutrition is probably the single most important health problem in developing countries. The national and international health sectors must now come to grips with their responsibilities in nutrition, identify their proper political needs, define realistic policies and strategies, generate appropriate technologies, and formulate applicable programmes. If we do not succeed in making effective and realistic nutritional activities a cornerstone of primary health care, we are hardly worth our salt as health managers. Once more we seem to have the knowledge but neither the political will nor the social imagination to apply it.

PROGRAMME BUDGETING AT THE COUNTRY LEVEL - A GOLDEN OPPORTUNITY

As another aspect of WHO's contribution to health development in countries, we are, as you know, about to introduce a new system of programme budgeting and management of WHO's resources at the country level. The main effects of this new system should be to develop the WHO programme budget in countries in terms of broad health programmes responding to nationally defined needs and priorities and

PRIMARY HEALTH CARE

Primary Health Care is essential health care made universally accessible to individuals and families in the community by means acceptable to them, through their full participation and at a cost that the Community and country can afford. It forms an integral part both of the country's health system of which it is the nucleus and of the overall social and economic development of the community.

Primary Health Care addresses the main health problems in the community, providing promotive, preventive, curative and rehabilitative services accordingly. Since these services reflect and evolve from the economic conditions and social values of the country and its communities, they will vary by country and community, but will include at least: promotion of proper nutrition and an adequate supply of safe water; basic sanitation; maternal and child care, including family planning; immunization against the major infectious diseases; prevention and control of locally endemic diseases; education concerning prevailing health problems and the methods of preventing and controlling them; and appropriate treatment for common diseases and injuries.

In order to make Primary Health Care universally accessible in the community as quickly as possible, maximum community and individual self-reliance for health development are essential. To attain such self-reliance requires full community participation in the planning, organization and management of Primary Health Care. Such participation is best mobilized through appropriate education which enables communities to deal with their real health problems in the most suitable ways. They will thus be in a better position to take rational decisions concerning Primary Health Care and to make sure that the right kind of support is provided by the other levels of the national health system. These other levels have to be organized and strengthened so as to support Primary Health Care with technical knowledge, training, guidance and supervision, logistic support, supplies, information, financing and referral facilities including institutions to which unsolved problems and individual patients can be referred.

Primary Health Care is likely to be most effective if it employs means that are understood and accepted by the community and applied by community health workers at a cost the community and the country can afford. These community health workers, including traditional practitioners where applicable, will function best if they reside in the community they serve and are properly trained socially and technically to respond to its expressed health needs.

Since Primary Health Care is an integral part both of the country's health system and of overall economic and social

Health for All by the Year 2000 A.D.

Recommendations of the Group on Community Involvement.

(Group 4)

The Group on Community Involvement met in New Delh on March 18. The following were present.

(i) Dr.K. S. Sanjivi, Chairman
11, Link Street,
C.I.T. Colony,
Madras-600004.

(ii) Dr. (Mrs) B.J. Coyaji Memebr.
C.MO., King Edward Memorial
Hospital, Sardar Mudliar Road,
Rasta Path, PUNE-400011.

(iii) Shri. R.R. Gupta, Memebr.
Joint Secretary,
Ministry of Health & F.W.

(iv) Dr. Vijay Kumar, Member.
Health Community Medicine,
Post Graduate Institute of
Medical Education & Research,
Chaudigarh.

(v) Dr. L. Ramachandran Memebr.
Director, Gandhigram Institute
of Rural Health,
Gandhigram. (District Madurai)

(vi) Shri. V.N. Kakar, Convenor
Member Se

Dr. R.S. Arole, Director, Comprehensive Rural health Project, Jamkhad-413201 (Distt. Ahmednagar) could no

2. The Group recommends that the concept that health is n only a basic right of man but also one of his essential res ponsibilities must be promoted vigorously in order to bring about greater community involvement in health care programm The comunity at present looks at health as the sole respons bility of the State as something to be administered by the Government to the people. The tendency needs to be changed The community should be given the feeling that promotion of health is a joint responsibility to be shared by the Govern ment and the people.

3. There cannot be any uniform pattern for the involvemen of the community in health care programmes for the country as a whole or even for any single region. Depending upon needs of the situation and availability of infrastructure other resources, the pattern of community involvement will inevitably differ from place to place. This important thi is that all sectors of the community should be associated with health care programmes at all stages-from planning to utilisation of resources. The comunity should be encourag to make monetary contributions to these programmes.

4. The Group feals that to bring about greater invovement of the community in health care programmes, it is importan that entry points, in tune with felt local needs, should b identified. Once the community gets the confidence that h programmes will help it in meeting its own needs, the part pation of the community in these programmes can be achieve with less difficulty.

5. The Group recommends that in relation to community inv ment, health care should embrace all aspects of health and family welfare, including maternal and child health progra nutrition programmes and family welfare services.

6. The Group feels that the community health volunteers i in the rural scene in the recent past can play an extremel ful role in bringing about community participations in hea programmes in villages. The weaknesses in the scheme as h come to light must be removed quickly. The Group is of s view that there should be no compromise with the essential principles of the scheme-viz. volunteers should not be Gov ment functionaries, they should command respect amongst th people they seek to serve, they should live in the village where they work and they should be available to the commun in all times of need. The Group recommends that the schem community health volunteers should be strengthened and enl with modifications wherever considered necessary.

7. The Group feels that in every village there should be community health volunteers and at least one of them must be a woman. This is particularly essential from the point of view of involving women in maternal and child care as we as family planning programmes.

8. The Group feels that the importance of the mother for promotion of health within the family and, through the fami in the community as a whole has not received due recognitio from health planners. The mother has a vital stage in the health of her children and cleanliness of her home. The Gr feels that special programmes should be designed to encoura mothers to emerge as leaders in community participation in care.

9. Cleanliness of the body and the mind is an essential concept embedded in the Indian cultural ethos. The Group feels that health education programmes have failed to take advantage of this situation. Further, whatever be the oth waknesses of these programmes, these are fare too inadequa and one does not find much evidence of their existence in society. In the old days hygeiene used to be one of the subjects taught in schools. At present in most of the sta health education has not been included in the formal educa tion system. The Group notes with regret that even though at numerous conferences recommendations have not been impl mented in most of the States. The Group feels strongly th if health is one of man's basic rights and responsibilitie health education must receive its due place in the formal education system.

10. The Group further recommends that health education sh be inducted in all programmes of non-formal education for various sectors of the society - Viz. agricultural extensi workers, industrial workers, cooperative societies and orga sations devoted to social welfare, particularly welfare of women and childfen. The Group also recommends that health education should be promoted systematically through the Nat nal Audit Education Programme launched by the Ministry of Education.

11. The Group took cognizance of the media explosion which the country has been witnessing for several years. It note with regret that even though mass media provide immense sco for the promotion of health care programmes and for the par cipation of the community in such programmes, these have be utilised only marginally and not in a systematic manner. T Group feels that the Government both at the Centre and in t States, should take the lead in remoulding this situation. There is dearth of films and other audio-visual media mater on health education. There is not much evidence of large s and systematic utilisation of print media. Drugs and cosmet are advertised on a massive scaled through all media. This potential should be used in a planned and systematic manner by the Government in promoting the positive as aspects of health and in achieving greater participation of the people in them.

12. The Group feels that at the grassroots greater use of interpersonal communication should be made to promote people involvement in health care programmes. The Group notes that the Ministry of Health and Family Welfare has launched a lar scale programme of organising orientation camps of opinion leaders in villages in order to promote family welfare. The Group recommends that general principles / of health care should always find reflection in family welfare and the forum of orientation camps should be utilised fully to increase the community's involvement in all health care programmes. The Group further recommends that women should be encouraged in particular to take part in the orientation training camps.

13. The Group feels that Government-sponsored programmes for the involvement of the community in health care should have an in-built mechanism of evaluation. The Group furth suggests that those responsible for conducting these progr mmes should be given refreshner courses from time to time.

(Note: The Group did not consider specifi the role of voluntary organisation community participation programmes ause this matter is being taken up greater depth by another group).

(Dr. K.S. Sanjivi)
Chairman.

Health for All by the Year 2000 A.D.

Recommendations of the Group on Community Involvement

Group 4. Additional Note from the Chairman of the Group

The recommendations of the group prepared by t convenor and approved by me contain all the points on whic there was unanimity during the discussions. I had circula to the group a note on the subject containing my views. T following two points contained in my note are considered s important that I am sending these additional recommendatio for the consideration of the entire National Committee on Health for All.

1. In continuation of para 3 of the Group(s recomm tions please add "community consists of all the families l in an area without any reference to their occupation or ec mic status. In our scheme for COHEDECs and Mini Health Ce it has been provided that each family should contribute, o behalf of all its members, 0.5% of its annual income subje to a minimum of Rs.6/- per annum and a maximum of Rs. 180/ per annuam. Here let me quote Dr. Mahler, Director Genera WHO "Are the costs exorbitant? Recent small scale studies shown that considerable improvements in people's health ca take place for as little as 0.5 to 2% of the yearly gross n product per person-or what amounts to a few dollars a year. This is by any standard a reasonable cost, around a hundred of what is spent on health by people in many rich countries So cost factors should not hinder governments when they cons if, and to what extent, they should commit themselves to th target of health for all by the year 2000". (World Health, November '79).

2. The National Service corps in the various colle should be mobilised for Non-formal and for health education a big way. To my mind giving them such jobs as building ro is a rather futile exercise. It is understood that most Un sities in India have taken a firm decision that comunity se should be compulsory for every student and that marks will actually be alloted for the same. More than the decision it is the exact method of implementing the decision in such a way that the entire community gets maximum benefit, quite ap from the good it will do to the student's motivation.

Extracts from

Health for All : An Alternative Strategy

Major Recommendations

Objectives:

1. The objective of the national health policy should be to provide health for all by 2000 AD. This implies the provision of a good and adequate health care system for all citizens, and especially for women and children and poor and underprivileged groups. It also implies a drastic reduction in the total morbidity and mortality. In particular, it will mean a fall in infant mortality from 120 to 60 or less, and in the overall death rate from 15 to 9. These objectives and targets are realistic and feasible. But they cannot be achieved by a linear expansion of the existing system and even by tinkering with it through minor reforms. Nothing short of aradical change is called for; and for this it is necessary to develop a comprehensive national policy on health.

Approach:

2. If this goal is to be realised, a major programme for the development of health care services is necessary but 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. Health also depends on a number of supportive services - nutrition, improvement in environment and health education. During the next two decades, therefore, the three programmes of 1) integrated overall development including family planning, (2)improvement of nutrition, environment and health education, and 3) the provision of adequate health care services for all and especially for the poor and underprivileged (through the creation of an alternative model proposed here) will have to be pursued side by side.

Integrated Development

3. The objectives of integrated development are to eliminate poverty and inequality, to spread education, and to enable the poor and underprivileged groups to assert themselves. This will include the following programmes.

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 eight hours a day; creation of adequate opportunities of gainful employment for women, with an emphasis on equity of remuneration and reservations to make up for past neglect, so that women become 'v8s8ble' assets to their families.

Report of a study group set up jointly by the Indian Council of Social Science Research and the Indian Council of Medi-

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 927, 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) Creation of a democratic, decentralised and participatory form of Government.

8) Rural electrification

9) Improvement inhousing with emphasis on the provision of houses for the landless and slum clearance.

10) organizing the poor and underprivileged groups.

Family Planning

4. 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 presen It will also imply a reduction in the average size of the family from 4.3 to 2.3 children, and the eventual stabilization of the total population at about 1200 million by 2050 AD. The family planning programme must be fully rehabilitated at an early date and converted into a people's movement closely linked to development. The emphasis should be on education and motivation, especially through interperson communication and group action. Incentives especially those of a compensatory character, should be widely used. While work with women willcontinue through MCH services, intensive efforts should be made to work with men also. While the health services will have a role to play in motivation also, their main responsibility is to supply the needed services and follow-up care. The alternative model of health services has been designed to meet these challenges fully and squarely.

Nutrition

5. Nutrition will have to be improved through adequate production of food, reduction in post-harvest losses, proper organization of storage and distribution and increasing the purchasing power of the poor through generation of employment and organization of food-for-work programmes. Great emphasis should be placed on improving the status of women and children and special programmes should be developed for specific nutritional disorders like iron-deficiency, anemia, or vitamin A and iodine deficiencies. In addition, supple-

Improvement of the Environment

6. Improvement of the environment will reduce infection, make programmes of nutrition more effective, and help materially in reducing morbidity and mortality. Safe drinking water supply will hav to be provided to all urban and rural areas. Good sewage dispersal tems should be established in all urban areas where simultaneously, massive programme of proper collection and disposal of solid wastes and their conversion into compost will have to be developed. Similarly, an intensive programme of improving sanitation, with special emphasis on proper disposal of night soil, should be developed in rural areas. 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. Urgent steps have to be taken to prevent water and air pollution, to control the ill-effects of industrialisation and to provide better work-place environment.

Health Education

7. Health education should become an integral part of all gener education and should receive adequate emphasis. Health education should also be an essential component of all health care; and the he care services should assume special responsibility for the health ed tion of the poor and underprivileged groups who need it most.

Alternative Model of Health Care Services

Within the health sector, our most important recommendation is that the existing exotic, top-down, elite-oriented, urban-biased, centralized and bureaucratic system which over-emphasises the curati aspects, large urban hospitals, doctors and drugs should be replaced by the alternative model of health care services described in detail in a planned and phased manner by 2000 AD. This alternative model i strongly rooted in the community, provides adequate, efficient and equitable referral services, integrates promotive, preventive and cu tive aspects, and combines the valuable elements in our culture and tradition with the best elements of the Western system. It is also more economic and cost-effective.

Maternal and Child Health (MCH)

9. MCH services should be expanded and improved. There should be attempt to cover all women and children with basic services with special attention to those 'at risk' through an essentially domicilia programme. The dais should be trained and fully utilised. The MCH staff at each level should be adequate, have specific responsibilitie (with an indication of priorities) and should receive job-specific training. Health education of the mothers should be an important component of MCH services.

Communicable Diseases

10. Communicable diseases still form the largest cause of morbidity and mortality and the fight against them should be continued with still greater vigour in the years ahead. A good surveillance system has to be set up and better coordinated efforts are needed. By 2000 AD, our object should be to eradicate or atleast effectively control diarrhoeal diseases, tetanus, diphtheria, hydrophobia, poliomyletis, tuberculosis, guinea-worm, malaria, filariasis and leprosy.

Training and Manpower

11. Under the new alternative model, the organization of the health services will be radically different from that in the existing system. A new category of personnel, the Community Health Volunteers will be introduced and it will be the main bridge between the community and the services. The middle level personnel will increase very substantially. Very important decisions will have to be taken about nurses, paramedicals, doctors, specialists and super specialists and these relate to their numbers, quality and duration of training, and value system. There should be adequate arrangements for the continuous in-services 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 manpower and training and taking effective action thereon should be a major responsibility of this Commission.

Drugs and Pharmaceuticals

12. There is need for clear-cut drug policy and a National Drug Agency to implement it. The pattern of drug production should be oriented to the disease pattern, with an emphasis on the production of basic and essential runs (especially those needed by the poor and underpriviliged groups) which should be produced in adequate quantities and sold at cheapest possible prices. The domination of the foreign section in drug production should be reduced further and price control made more effective by reducing overheads and packaging costs and adoption of generic names. There should be strict quality control, supply of adequate drugs to the rural sector, and a move in the direction to make the clients pay for the cost of drugs.

Research:

13. The priority areas obviously are primary health care, epidemiology, communicable diseases with a special emphasis on diarrhoea, environmental research, and research on drugs, problems of rural water supply and sanitation, indigenous medicine, health implications of industrial development, and family planning. It is also necessary to promote research on social aspects of medicine and especially on economics of health, jointly under the ICMR and ICSSR. 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 ofbiology, and a determin bid to build up high-level indigenous research capability with a view to attaining self-reliance.

Administration

14. It is necessary to redefine the roles of the Central and Stat Governments in view of the large powers delegated to the local bodi at the district level and below. Voluntary agencies will have to function within the overall policy laid down by the State. But the 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 redefinit of roles and mutual adjustment. This is the responsibility of the administration to secure through good leadership and proper trainin A new and efficient national information system should be created a adequate arrangemen s made for moreeffective coordination at all le

Financial

15. The total investment in health services should be substantial raised and health expenditure should rise by 8 to 9 per cent per ye at constant prices and reach about 6 per cent of GNP by 2000 AD. T existing priorities should be radically altered and the bulk of the additional resources will have to go into promotive and preventive vities, in rural areas, in the development of supportive services li nutrition, sanitation, water supply and education, and for providing health care services to women and children and the poor and underpri leged groups. This will need taking of both positive and negative d sions. While the ma jority of expenditure on health in the proposed organization will be the responsibility of local bodies who will exercise financial control, basic responsibility of financing health will continue to rest with the Centre and States. An effort should also be made to tap local taxes and individual payments to cover dru costs.

National Health Service

16. The alternative model proposed here is a large step in the c re tion of a national health service, but it does not create it. In ou 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

17. The programme suggested here to realise the objectives of heal for all is as existing and worthwhile as it is realistic and feasibl Its success will depend upon our capacity to create a mass movement and the ranks of millions ofyoung men and women to work for it. It will be proportional to the extent to which it is possible (i) to reduce poverty and inequality and to spread education; (ii) to orga nise the poor and underprivileged groups so that they are able to assert themselves; and (iii) to move away from the counter-productiv consumerist Western model of health care and to replace it by the alternative model based in the community as is proposed in this Report.

Report of the Working Group on the Role of Voluntary Organisations for the goal of Health for All by 2000 AD.

1. The Working Group constituted for making recommendation on the role of voluntary organisations in the context of th goal of health for all by 2000 AD met at Nirman Bhavan, New Delhi, on 20th March, 1980, under the Chairmanship of Dr. K Rao. The list of participants is attached at annexure.

2. The meeting generally considered drawing attention to t following aspects of the matter. viz.,

(i) the functions that could be assigned to the volunt organisations in replacement/reinforcement of the wor of State and Central Government systems at the field l and

(ii) the interaction and mutual relations between the Governmental system and the voluntary organisations.

3. After detailed deliberations, the follwing suggestions emerged:

(a) Voluntary organisations in this context could be de-fined as those organisations which are non-goverment non-pr fit making in character, and not fully funded whether dire-ctly or indirectly only by the Government. While private o ganisations also fall in the general category of non-goverr mental organisations, unless they fulfil the criterion of r profit organisations, they could not be qualified for assi-stance from Government resources.

(b) There is a definite and important role for voluntary and recognised private organisations in delivering health care services as contemplated in the concept of health for all by 2000 AD. The work in this field cannot be carried our only by Government agencies; the work of all organisa-tions in this field will require coordinated inter-meshing t make optimum use of all available resources - men, money and materials - to the nation.

(c) Promotion of community participation to the largest extent possible in order to generate demand for health services as well as utilisation of such services, should be a common goal of all organisations in this regard.

(d) Voluntary or recognised private organisations will have a role to play in all aspects of health services, such as service delivery at different levels from the periphery to the highest referral points - curative, preventive, pron and rehabilatative, including prophylaxis coverage; educati and motivation, including health education, training of

para-medical or other workers, such as CHVs, Dais, etc., research into health care delivery system in all these aspe including undertaking innovative approaches; field studies to test out assumptions in accordance with their capacity.

(e) In all the functions mentioned above, the goal of primary health care should be kept in the central focus. Voluntary organisations also should bear in mind cost effec veness of their activities vis-a-vis governmental systems.

(f) The need for coordination of activities of all voluntary organisations with those of the Government is of paramount importance. To achieve dialogue between the Government and the voluntary organisations it would be nece ssary to set up Standing Committees at the Central, Stat local levels. These Committees should look into all aspect of work as well as relationship between the Government and volantary organisations.

(g) Where voluntary organisations have taken root, duplication on similar services from the Government could be avoided, such as in the areas of mini-health centres of Tamil Nadu or similar progammes in other States.

(h) Recognistion of voluntary organisations for their work as well as for the purpose of Governmental support to would be a proper step. Procedures for this purpose may ha to be worked out.

(i) The work of the voluntary organisations must have maximum flexibility suited to the capacity, manpower availa bility, areas of operation, financial strength, and the gene ral objectives of each organisation. While, therefore, the should be no regid pattern of assitance from the Government to such organisations there would be need to make available s standard patterns around which changes can be made to suit ea organisation.

(j) Voluntary organisation must be able to receive su- pplies from the Government for general programme purposes su as ANM Kits, vaccines for immunization, health education mat rials, WHO Handouts, etc. In addition, recognition by way of participation in policy making bodies would also give a boost to these organisations.

this and also to maintain close and continuous

(k) Only those organisations which fulfil the criteri of voluntary organisations, as defined above, and which have a secular outlook and provide free accessibility to all sect of people, should be recognised and afforded assistance from the Government.

(l) In the field of providing financial assistance to voluntary organisations, establishment of an autonomous and financial body like the Agricultural Finance Corporation, etc. could even be considered. Such a body could receive a ma corpus fund by way of support from the Government as also private grants, including grants from foreign donors. It co also be provided with annual subventions. Such corporation make available funds in turn to voluntary organisations. Fo purpose of raising funds, specially for health coverage, tax insurance, local cesses and people's contribution for servi rendered according to financial status of the individual, co also be considered.

(m) The need for vertical as well as horizontal link of all voluntary organisations with the overall health infra structure was repeatedly emphasized.

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Annexure:

LIST OF PARTICIPANTS

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COMMUNITY PARTICIPATION - ROLE OF DIFFERENT AGENCIES IN MULTI-SECTORAL APPROACH

by
Dr. K.S.Sanjivi
Ex-UNICEF Consultant on Primary Health Care

Before any discussion of the topic assigned to me is comme I wish to comment on the term "Community Participation" itself. there in modern India the feeling, awareness of the community i sense of "for a nighbourhood/body of people living in same loc not in the sense of "the antagonistic religious and racial comm in a district". Both these quotations are taken from the Conci Oxford dictionary. The politicians in India should be thanked will "blamed" be the correct term - for this position in which "community" has become a dirty word and not understood in the s way as it should be in any modern society. It is therefore ess tial that we should as a first step restore a proper community ing as an area, neighbourhood feeling that was part of our anci culture.

Primary Health Care must necessarily have its origin in th most remote villages where the problems arise. It will be bet therefore to talk about community action with participation by Government or organised voluntary health agencies. The program should be conceived and executed by the community with whatever technical and financial support may come from the Government or other agencies.

To reiterate that the organizations for Primary Health Car start in the villages is in consonance with Sutton's Law. Sutt an Australian Bank robber when asked why he was robbing banks i particular, gave the simple reply "because the money is there"; likewise the problems of health care are in the villages, and u slums and not in New Delhi.

A distinction should be made between voluntary agencies wh on par with the Government can be regarded as donors, and the i viduals in the community, the consumers of health services who the recipients. Our effort should be to alter the role of the community from that of a passive recipient to that of an active initiator. Therefore I shall start with the illiterate citizen who to a large extent are the beneficiaries. Here the mistake often made in thinking that an illiterate person is un-intelli God, or if you like nature, has endowed all human beings with a basic intelligence and the villager who has not had the opportu to go to a university is nevertheless very intelligent and capa of providing excellent support to the health team. In 1973, th WHO World Health Day's Theme on April 7th was "Health begins at

We conducted a number of meetings, to stress how the most imp reliable and dedicated para-medical worker in a health team, the mother in the house. Field experience since then has furt given support to this concept that if only she can be properl volved many of the targets can be achieved.

In our programme we have local action committees, who have been told clearly that the health centre is their proje to which the medical profession, with its auxilliaries, only provides the technical skills. It should not appear to be a paternalistic condescending gift of better off persons to the inferiors.

The Community Health Volunteer/Lay First Aider is the on individual who can make maximum contribution to health educat In her training, therefore, we emphasise environmental sanit personal prophylactic methods, improved nutrition with locally available products, mother and child care, and family plannin

Talking of environmental sanitation, one notable area in which community involvement has failed is in the individua families putting up their own cheap latrines even when they c afford it.

Taking another example, the resurgence of malaria is not due so much to the resistance developed by the mosquitoes to pesticides or by the malarial parasites to chloroquine, as i is due to the failure to build up the infrastructure. The in structure should require every householder to take care of th mosquito breeding foci in his own surroundings and report eve episode of fever to the MHC/CHV. This is a clear example of community involvement without which public health measures ca succeed.

We often talk of health care delivery. It should be rea that health care cannot be delivered; it is essentially a "do yourself" proposition. For example, drug addiction, alcoholi smoking and sex permissiveness are four, recent important add tional causes of disease. None of these can be controlled in community unless the individuals involved are motivated to co operate in their cure and prevention. Likewise patients in n of prolonged treatment (e.g. pulmonary tuberculosis, leprosy) c obtain a cure even with modern, wonder drugs if they default taking the drugs.

Health Education therefore is of the utmost importance. Health Education specialization is a profession practically n existent in India. It is questionable whether we can afford category; every health worker should therefore be a health educator.

Briefly the objects of health education are (a) to educa people and alter the behaviour, where necessary, to promote a maintain their health; (b) to impart the minimum knowledge required for people to be aware of the factors that affect he and recognise the early symptoms of disease; (c) to assure th people of the availability of the needed services and the ser

It has been shown that it is comparatively easy to achieve success in situations depending on techniques eg. vaccinations, mosquito control. But where techniques play only a minor part and people must be persuaded to change their habits, the situat becomes much more difficult eg. choice of correct food, smokin family planning.

It will thus be seen that health education must adopt dif erent approaches and must be continuous and simple.

Most authorities believe that mass media do not produce as consistent and good results as personal man-to-man approach. O viously the latter will require many more teachers of health ed cation; that is why health education is stressed as the most im ant function of the CHV.

The ideal set-up for community health must provide for the following essential requirements:

A health post manned by a lay first-aider/community health volunteer for every 1000 population.

A male and a female multi-purpose worker for every 5000 population;

A doctor being available at the mini-c ntre for atleast three hours a day on three days a week;

The identification of, and liaison with, a referral hospital within a reasonable distance.

The LFA at the Health Post is in fact the most effective v teer in health work and all organised voluntary health agencies only subordinate to these Queen Volunteers. The mother in the house has been justly acclaimed as the most dependable medical xiliary. In view of her importance we ensure that the LFA is selected, trained and supervised in the proper way.

"The effects of a world wide plan of action on behalf of Primary Health Care, extend well beyond the frontiers of healt itself and into the economic and social fields" said Dr.Mahler (Director General, WHO) at Alma Ata.

Of the many facets which one may consider in "integrated/t rural development" abolition of illiteracy, maximised through F Formal Education, is very important and should be regarded as a project that can be taken up even by health agencies. Among th reasons for the failure of community participation in health p grammes set up for their own benefit is the lack of knowledge o the average citizen on the possibilities of modern medicine and availability of solutions to his problems. He now has consider fear and diffidence in reaching those who can deliver the goods The inadcessibillity to the health services really arises out o illiteracy and, true democracy and illiteracy are incompatible as much as the former demands on the part of its citizens a kno ledge of all its institutions.

Here the National Service Corps in the various colleges should be mobilised for non-formal and for health education i a big way. To my mind giving them such jobs as building roac is a rather futile exercise. It is understood that most Uni- versities in India have taken a firm decision that community service should be compulsory for every student and that marks will actually be allotted for the same. More than the decisi itself is the exact method of implementing the decision in su a way that the entire community gets maximum benefit, quite a from the good it will do to the s tudent's motivation.

Next in importance is the production and utilisation, at the local level, of nutritional needs -obtainable from agri- culture (staple carbohydrate); horticulture (vegetables and f animal husbandry (milk) and poultry (eggs).

Unorganised community/citizens/sharing an old traditiona customs is not to be given up for the western models of centr impersonal, official ridden institutions. CHARITY is to be pron as SHARITY, the CH as in Chicago. The poorest citizen in a w state need not ask for charity; he is entitled to share the available resources/facilities with the richest.

The challenge is tofind the solutions for poverty and ap local community action, under proper guidance and leadership, can cure the latter atleast and that will be an essential fore-r for curing the former. Shultz (Royal College of Medicine, I national Congress Symposium No. 24, P. 57) has underlined the importance of stressing on self interest which is a natural and an intrinsic aspect of human nature.

Ergonomics is the management of people. It is time one forgets New Delhi, metropolitan elite and concentrate on the poor people where they live and change their attitudes if possible.

We have no doubt that a very effective way of involving community, is to get a monetary contribution from each family The principle of obtaining such contributions from the commun is no longer disputed.. No Government in the world can offer provide all health services free, i.e. on its own general rev Besides such a personal conttribution will ensure the coopera and wholesome participation of the community, Any service wh is entirely free at the point of consumption is bound to be abused and is bound to enormously increase in cost year after year, as has been demonstrated in UK National Health Service.

In our scheme of Medical Aid Plan and Mini Health Centre it has been provided that each family should contribute, on behalf of all its members, 0.5% of its annual income subject to a minimum of Rs 12/- per annum and a maximum of Rs 200/- per annum. Here let me quote Dr.Mahler, Director General of WHO: "Are the costs exorbitant ? Recent small scale studies have shown that considerable improvements in people's health can t place for as little as 0.5 to 2% of the yearly gross national

This is by any standard a reasonable cost, around a hundredth what is spent on health by people in many rich countries. So factors should not hinder Governments when they consider if, a to what extent, they should commit themselves to the target of health for all by the year 2000" (World Health, November '79)

In addition, at the Health Posts manned by the Lay First Aiders, which form an integral part of the Mini Health Centre there is a provision for collection of 25 paise from the patie for the symptomatic treatment given by the LFA. Patients nor seek curative treatment only from the Mini Health Centre and t go to the LFA only when a sudden symptom arises at odd hours a she gives the symptomatic treatment, based on the complaint, f once only after collecting the 25 paise. She also tears off a coupon, writes on the back, the name, the complaint and the tr ment given. The LFA has been provided with a Hundi box in add to the kit bag. The Hundi box has two slits, one for the coin the other for the coupon. The supervisory staff open the box fortnightly intervals; the coupon provides both a financial an technical check on the LFA's performance. This charge is to ensure that the LFA is not taxed without a real need. She has been empowered to waive this payment in a really poor patient enter the fact on the coupon.

The pre-payment plan is better than payment for each serv A combination of both systems is effected when 0.5% of the ann income is charged for the community health programme and furth charge, if any, made when the need for referal arises. Of cou it is understood that while the family will contribute accord to its ability to pay, the services provided will depend on t medical needs and will have no relation to the quantum of the family's contribution.

It is therefore imperative that, on behalf of their emplo the Central and State Governments should offer 0.5% of the sala of each employee living in the MHC area. This will be towards individual's/community's contribution and will have nothing to with the expected Government grants (totalling 75% from the Ce and State Governments) to meet the annual recurring expenditur

Likewise the 0.5% contribution on behalf of industrial wor covered by the ESI Corporation must be transferred to the MHC entitled to it.

I began by saying the community initiates and the Governm should participate; likewise at the end I wish to focus evalu not on the lowest level of the LFA/CHV but on the highest leve For example, will Governments and ESI Corporation contribute o behalf of their employees? As regards the financing of health there are several methods which need to be urgently evaluated particularly on their content of preventive services. These schemes like, the Central Government Health Scheme, The Employ State Insurance scheme, the "awards" given by large employers the Life Insurance Corporation and the Nationalised Banks real provide very little for prevention of disease and maintenance

Finally, let us consider organised voluntary associations It is good to remember that voluntary health agencies have pla a significant role in the development of health care in India. Their main assets are (a) in their capacity to enlist the serv of devoted workers, particularly doctors, (b) to tap private f cial resources for the development of health and (c) to work ou operational experiments due partly to the personnel they can command and partly to the grater academic and administrative f dom they ordinarily enjoy. Their main handicap is the inadequ of financial resources available and this inadequacy is incre continuously because private charity is being spread too thin over an ever increasing number of voluntary organisations. I is obvious, therefore, that the voluntary organisations can pl a very vital part in the reconstruction of health care if the three principal assets mentioned earlier are recognised and d oped to the full and if their principal handicap is obviated through special financial assistance.

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"HEALTH FOR ALL BY 2000 AD

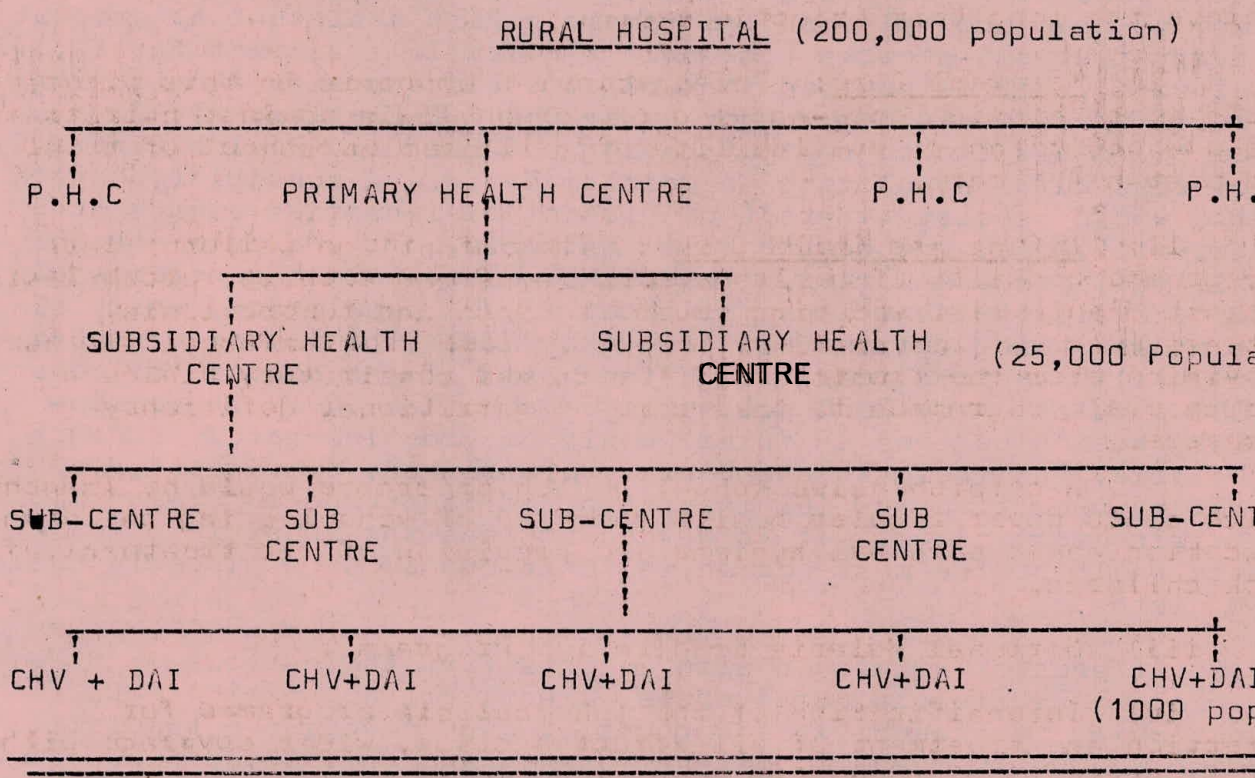
Contents

3.3.5 Every Primary Health Centre area has 2-3 or even more dispe saries of allopathic/ayurvedic/homoeopathic system. More and more such dispensaries are being opened. It is envisaged under the MP scheme to have one male and one female health assistant at one ou of every four sub-centres (one male and female assistant for 20,0 pppulation). It is propsed that all the dispensaries functioning in rural areas would be brought under the PHC Complex. It is pro posed to accept the concept of having a Subsidiary Health Centre every 2500 rural population on uniform basis. A subsidiary healt centre would consist of staff of present dispensaries, one health assistant female, one health assistant male, and one male and one female multipurpose worker. These subsidiary health centres woul undertake all the functions for about 25,000 population, which at present are being carried out from the PHCs. The number of subsi diary health centres required on the basis of one centre for abou 25,000 population by 2000 A.D.would be about 26,960. These sub- sidiary health centres in future would provide laboratory support to Malaria, Tuberculosis and Leprosy programmes, services for vasectomy operation and IUD insertion and to attend to common min obstetric emergencies. It is envisaged that the subsidiary healt centre would be the most peripheral unit manned by a properly qua fied doctor.

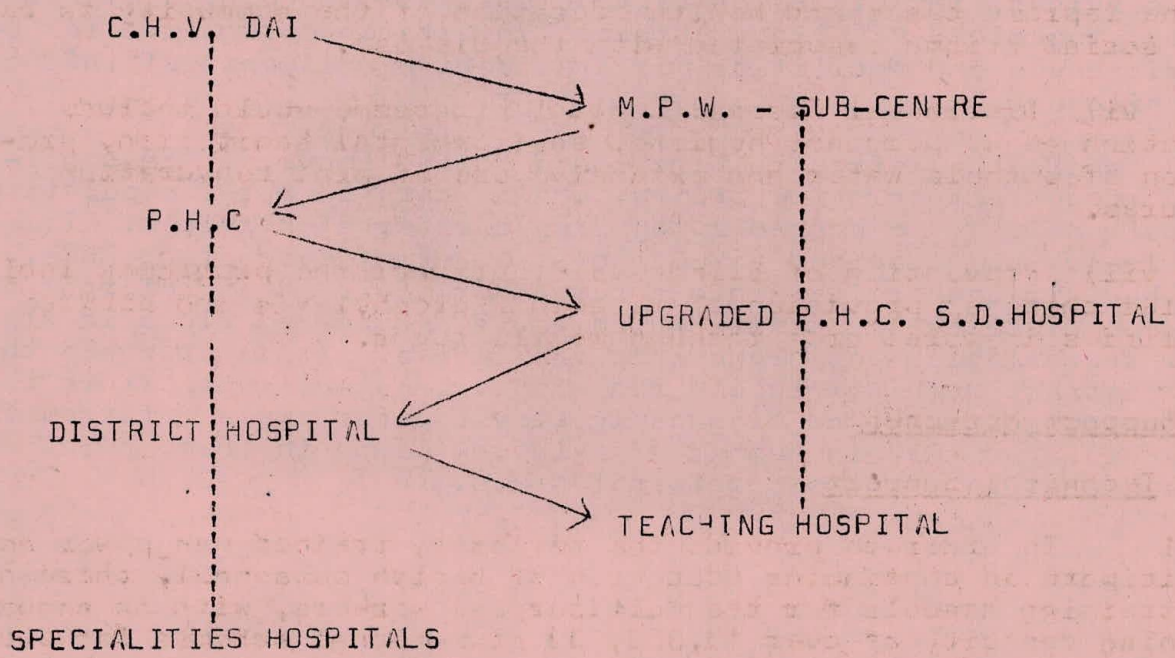
3.3.6 At present Primary Health Centres form the nucleus of prov ing health services in rural areas. These are about 5534 PHCs functioning at present in the country, each covering a populatio between 80,000 to 1,25000. It has been found that these PHCs are unable to provide adequate health coverage to such a large segmen of population. Additional PHCs would be established onwards in a phased manner so as to have one PHC for every 50,000 population In particular, the PHCs would be equipped to provide basic labora tory services, facilities of certain surgical procedures like vas ectomy, tubectomy MPP Minor surgical interference required in ob- stetric cases and facilities for treatment of ailments of infancy and childhood.

3.3.7 While the infrastructure, as detailed above, it is consi- dered adequate to provide primary health care to rural population it would need to be backed up by proper referral services. It has already been decided to upgrade one out of every four PHCs, a sub-district-hospital into a rural hospital. Next referral po would be district hospitals, which would provide services in all major specialities and diagnostic facilities. It is proposed tha each district hospital should run a spcial out-patient clinic to provide consultancy and diagnostic services for cases referred fr rural area and certain number of existing be ds in these hospital may be reserved for these referral cases.

RURAL SERVICE DESIGN FOR PHC



REFERRAL SYSTEM



3.3.8 In India about 21% of the total deaths are in the age grou 0-1 year and another 10.4% among the age group 1-4 years. Keepin in view the major causes of deaths, the main health programmes t o achieve the long term objectives are:

i) Maternal Care: The particular emphasis in this progra would be to provide ante-natal care, prophylaxis against nutritio -raluna and tetanus, availability of a trained personnel of natal and post-natal care.

ii) Infant and Child Care : The infant and children care programme consists of health education of the mothers, prophylax against diphtheria, whooping cough, tetanus and tuberculosis, extensive use of rehydration therapy in case of diarrhoeal diseas provision ofor the treatment of fevers and respiratory diseases and special programmes to take care of nutritional deficiency diseases.

A comprehensive school health programme would be launc which could cover regular health check up of school going childre education about personal hygiene and provision of the treatment o sick children.

iii) National Malaria Eradication Programme.

iv) Intensification of the Tuberculosis programme for detection and treatment of all effected cases, wider coverage wit B.C.G.vaccination and health education.

v) Leprosy Eradication programme would include screening of population for detection and bring under treatment all cases suffering from leprosy. The Programme would cover the rehabilita of the leprosy cases and health education of the community to rem the social stigma associated with the disease.

vi) Diarrhoeal Disease Control Programme would include education about personal hygiene, environmental sanitation, pro- vision of potable water and extensive use of oral rehydration mixtures.

vii) Prevention of Blindness Programme: the programme inclu regular check up provision of Vitamin A prophylaxis and service facilities in rural area through mobile teams.

4. Support Measures

4.1 Technical Support

4.1.1 In order to provide the nedessary trained man_power an participate in continuing education of health personnel, there a 390 training schools for the Multipurpose workers, with an annua training capacity of over 13,000, 33 promotional schools for the training of Health Assistants, 20 Nursing Colleges to train Pub Health Nurses and Sister-tutors, 44 Health and F.W.Training cent provide refresher and orientation training to the P.H.C.Staff.

4.1.2 The country has adequate capacity to train required medi man-power and specialists through its 106 medical colleges.

4.1.3 The various professional organisations like Indian Medic Association, Trained Nurses Association of India and others arran refresher training to their members.

4.1.4 In India, besides the government, large number of volun- tary organisations are engaged in providing health care to the people. The full advantage would be taken of these organisations by fully co-ordinating their work with the efforts of the Gover- ment in providing health care to the people.

4.1.5 The spcialised U.N.Agencies like UNICEF, UNFPA, WHO, UNDP are assisting India in various aspects of health programmes. Full advantage is taken of their technical expertise in developi the programmes for achieving Health for All.

4.2 Managerial Support

4.2.1 The managerial support to the primary health care programm at present is provided by the Central Institutes, particularly by National Institute of Health and F.W., All India Institute of Hyg and Public Health, Calcutta, Gandhigram Institute of Rural Healt and F.W., Gandhigram. It is proposed to strengthen these Institu further so that they may take up the following functions;-

i) Review the training programmes of various health functionaries;

ii) Participate in planning, implementation and evalua- tion of primary health care programmes;

iii) Undertake training of the trainers and provide guidance to the principal training institutes;

iv) Develop training methodologies, training aids and material;

v) Operational research studies on Primary Health Care System and utilization of manpower and facilities.

vi) Impact of the primary health care programmes on the health status of the community.

4.2.2 In addition, the support is also available to the healt sector from the national institutes in the field of Management, Public Administration, Communication, Man-power Development and Training.

4.2.3 The managerial support for the Primary Health Care deve- lopment and implementation is also derived from exchange of info mation and observation visits by the planners and programme mana to the other countries particularly the countries of the South East Asia region, which have much in common in the field of heal

4.3 Research and Development

In India the research in the field of health is co-ordinate by the Co-ordination Committee constituted by the Ministry of Health & F.W. The Committee provide guidlines and identify the priority areas. The research councils, Indian Council of Medica Research, Indian Council ofResearch in Ayurveda, Research Counci in Unani, Council of Research in Homoeopathy coordinate the research work in their respective fields. Besides this the operational research is being carried out by the different universities and medical colleges. Priority is given for the operati research in the field of primary health care delivery system, appropriate technology and management information system.

4.4 Information

In order to meet the requirements of planners and adminis stators, a properly built up information support is indispensab

4.4.1 Medical Care Programme

Date generated through medical care programme are useful not only for efficient management, planning and evaluation of m care programme but also for working out a morbidity and mortali pattern of the community and epidemiological studies as reasona accurate diagnosis of diseases is available. The requirements medical certification of causes of deaths and uniform classific tion of diseases is not uniformly observed by all hospitals.

It is proposed to strengthen the medical record keeping in hospitals and to adopt the Ninth Revision of Internati nal Classification of Diseases and new lists for tabulation.

4.4.2 Health Man-power:

Formulation and implementation of a realistic National Health Policy needs assessment of available health man-power an training facilities are essen ial. At present registration of professional by the statutory councils in respect of doctors, n dentists and pharmacists is the main source of information in respect of these categories. Council of Scientific and Industr Research undertakes voluntary registration of highly qualified Indian doctors abroad and those returning to India. Studies to estimate the stock of health professionals and the extent of brain-drain is undertaken by the Institute of Applied Man-power Research. Inspite of these efforts health Man-power data are not quite satisfactory.

It is proposed to strengthen the present mechanisms and to establish man-power units at the Central and State levels to coordinate the collection of information and develop the data collection on health man power, particularly in respect of more categories of health personnel, about whom no informati is collected at present.

4.4.3 Epidemic Intelligence:

National Diseases Control Programmes of Malaria, Filaria, Tuberculosis, Leprosy, Cholera, Trachoma, E.P.I. Disease and S.T have developed suveillance mechanism with a view to facilitate t containment. However epidemiological services are not yet well- developed. It is proposed to collect regularly statistics of ca and deaths of about 20 communicable diseases on countrywide basi

4.4.4 Primary Health Care:

i) It is proposed to strengthen the existing mechanism of collection of health information generated from rural communitie through basic health workers.

ii) Community health survey registers and village or town peoples to provide socio-economic and demographic situation of t community are being prepared. They would be further consolidate provide useful summary data on distribution of population by imm nisation status, family planning practices, nature of disabiliti chronic ailments, occurance of communicable diseases, maternal a child care, vital events, health education activities and many other useful informations.

4.4.5 Surveys and studies:

In order to meet the requirements, data from official hea statistics would be supplemented by special surveys and studies, particularly in the fields where the information is not being co cted routinely.

5 Generation and Mobilization of Resources

5.1 Human Resources/Development

5.1.1 Based on the health infrastructure required for the deliv of primary health care and back-up services required to support a long term plan to meet the requirements of trained manpower ha been drawn up. The country has developed the potential to train the required number of medical, paramedical, auxiliary and volun workers and it is proposed to put them in position in a phased manner during the next two five-year development plans (1980-85 and 1985-90). Necessary training facilities have also been crea to provide the trained trainers for manning the various training institutions.

5.1.2 The programme of re-orientation of the health workers and primary health centres Medical Officers has been made an integra part of the training programme in the new health plan. It is proposed to provide even to ten days reorientation to all the h personnel every year. The re-oreientation to the health personn would be provided by the Basic Training Institutions in collabo with the district level health personnel.

5.1.3 In view of the very large number of Community Health Vol eers (CHVs) it is not proposed to provide them institutionalise re-orientation training. The re-orientation training of the CH is being carried out in batches in the periphery by the medical officers and Health Assistants for one day every month. This i supported by a "correspondence course", which deals with the he problems indicated by the CHVs themselves. This programme has been launched from October 1979 and at present done on quarterl basis, but it is proposed to make it monthly in future.

5.1.4 The programme of health education of the community is carried out through group and inter-personal communication by t field staff. In addition, over 50,000 orientation camps are hel every year. Each camp is attended by 40 community leaders who in turn are expected to pass on the knowledge to the community members. In addition, full use is made of mass media like radi films, T.V. and print media to educate the public regarding the health problems. The Mass Education and Media Division of the Ministry of Health & F.W. and C.H.E.B guide and provide technic support to the similar units in the States to carry out the hea and population education activities.

5.2 Financial and Material Resources

To meet the increased requirements of financial and mater resources in the health sector following steps are proposed to be taken:

5.2.1 Higher budgetary provisions for health sector.

5.2.2 Preferential allocation for the unserved areas and popul tion and to the programmes specific to the needs of vulnerable section of the community.

5.2.3 Maximising the available resources by the adoption of appropriate technology.

5.2.4 Involving the community and encouraging them to partici and share some of the cost of primary health care.

5.2.5 Co-ordinating the programmes with the efforts of volunta organizations engaged in providing health care to the community

5.2.6 Utilizing all the trained man-power and facilities avai under the various Indian systems of medicine for the delivery primary health care.

5.2.7 Taking advantage of the assistance available from forei sources, international agencies and T.C.D.C. for the developme and implementation of Primary Health Care Programme.

Budgetary allocations for IV, V and VI Five-Year Plans as well as preliminary projection of Resources Estimates are give below:

I. Table I Showing Budgetary Allocations for Health during the Year (1969 - 1983)

Item	IV Plan (1969-1974)	V Plan (1974 -1978)	VI Plan (1978 - 83)
	(In Million of Rupees)		
(A) Public Health i) Rural Health	765(17.5%)	1203 (17.6%)	4900(36.8%
ii) Communicable Diseases Control	1270(29.3%)	2651 (38.9%)	4500(33.8%
Total	2035(46.7%)	3854 (56.5%)	9400(70.6%
(B) Others (including Urban institutions etc.)	2304(53.3%)	2962 (43.5%)	3900(29.4%
Grand Total	4339(100%)	6816 (100%)	13300 (100%

Allocation for Nutrition and Water Supply are shown in Table II below:

II. Table II Showing Plan Allocation for Nutrition and Water Supply Sanitation for the period (1974-

		V Plan (1974-1978)	VI Plan (1978-83)
		(in Million of Rupees)	
(A) Water Supply and Sanitation	Rural -	1940	3470
	Urban -	3800	4060
	Total -	5740	7530
(B) Nutrition		1156	1745

III. Gross approximations of resources needed for attainment of HFA/2000 amount to 71820 Million of Rupees over and abo the current level of allocations for 1980 - 2000. Thus, there will be an average shortfall of 17,955 million of Rupees per each five-year plan period.

6. Inter-Sectoral Collaborative Mechanism

The National meeting on India's strategies for achieving He for All appointed separate Working Groups to recommend the mechan for intra and inter-sectoral collaboration and they have recommen

6.1.1 Setting up of a National Coordination Committee for Health for All under the Chairmanship of the Prime Minister with ministe of all the economic and social welfare Ministries as its members.

6.1.2 A committee to review the progress of Revised Minimum need Programme (R.M.N.P) has already been constituted under the Chair manship of Cabinet Secretary. This committee would appraise the implementation of the R.M.N.P in respect of health, housing, wate supply, sanitation and social welfare programmes.

6.1.3 To bring about meaningful coordination in the plan approac and implementation of programmes by various concerned Ministries, a Standing Coordination Committee under the Chairmanship of Advis (Health) Planning Commission should be set up with Joint Secretar of the concerned Ministries as members.

6.1.4 Similar committees should be set up at State and District lev

7. Monitoring and Evaluation

7.1 In view of the high priority given to the rural health prog the need for developing an efficient organization for monitoring evaluation is well appreciated. The steps to build up such an or zation would involve:

7.1.1 Improvement of system of Maintenance of records and data reporting from periphery.

7.1.2 Standardisation of definitions, reporting procedures and tabulation plans.

7.1.3 Improvement of system of storage, retrieval and data handl

7.1.4 Providing in-service training to health statistical perso

7.1.5 Establishing machinery and mechanisms for sample surveys and special studies and programme evaluations.

7.2 The indicators to be used initially would:

7.2.1 Health Status Indicators

Like Death Rate, Birth Rates, Infant Mortality Rate, Chil Mortality Rate, Maternal Mortality Rate and expectation of life a Births.

7.2.2 Health Organization Indicators: would cover health organ zations and health manpower in relation to population.

7.2.3 Health Service Indicators: would be in particular relati to the national health programmes like:

- percentage population covered by E.P.I
- percentage of expecta nt mothers provided anti-natal care prophylaxis against anaemia and tetanus
- percentage of deliveries conducted by trained personnel
- percentage of couple using contraceptive methods
- number of fever cases investigated
- number of tuberculosis, leprosy cases detected and brought under treatment, and so on.

7.2.4 Health Impact Indicators

These would include disease specific morbidity and mortal particularly in respect of prevalent communicable diseases.

STRATEGIES FOR HEALTH FOR ALL BY THE YEAR 2000 * - INDIA

1. Main Health and Health Related Problems

1.1 India is a vast country with a population of 646 milli (estimated as on 1st March, 1979) and density of population of about 196 sq.Km. Though the rate of population growth in the decade has come down from 2.24% to 1.95% per annum and is like to go down further to 1.64% per annum by 1991, the population projection indicate that the country's population would increa about 799 millions by 1991and to 917 millions by 2000 A.D. Ov 78% of the country's population is settled in 575936 villages, nearly half of which have a population of 500 and less. Even amongst urban population, there are only 370 towns with popula tion of 50,000 and over, remaining of the Urban population re- side in small towns. Children in the age group 0-14 constitut little over 40% of the total population. There is a vast dis- parity in dispersal of population from areas to areas. While density of population in States of Kerala and West Bengal is over 500 per sq.km., it is less than 50 per sq.km. in Mizoram, Arunachal Pradesh, Manipur, Meghalaya, Nagaland, Sikkim and Andaman and Nicobar Islands.

1.2 Only 32.93% of the total population constitute the wor ing population resulting in a higher dependancy rate. Being p dominantly agricultural country about 70% of the working popul tion is either cultivators or agricultural labour. Employment among woman is extremely low, only 17.36% of the working popul tion is female. Per Capita G.N.P for the year 1977-78 was onl Rs 1163 and per capita availability of foodgrains only 472.6 g Using caloric consumption as a norm it is estimated that 48% of the rural and 41% of urban population is living below the poverty line. Unemployment is estimated to be 20.6 million person years during 1978. The concept of poverty is wider and includes not only those unemployed and poor but also those who are fully or partly employed and earn very little because of l productivity or low wages. There are certain disadvantaged gr in society like scheduled castes and scheduled tribes, which continue to suffer from social disabilities and poor economic status.

1.3 Inspite of primary education being compulsory and con- certed national efforts, literary rate continue to be low- onl 39.44% male and 18.69% female being literate. While literary percentage has increased appreciably in the recent years, the number of illiterates is estimated to around 387 millions, majority of them belong to 30+ group.

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* Report of the Joint WHO/UNICEF Meeting on Strategies for Hea For All By the Year 2000, New Delhi, 24-30 June 1980.

xix) Encourage research on alternate appraches to health car delivery systems and a discovery of simple low-cost app ropriate technology.

xx) To provide legislation support wherever necessary.

2.2 Social and economic policies: The social and economic pol of the Government are directed towards:

2.2.1 Launching of new economic programme through country's Fiv Year Development Plans to focus attention on twin objectives of increasing production and promoting social justice.

2.2.2 To make the reduction of disparities of all kinds - soci economic and regional - one of the central objective of develop planning.

2.2.3 To direct the planning to solve over a period of time th problems of the poor of all communities, expecially tribal, har backward communities and regions.

2.2.4 Provision of fuller employment as a surest means of prom greater social justice, by augmenting agricultural productivity vigorously implementing land reforms.

2.2.5 Vigorous efforts to implement the 20 point socio-economi programme launched by the Government.

2.2.6 Very high priority to the elementary education programme increasing enrolment for secondary education with vocationalisa the secondary stage, and additional facilities for weaker secti of society and in backward areas for university education; and strengthening of national adult education programme.

2.2.7 Launching of Integrated Rural Development programme with social services inputs.

2.2.8 Special development plans "Tribal sub-plans" for the dev ment of tribal economy.

2.2.9 Special services for the welfare of backward classes.

3. Main Long-Term Programme

3.1 Objective

3.1.1 General Objectives:

i) To provide improved health care delivery system to make primary health care services available to all by 2000 A.D.

ii) To make people conscious of their health needs and to make them plan and participate in the health programme.

iii) To improve the standards of environmental sanitation and personal hygiene leading to reduction in incidence of diseases and healthier life.

iv) To improve maternal & child health services.

v) To create awareness about the need and advantages of small family and encourage adoption of contraceptive practices

vi) Control/eradicate common communicable/and infectious diseases.

vii) Bring down by about 50% death rate; and maternal and in mortality rates.

3.1.2 Specific objectives

Showing targets of "Health for All by 2000 A.D."

	Present	2000 A
Crude Death rate	14.1	9.0
Infant mortality rate	129	Below 60
Perinatal mortality rate	60-109	30-35
Preschool (0-5 years) death rate	35-40	10
Maternal Mortality Rate (MMR)	5-8	Below 2
Life expectancy at birth	52.6 M 51.6 F	64 yr
Birth-weight below 2500 g.	30%	10%
Crude birth rate (per 1000)	33.2 (1978)	21.0
% Effective couples protection	22.0	60.0
Net reproduction rate	1.67	1.0
Natural growth rate	1.9 (1978)	1.26

	Present	2000 A.
Family size	4.3	2.3
% pregnant mothers rural receiving ante-natal care	46.3% (estimate)	100%
% of deliveries by trained birth attendants	10-15% (estimate)	100
% population with protected water supply	R 10 U 80	100 100
% population with sound excreta disposal	R 10 U 34	50 100
Immunisation status (percentage coverage of pregnant mother and infants)		
a) TT	21%	100
b) DPT	51%	100
c) Polio	18%	100

3.2 Approaches:

3.2.1 The main objective will be to provide better health care services to the rural areas and poor people.

3.2.2 People has the right and a duty individually and collectively to participate in the development of health. Government and the medical professions would help the people in realisation of their responsibility by providing a large band of health workers from among the community itself to take care of basic health needs of the community.

3.2.3 Government recognises the need for more equitable distribution of health resources, and in order to correct the past imbalances, preferential allocations would be made for developing health facilities in rural areas. Even while developing health services in rural areas, priority would be given to satisfy first and foremost the health needs of mothers and children and of weaker sections of the society.

3.2.4 The main emphasis would be on preventive, promotive and rehabilitative aspect of health which would be integrated with the functions and responsibilities of all those institutions, which at present are providing only curative services.

3.2.5 In providing primary health care to the people, full advantages would be taken of the traditional methods and techniques which are scientifically sound, familiar and acceptable to the community, and easy to adopt. For this purpose, the facilities and man power presently available and developed in future

under different Indian system of medicine would be fully utilised in the delivery of primary health care.

3.2.6 Primary Health care would form an integral part of the hea system. Proper linkage would be established so that the total he system supports the primary health care programme by providing consultation on health problems, referral of patients to local an more specialised health institutions and supervision and guidance

3.2.7 The further expansion of health facilities under different systems of medicine would be so planned and coordinated that they support and complement and not compete with each other in providi health care.

3.2.8 The medical education would be restructured to give it a positive bias towards community health.

3.2.9 The training programmes of health workers has been modifie to give it a special orientation and technical training to meet t health needs of the population, they are to serve.

3.2.10 Education, motivation and provision of services for incre sing the adaptation and practice of contraception would form an integral part o the primary health care system.

3.2.11 The pace of providing safe, adequate and potable water supply to the villages would be accelerated.

3.2.12 Appropriate technology would be developed for adoption fo safe disposal of spent water and human-wates to improve the sani- tation.

3.2.13 Necessary guidance and support would be provided to weake sections of the community for construction and improvement of housing facilities in villages.

3.2.14 In order to facilitate planning, evaluation and implement of the national health plan and policies, the health information system would be strengthened and streamlined.

3-2.15 The evaluation system would be built up, so that the imple tion of the policies, strategies and the plans of action can be m tored and their impact in improvement of the health status of peo can be assessed.

3.2.16 The Primary Health Care programme would be fully coordina with other socio-economic programmes like Integrated Rural Devel ment Programme, Nutrition Programme, Integrated Child Development Scheme, National Adult Education Programme, which have been laun- ched by different Ministries/Departments of the Government.

3.2.17 Various social and voluntary organizations working in rur areas would be encouraged to participate in the implementation of the health plans and the delivery of the primary health care.

3.2.18 No linear expansion of curative services in urban areas

except in few cases where the need for such expansion is justifi on sound principles of need and priority. In such cases urban areas would be expected to meet a part of the cost of these faci- lities.

3.3 Health System:

3.3.1 It is estimated that by the year 2000 A.D., the populat of India would increase to 917 million - 674 million rural and 24 million urban. The subsequent five year development plans of the country would take into account the need of health infra-structu required for the delivery of the primary health care to this inc sed population. The health infrastructure envisaged would be a follows:

3.3.2 The Government has already accepted the policy of creati a band of voluntary health workers by training persons selected b the community under the Community Health Workers Scheme. It is proposed to train about 5.8 lakhs CHWs during the present plan pe 1980-85, so as to have one CHW for every village. Thereafter Gov nment propose to continue the training programmes for creating in creasing number of health guids/health promoters in rural areas, who can take up preventive and promotive aspects of health care on voluntary basis.

3.3.3 The dais (indigenous birth attendants) training programme has already been intensified and it is proposed to train 5.8 lak dais by March, 1983 so as to have one trained dai for every villa Realising that in large number of villages, there is more than on dai functioning at present and each dai is traditionally attached to only limited number of families, the dais training programme w be continued beyond 1983, with the aim of training all the dais practising in rural areas. There are certain parts of the countr where indigenous dais do not function and their role is performed by elderly women of the family. A programme through village Wome clubs would be launched to educate them regarding the needs and c of expectant mothers during ante-natal, pre-natal and post-natal period.

3.3.4 It has been accepted to have a health sub-centre with one male and one female multipurpose worker for every 5000 population There are about 50000 sub-centres by the end of Year 1979-80. It is proposed to have additional 30,000 sub-centres during the plan period 1985-90. Based on the present norms, country would need about 1,34,800 sub-centres by 2000 A.D which would mean establish of 23,000 additional sub-centres after 1990. These may be opened during the period of 1990-1995, so that the norms of having one subcentre for every 5000 rural population on 2000 A.D. population base is achieved. At present the functions of a sub-centre are limited, and it is not able to meet even some basic health needs. It is proposed that the facilities in future would be provided at all the sub-centres for IUD insertion, and simple laboratory in- vestigations like routine examination of urine, for albumin and sugar. The MPWs would be trained for this purpose. Creation of those facilities would undergo long way in greater acceptance of IUD and detection of common complications of pregnancy.

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WILL PRIMARY HEALTH CARE EFFORTS BE ALLOWED TO SUCCEED?

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Abstract—It is suggested that the consequence of following Primary Health Care (PHC) principles as guidelines for health care development must of necessity lead to socio-economic and political restructuring in most countries. We are well aware that health status is determined more by the social and economic situation of population groups than by curative health services. The holistic approach of primary health care includes a concern with such factors. PHC, if it is to succeed, must ultimately lead to a reduction in the greater benefit for the few to the greater benefit for the many. This will receive strong opposition.

The situation of a PHC programme in Guatemala is presented as a case of PHC efforts which were succeeding being violently opposed. This is compared with PHC development efforts in Tanzania where, unlike Guatemala, there has been a conscious effort at restructuring the society and where national development policies are in tune with PHC principles. The future of PHC in Tanzania will depend more on whether or not the organization and management of selection, training and implementation processes, and the minimal available resources, will lead to success, than on whether or not it will be allowed to succeed.

It is concluded that the situation in most countries comes closer to that of Guatemala than of Tanzania and that many people and institutions in hierarchial, non-egalitarian societies will spend a great deal of energy to prevent PHC programmes from succeeding. This forces us to consider the promotion of PHC in a much more serious manner than we might wish.

It is my contention that the natural consequence of accepting Primary Health Care (PHC) principles as guidelines for health care development must be a restructuring of the socio-economic conditions existing in most countries of the world [1]. In the light of this one must ask whether or not the implementation of PHC concepts is really possible. Will PHC efforts be allowed to succeed? Most countries do, of course, profess a desire to improve the health status of their populations. Much verbal support is given to the PHC approach and many countries have formulated national PHC plans. It is espoused as the most appropriate means for achieving 'Health for all by the year 2000' [2]. But the degree to which such efforts are being allowed to be implemented depends on existing national political, as well as socio-economic, characteristics.

PHC is not only a matter of curative medicine and that which we have come to think of as preventive medicine, but is concerned with active health promotion and development activities:

> The practice of medicine is only a small part of the total pattern which includes responding to total community need, whether that be in the field of agriculture, marketing, housing, home-crafts, nutrition, family planning, schooling, transport . . . " [3].

It is by now a well established fact that such improvements as clean water, enough food, a minimal economic level, environmental sanitation and the like, are the crucial factors affecting health status. McKeown, in his review of health statistics from England and Wales over the last several hun years has clearly shown this to be so [4]. It i course, these ideas which are being restated in various declarations of PHC.

The concern of any government advocating should be with making changes to improve the situation of communities. Such improvements quite often the consequences of basic changes i social and economic situation of particular p lation groups, and are related to issues of s justice, equal access to available resources and return for one's labour [5].

As such PHC is nothing new. We may recogni PHC principles much of the philosophy expresse Virchow more than a hundred years ago. "Med is a social science and politics is medicine on a scale" [6], and more recently by Dubos [7] and o [8],

> "... health and illness are to a considerable determined by the existence of a particular mode of and economic organization ..." [9].

The growing acceptance of the (renewed) perspective is not only a challenge to medical health professionals but to anthropologists and social scientists as well [10]. As Foster states,

> "On the surface, at least, it looks as if the time is prop for anthropologists to play an increasingly important international health programmes" [11].

Even if PHC is only a fad or a hopeless and i sible dream, rather than the enduring enterpri may wish it to be, social scientists must now ta opportunity to have their voices heard and to concrete contributions to the processes of h development (in planning and implementation a

*The views expressed in this article are those of the author and do not necessarily represent those of the institution with which he is associated.

as in evaluation) which draw on the holistic perspective for which there was only limited receptivity in the past [12]. If social scientists, who attempt to understand the 'human condition', are to participate in these processes they must be concerned with issues of justice and human rights—with analysis and exposition of exploitation, and they must discuss (health) development in terms of such analysis [13].

A few countries, such as China, have attempted revolutionary restructuring of the total society. Without necessarily holding these countries up as paragons (the reality does not always mirror policy!) PHC efforts related to such general development operate within quite different parameters than health development efforts in countries which do not profess such encompassing reconstruction policies [14].

Despite the common pronouncements of brotherhood, equality and freedom, most countries are not engaged in social reconstruction but are quite clearly maintaining stratified socio-economic as well as political structures which benefit the 'haves', not the 'have nots'. In these societies, PHC, as ultimately a social enterprise, may be seen as subversive and even revolutionary.

A great deal of reliance has been made on the so called barefoot doctor or Village Health Worker (VHW) to provide PHC services to village communities [15]. In all too many cases, however, such services have consisted almost exclusively of simple treatment for a few diseases. This does, of course, constitute a real service as McKeown states:

> The conclusion that medical intervention is often less effective than has been thought in no way diminishes the significance of the clinical function. When people are ill they want all that is possible to be done for them and small benefits are welcome when larger ones are not available [16].

Curative medicine is what people themselves want and providing this is usually what official and unofficial national and local decision makers see as the rightful role of health workers. Provision of curative medicine is also held out by the authorities as a sign that they are concerned with, and are doing something to improve, the health of the population. But putting plasters on boils will not reduce the number of sores which will fester. It does not attack the underlying causes of disease prevalence. It does little to improve the overall health status of the community.

To bring about such improvement is a difficult task. It is not achieved through the kind of health care which can be delivered by a technically capable health worker, at whatever level, through an injection or other clinical treatment. It requires active engagement on the part of the people themselves and changes within the structure of their community. One of the functions of the PHC workers, therefore, is to increase people's awareness of their own situation, to help them to recognize problems and to develop a reasonable and jointly agreed upon plan of procedure. Some have called it a process of 'conscientization' [17]. Health workers

> "... must create in the people an understanding that they have the ability to solve most of their problems themselves, that assistance is available when it is needed and that occasionally public action is necessary.... The challenge is

to increase the people's control over their enviro [18].

We know well enough, however, that the sit of rural communities is not entirely controlled people in those communities themselves. Ce what is necessary is self-help action and cha health related behaviours. But there are other forces at work, such as the manipulation of prices and the control of resources by a ruli [19]. Can or should VHWs also motivate their neighbours to influence or to improve the re ship which exists between the villagers and forces?

If a VHW takes on the role of PHC worke broadest sense he/she may be seen, accord David Werner, as:

> "... an internal agent of change, not only for heal but for the awakening of his people to their human p and ultimately to their human rights. In countries social and land reforms are sorely needed where opp of the poor and gross disparity of wealth is tak granted it is possible that the health worker knows a and thinks too much. Such men are dangerous. They germs of social change" [20].

Some may ask if we have the right to motivate to discuss and encourage changes outsid confined arena of medical care. Should issues s improved marketing mechanisms, buying c atives and land tenure questions be include many countries this will mean stepping on dan ground. It may mean that VHWs, and the vi they motivate, put themselves at risk—at r repression or even open violence and brutal re [21]. Such reprisals to health workers in Bangladesh [22] and in Guatemala [23] testify danger involved. Many have been killed, and intimidated and forced to abandon their work answer is not simple.

Following the PHC approach does not neces mean that VHWs should forcefully challenge e power structures nor that VHWs should be r tionaries; much can be done conservatively. Bu not always easy to anticipate what the reactio be to a group of people which becomes mor reliant and less susceptible to manipulation outside. This article addresses the question, PHC efforts be allowed to succeed?" by desc the fate of a project initiated in the Departm Chimaltenango, Guatemala some twenty year by a private voluntary agency. This progr focused on the selection, training and use of VH *promotores de salud*—who worked on a par basis in their own communities of Cakc Indians. More than 85% of the population Department is Indian. But the programme also involved with agricultural improvement operatives, water development schemes, Ma and Child Health services and additionally hospital for the Cakchiquel population [24].

The philosophy of this programme is summ in the statement:

> "... the service is for others, on their terms, at their l understanding, in their language, and with their best i always the important stake in the deal ... nothing gen will happen in the offering of total community m services until such services are dispensed generally b

unsophisticated on the patient's terms, and not by the sophisticated powerful who sell medicine as a commodity at their price [25]".

This programme was controlled by a board made up of the Indians themselves. Indian peasant men were chosen by their own neighbours for training and returned to work on a part-time basis in their villages as health workers. Once a week they participated in a half day continuing education session and once a month a skills evaluation exam was required for them to be able to maintain their status as VHWs. The training programme began and ended with a week of classes, but the core of the instruction was carried out during one day per week for a year at the programme's hospital and clinic facilities in the town centre. It was deemed important not to remove the trainees from their villages for too long. The programme does receive some funding for its various activities but:

"...even if all costs must be borne by the patient, the ... programme demonstrates that many communities, which could otherwise not afford a physician, can support medical services delivered by non-physicians" [26].

It was felt important that the service should be something the villagers themselves could control and support.

Village people tended to trust, understand and rely on the VHW because they identified with him as one of their own. It was significant that health workers were also peasant farmers dependent for their livelihood on cultivation before they were practitioners and as such were integral members of their communities. This understanding of the community and intimacy with the lives of its members, was crucial. When treated by the VHW the villagers said they understood the treatment since it was administered by one of their own, in their own language, and in a style and setting familiar to them, interspersed with the full range of gossip that occurs in ordinary conversation. The VHWs practised a simple form of Western, cosmopolitan medicine, but it was framed within the socio-cultural milieu of the patients the programme serves.

The programme continuously impressed upon the VHWs that although the importance of curative medicine should not be minimized, it could not by itself break the cycle of poverty and repeated ill health [27]. Thus the involvement in agriculture, land tenure, water, sanitation and other village efforts beyond the narrow confines of medicine was constantly encouraged. This programme helped in making the Indian population in this part of the Guatemalan Highlands increasingly conscious of their own collective situation. And, with increased communication between different Indian communities throughout the country, they recognized that their own situation was quite similar to that of other communities. A severe earthquake in 1976, in addition to causing a great deal of destruction and killing more than 20,000 people, also seems to have increased communication between Indian groups, and prompted various self-help activities. Villagers realised that they could take certain actions to improve the situation within their own communities so that they would have less of a need, for example, to become seasonal migrant labourers on the lowla plantations.

In one village a co-operative venture was start In another an agricultural improvement project. still another a chicken project; several villages c wells and installed piped water. A few joined toget and were able to buy a piece of land which worked co-operatively. Here and there the spirit self-help and co-operation in bringing about sn development efforts blossomed and began to impr the lives of those involved.

Many of the health workers as well as other vill leaders and special 'improvement committees', w in the forefront of bringing about such projects their villages. Most still spent their time treating t sick neighbours and dispensing medicine but as philosophy of the programme was based on a holi view of health other activities were also seen by th as central to their health work. It is after significant that these workers are called 'promot de salud'—*promoters* of health.

At the end of the 1970s and during the first y of the 1980s certain factions within Guatemala came increasingly concerned and threatened by t activities which seemed to improve the lot of Indians. The repression and sporadic violence w had been at a relatively low level throughout 1960s and 70s started in earnest [28]. Those villa attempting to make changes were called unpatri traitors and communists by those who benefited f maintaining a suppressed and dependant Indian p ulation. Most villagers were quite ignorant ab such political theory, however, and were simply volved in bringing about some small improvemer the lives of their families and their neighbours. P military gangs from the towns invaded the c tryside. Houses were destroyed. The incidenc torture and murder increased, reaching a new during the Lucas regime of 1978–1982.

The VHWs were some of those particularly so out in their villages for reprisals. Many were ki Eleven of the 49 VHWs in the Chimaltenango gramme were 'eliminated' and members of families were killed. Many went into hiding [29]. were far from being revolutionaries in the true s of the word. They were not involved in aggre actions, either armed or unarmed, against the l lords or others with power and privilege outside villages. But in attempting to make changes in villages and become more independent and reliant they were seen as threatening the exi power structure.

Why were these self-help activities more th ening now than before? The answer may be fou the fact that although Indians have been acti efforts to improve the situation in their villages long time it is only recently that a collectiv national, consciousness has developed. Accordi Shelton Davis, what had taken place was a:

"...transformation from a local, community based nomenon to a national political movement [and it i which] has led to the recent political violence against I communities" [30].

Until recently Guatemalan Indians drew their tity from their own village, or from the town to v

it related, and did not have substantial collaborative ties with Indians elsewhere. Changes did, of course, occur as a result of the revolution in 1944 and during the more egalitarian governments of Arevalo and Arbenz which recognized the rights of the Indians. During this time a few Indians were elected to local political office. This political participation, the activities of the labour movements (e.g. the formation of the National Peasant Federation of Guatemala) and the agrarian reform bill which gave rise to local co-operatives had significant impact on the Indian population. But at the time of the coup in 1954, which brought a return to a successive number of repressive regimes, a national movement had not been established among the Indian population.

It was not until the mid-1970s that co-operatives, growing out of the Catholic Action movement—originally an 'anti-communist and anti-protestant' movement—again flourished. Politically, Indians made great strides through their participation in the election of 1974 when they won a number of mayorial seats. More significant than municipal victories, however, was the election of an Indian representative from the Department of Chimaltenango to the national congress, the first time that this had occurred. This represented not only a 'first' in Indian representation from Chimaltenango but "it marked the beginnings of political co-operation among Indians across municipal boundaries" [30].

The 1970s also saw a rejuvenation of the labour movements and at this time these consciously attempted to establish bonds with the Indian population. In 1978 the Committee for Peasant Unity (CUC) was established which was the first organization to unite Indian and non-Indian peasants alike.

Village improvement schemes throughout the country were now no longer simply viewed within a local context because:

> "by the end of the 1970s a major political mobilization had taken place among the Guatemalan Indian population. The social and economic horizons of this population had not only been expanded by the activities of foreign missionaries and participation in rural co-operatives, but also new alliances had been formed among socially conscious Indian leaders, opposition political parties and an increasingly militant labour movement" [30].

Such political participation and collaboration on the part of the Indians were not tolerated and as a consequence anyone promoting village improvement projects, no matter what their nature, was suspect and treated violently.

In March of 1982 Guatemala had a change of government*. The Chimaltenango health programme which had come to a stand-still in 1980 is beginning to partially function again; at least the hospital and clinic and some of the other activities are operating. Many of the VHWs, however, are still inactive or in hiding. They are fearful that they or their families may come to harm should they again actively resume their health work.

It is claimed by the Government and in the international press that the rate of violence which characterized the Lucas regime has now been greatly reduced and that there is a renewed sense of in the country. Others are not so optimistic, h especially not with respect to the Indian pop [31]. There are still reports of repression, killi even village massacres [32]. Amnesty Inter has claimed that at least 2600 people wer during the first six months of the new regime [number of Guatemalan Indians in the refuge in Chiapas, Mexico, continues to increase da number of displaced people within the coun been stated as numbering in the hundr thousands [34]. The situation in Guatemala fact it is in most of Central America, is critic future is at best uncertain.

What the future will hold for this progra difficult to say. But it seems quite clear that s the individual workers were killed, not becau were political revolutionaries, but because the begin to show some form of success in terms goals. I believe it was precisely because thes efforts were succeeding that they were rep They were not allowed to succeed! As Oscar G one, has stated, "it is regrettable that in all to countries the interests of the few are exce destructive of the health needs of the many Bryant, in 1973, raised the same issue:

> Health is but one of a number of social benefits c populations are deprived, and any inquiry into the redistribution of those benefits should be concerned basic structure of society, the way in which p balanced, and the extent to which there is a late ingness to share that power and those benefits [36

One is justifiably sceptical about whether t willingness to share such power and whethe with power will come to see it as their interest t more equitably available resources.

The socio-political background and the devastating situation in Guatemala can not plored in detail here, but must be understood considering the prospects for PHC in that c (numerous sources exist for this purpose) [37] temala is not unique, however. In any hiera and non-egalitarian society PHC efforts, w seen within a local or national context, repressed when they begin to succeed, since suc necessity implies an attack on existing socio-p and economic structures. The violent repres the VHWs in the Chimaltenango Programme course not a direct result of, nor proportional threat their activities represented to local elit these activities were associated with those of throughout the country which at this point i temala's history could have succeeded, collecti restructuring the total society.

Some may well ask if the attempt at crea successful PHC programme was worth it; if t in terms of death and fear, which still remain worth whatever advances were made. Was it the slight (and temporary) improvements in th of the people? Are the people really any bet now than before? In many ways the situation Indians today is immeasurably worse than it w years ago and only they themselves can whether whatever advances and whatever ne sciousness and determination gained were 'wo

*This regime was in turn overthrown in a coup in 1983.

In comparison, the development of a PHC programme in a country such as Tanzania is quite a different matter [38]. It is true that there are many problems to be faced in that country as well, and that people with power are not eager to share it: the 'Bwana Mkubwa' (big man) syndrome still exists. Nevertheless from Independence (1961) onwards, Tanzania was concerned with restructuring the whole society and, since the Arusha Declaration [39] in 1967, which formed the blueprint for Tanzania's development, an emphasis has been placed on self-reliance, on 'sharing the little we have' and on extending social services to the rural sector. The equitable distribution of health services was a major concern and health was seen, already then, as an integral part of an overall social and economic development process. It is quite a different matter to develop a PHC approach within such an atmosphere. Here the main problems are lack of drugs and transportation—of limited resources—and problems in management and organization [40].

In 1974 the final stages of a 'villagization' programme was carried out with the objective of locating the total rural population in villages [41] instead of being dispersed in isolated settlements. The main justification for this transformation included the provision of educational, water and health care services. It was stated that although every person had a right to such services they could not be provided easily to widely scattered populations living in settlements of only a few households each. Except for a relatively small nomadic population rural Tanzanians now live in 8300 villages and in more than 3000 of these there are government health units.

Hospital services continue to account for the largest share of the health care budget but since the late 1960s, and throughout the 1970s, a definite shift has taken place. Health resource allocation for the rural sector was only 20% in 1971 but more than twice that, at 42% in 1981 [42]. From 1972 to 1980 the number of urban doctors increased by 43% (to 598) whereas the doctors in rural areas increased by 153% from 216 to 547 during the same period. The number of Rural Medical Aides (RMAs) increased five and a half times to 2800 in the rural areas and there was a ten-fold growth of rural health centres and a near trebling of rural dispensaries (Table 1). In 1979, it was found that 92% of the population were within 10 km, and 70% were within 5 km, of a health facility, and 45% had such a facility within their place (village) of residence.

Despite the vast improvement in the rural PHC infrastructure health statistics have not shown marked improvement in many areas [43]. It is recognized that this is not simply related to the functioning, or non-functioning of curative services but is tied to a number of other factors such as the availability of food as well as inadequacies of preventive and health promotive services. Attention is being focused on the improved functioning of existing health units and staff through special training programmes and operational research [44].

Even with improved functioning of existing units it remains that these exist in only one third of the country's villages and that time and limited economic and manpower resources make it unrealistic to think

Table 1. Development of rural health care infrastructure in T
zania 1961–1980

	1961	1972	Target 1980	Actu 198
Health centres	22	99	300	23
Dispensaries	975	1501	2300	260
Medical assistants	200	335	1200	140
Rural Medical Aides	380	578	2800	231
MCH aides/village midwives	400	700	2500	207
Health assistants	150	290	1800	68

From: AFYA, United Republic of Tanzania. 1982, Country Re
of Tanzania. Prepared for the WHO Workshop on Prin
Health Care, Ethiopia, 1982.

of a dispensary, let alone a health centre in ev
village within the foreseeable future. Attentior
re-focusing on the selection, training and use
village health workers. These are the *Wahuduma*
Afya vijijini, now known as Community Health F
moters (CHPs). The newly re-formulated Natic
PHC Guidelines document, which was preparec
1980–1981, is centrally concerned with establish
CHPs in the villages without an official health fac
[45].

Community Health Promoters have existed in T
zania for some time with a substantial numbe
them being trained since the late 1960s. Many
those trained in the late 1960s and in the 1970s v
relatively young men and women with at lea
standard seven education. They were not part of
official health system but were voluntary wor
who were to receive some financial support from
village in which they worked. In most villages
support was not forthcoming, or at least only irr
larly so and in very small amounts. Supervi
support from within the village and perhaps r
significantly, from health personnel within the off
health system, was sporadic (or non-existent).
CHPs often felt isolated and as if no one particu
cared what they did. Drugs were often in short su
and even when transportation to the district hos
was possible, sufficient drugs might not always
been obtainable there either. These and other p
lems were the reasons for a relatively high drop
rate so that only a small proportion of those tra
remained active for long.

The new national PHC Guidelines have attem
to overcome some of the problems of the
programmes of the past and of those existir
present. It is now proposed that, allowing for reg
differences and being sensitive to specific nee
individual communities, a relatively standardize
months curriculum be carried out for CHP tra
in all parts of the country. The training should
place in health centres, dispensaries (and c
opment colleges/institutes) rather than primar
district hospitals, with a substantial portion c
time also spent in the trainees' home villages. T
selected are preferably to be older, married and
established than those trained in the past. A
deal of emphasis in the training programmes sl
be placed on ways in which to provide preve
services and means by which to motivate villag
carry out health promotive activities. Some fo
payment of an honorarium will be established b
government without necessarily making the

full-time employees as such; the post is still seen to be voluntary.

Recognizing the need for supervision, a great deal of time is being spent in preparing PHC Coordinators and in setting up a coordinated PHC system at division, district and regional levels, within which CHPs can function. Greater involvement of villagers is also foreseen.

Training in how best to carry out preventive services is emphasized, as are methods for the provision of regular supervision and support. The organizational structure which can facilitate the various aspects of supervision and support, continuing education and motivation, regular drug supply, record keeping and monthly reports, planning and evaluation, is being readjusted. Although CHPs would essentially remain voluntary and not official employees of AFYA, such a structure would strengthen the linkages between the village health posts and the dispensaries and health centres.

Such linkages are extremely important as too often the tendency in many countries has been to equate PHC simply with CHPs; as if PHC is something they, and they alone, should do, with the rest of the system going on as before. Obviously, CHPs are, and should be, carrying out PHC efforts on the village level, but such efforts can best be carried out if they are inter-linked with services guided by a PHC approach at other levels within the health care system.

Tanzania has made a strong recommitment to a PHC approach and has decided that as a part of this approach, which implies providing health services equitably to all the people, the training and use of CHPs must continue to be central. A restructuring is taking place and the PHC orientation is being strengthened at all levels. What is important is that the PHC plans are seen as part of the overall socio-economic development of the country and that there is a national political will supporting the changes necessary for making PHC successful.

This is not to idealize Tanzania. Tanzanians themselves would no doubt think such a presentation of their country foolish—the devastating economic situation, for one, has had drastic repercussions throughout the whole structure of the society and in all sectors. But it remains true that the existing development policy, despite its shortcomings, is one which is very much in tune with the overall policy of PHC. The question here becomes not so much whether or not a PHC programme will be allowed to succeed, or a successful programme will be allowed to continue, but rather whether organization and management of selection, training and implementation processes, and the minimal available resources, will lead to success. These are problems of a different order from those prevailing in Guatemala.

Most developing countries in the world probably fall somewhere between Guatemala and Tanzania. Unfortunately there are probably more countries in which PHC programmes will *not* be allowed to succeed than those in which such programmes will be slow in achieving success because of lack of resources and organization. The implementation of PHC calls for social change in village communities. If the definition pronounced by the Alma Ata Declaration is to be taken seriously, it must be tied to "... the overall social and economic development of th munity" and be a development process wh pends on the people's "... full participation .. spirit of self reliance and self determination" [4 we know well enough that many people and tions in developing and developed countri expend a great deal of energy to prevent suc grammes from succeeding.

But whether PHC efforts receive only mil opposition or the kind of repression which too in Guatemala we are now quite aware that th be resisted in one form or another. The Guat situation is but one example which forces us t the promotion of PHC in a much more manner than perhaps we would wish. The v proceed should, of course, be distinct for pa situations but I believe we can only respond affirmative to Ray Elling who states:

"To look aghast at WHO, or smile wryly to one's se idea of truly supporting PHC would be to give in be battle has been fought. Will we cooperate with th wish to avoid the kind of fundamental social and economic changes in the world system as well as changes which will be necessary to achieve health fo will we get in the act to bring about such change

Acknowledgements—I greatly appreciate the comm colleagues and friends; they are not responsible, h for the final version of this article.

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People of Guatemala estimated in 1982 "... that some 80,500 have been assassinated under bloody dictatorships that have continued with U.S. support from 1954 to our day". Violence and repression of the Indians have been continuous occurrences in Guatemala ever since 1524 when 3000 Quiche Indians were massacred by Conquistador Pedro de Alvarado. Within recent history this violence reached new heights during the 1978–1982 regime of General Lucas Garcia.

29. "Te escribe esta carta con el corazon. Eche pedazo perdi mi casa, mi negocio, mi ijo baron de 18 ano fue capaturado por la policia ... el ano pasado, ya nunca aparecio. Estamos excondido con el resto de mi familia en un lugar de Guatemala. Por motivo que yo soy un lideres Indigena abierto y publico colabora alqualquer programa que abla de desarrollo ..". "I write this letter with my heart. I lost my house, my small business, my 18 year old son was captured by the police on the ... last year, and was never seen again. We are hiding with the rest of my family in some place in Guatemala. (This happened) because I am one of the indigenous leaders who openly and publicly collaborate with whatever programme concerns itself with the development (of our community) ...". Letter from a village health worker.
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EDITORIAL PERSPECTIVE FOR VOI III No.2 on PRIMARY HEALTH CAR

BY IMRANA QUADEER,

During the serventies,in many national and Internationa Circuts of Health Bureaucracies Primary Health Care (PHC) ha become a panacea for all the evils of the poorer nations. WHO has projected it with all its convictions and the member nations have accepted it with equal vigour. As professed in Alma Ata declaration, it means.

> "Primary Health care is essential health care based on practical, scientifically sound and socially acceptabl methods and technology made Universally accessible to to individuals and familiesin the community through th full participation and at a cost that the community an country can afford to maintain at every stage of thei development in the spirit of self reliance and self-determination. It forms an integral part both of the country's health system of which it is the central function and main focus, and of the overall social and economic development of the community".

Today when this strategy has been accepted by such a large of countries, there is a need to examine it potential stren and weaknesses.

The idea that health is closely related to people's li and working conditions and that it is an outcome of their s economic environment was vocalised by men in different fiel like John Snow Engels and later Virchow in the west. It manifested itself in the sanitary movement of the 19th cent In India and other parts of the east it had much deeper roo visible in the method of ancient medical science itself and the cultures of Harappa and Mohan Judaro. In India during struggle for independence, a demand for comprehensive healt was a part of the national movement. Why then this sudden fervour for projecting PHC as a new concept by internationa national official circles ?

Politics of PHC then becomes a crucial issue. To unde this one has to understand the role that U.N. and WHO have in the overall politics of the world. Always supporting th interests of the imperialist nations, these organisations h used the liberal tools of aid, support and providing consul to diffuse, control and direct crisis situations. The effo develop an alternative world economic order in the 70's was such spurious exercise and as a part of it the notion of alternative health care for the third world. The motives b it were to check impending destructive and costly reactions from and within third world nations whose poverty, disease squallor were becoming threats to stability. PHC was the b of the liberals in the imperialist camp and WHO projected

At the national level the concept of PHC acquires multi dimensions. Given the particular hue of the government, the implications have varied from Africa to South east Asia and Eastern Meditarranean regions. The issue is what use does national government make of the concept. Does it use it as concept is presented by the Alma Ata declaration and makes part of its effort to develop an integrated strategy for the betterment of its people as in Angola, Tanzania and Mozambi or allows the concept to degenerate into a slogan behind wh the same old strategies with some new features continue to implemented - at a faster rate perhaps with the additional from the international fund givers as in India and Pakistan

A grasp on the national politics of PHC requires an un standing of the country's socio-economic and political stru and the nature of its government and health service structu Only such an understanding allows one to assess the potenti ies or limitations of the system to achieve PHC. An exampl the interplay between PHC and Politics is the level at whic is integrated into the planning process of a country. Thus Chiness and Vietnamese incorporated PHC in the very process national planning right from the period of their independen without giving it a name. In contrast, India made so much and then relegated PHC to the care of the health ministry w the overall planning processes took their own directions. another example is the implementation and outcome of progra introduced under the banner of PHC. These programmes which may have a potential of providing much needed services are overtaken by the local power elite through their links with health and administrative bureaucracies. The nature of the latter thus becomes the primary determinant of the outcome. community healthguides scheme and the drinking water supply through borehole hand pumps in India are two such example.

Another dimension of the PHC efforts at the national l is the setting of priorities and selection of technology. India despite the official acceptance of implimenting PHC b 2000 AD the heavy emphasis on urban based services and cura approach in rural areas continues with heavy dependence on expensive equipments and drugs. The drug policy needed to provide PHC is still being avoided. Can issues of prioriti and technology be then isolated from politics? A simple bu revealing example is the supply of "Electrolyte" packets in community Health Guide's kits ! Does it show any links betw the health administrators and the drug industry who know th addition of so many salts to the basic mixture only increas cost and not effectivity!

If the concept of PHC is getting distorted in the hand the not so democratic government and is becoming a tool for creating two types of services, one for the rich and the ot for the poor, should it be criticised, rejected, accepted a an unavoidable distortion or used to broaden the base of democratic movements? These are some of the questions whic need to be answered by those who are working in the intere of people's health. Can PHC as a concept become an inspira for those involved in peoples struggle for their rights?

There are many small or regional projects experimentin with implimentation of primary health care. What is the ro of such projects in focussing upon the issue of PHC or in diluting it?

In the academic circles, in the name of professionalis the need to achieve results, a concept of "Selective PHC" h been circulated which means let us not talk of comprehensiv development but do what we can without disturbing the exist balances. This is attractive to those who would like to go back to singing praises to powers of technology and manager competence. There is need to examine such concepts thread bare to show their reactionary ideology as well as monfeasi

Are there any lessions that we can draw from the exper of the socialist countries which have tried to provide heal care not in isolation but as a part of their total developm processes? These are the major questions which need to be addressed when one is dealing with the bipronged weapon of Primary Health Care.

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COVER

The life and death of Primary Health Care

The Alma-Ata Declaration of 1978 set out for humankind the goal of *Health for All by the year 2000*. It also declared that 'Economic and social development... is of basic importance to the fullest development of health'. The truth of this observation was amply demonstrated by the fate that befell the concept of Primary Health Care which had been adopted by the Conference as the means to realise the above goal.

David Werner

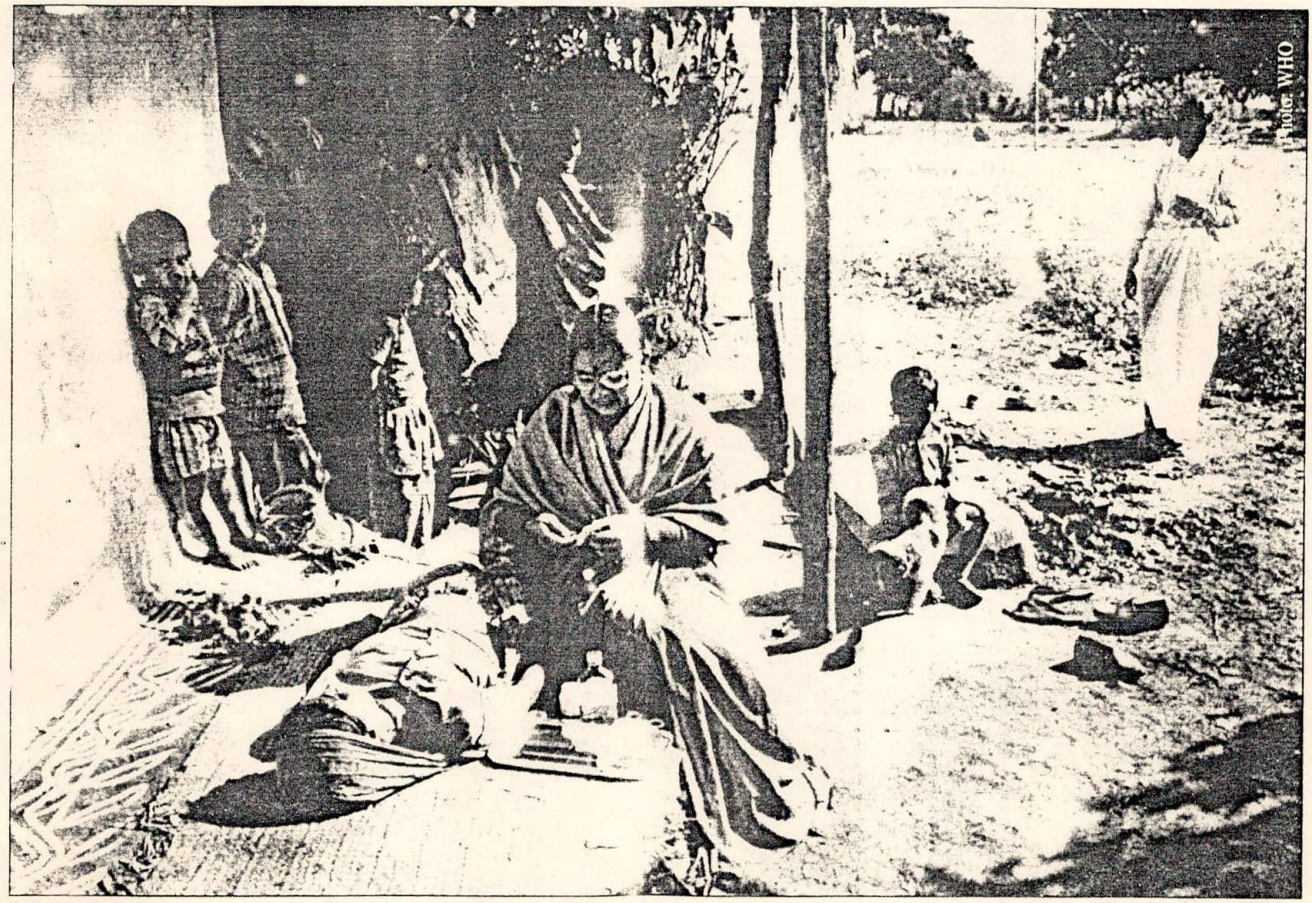

Photo: WHO

Primary Health Care was conceived as a comprehensive strategy which would include a people-centred approach to health services.

TO those of us committed to the dream of **Health for All**, in today's troubled world one thing becomes increasingly clear: The health of people – as individuals, as communities, and as an endangered species on this fragile planet – is determined less by health services than by the relative fairness of social structures. In last analysis, the overall health of the world's

between love and greed. To gain a clearer understanding of the fate of Primary Health Care over the last 15 years, we therefore need to place it in that context.

The Alma-Ata Declaration of 1978 was seen by many as a breakthrough, for it officially declared that **the pursuit of health is inseparable from the struggle for a fairer, more caring society.** The Declaration – drafted at a Kazakhstan, and endorsed by the world's nations – was a response to the failure of Western Medicine to meet the health needs of a large sector of the world's people, especially those in the South. Based on costly doctors and urban 'disease palaces', the Western medical model catered to a small, privileged minority. Its high cost and limited outreach in some ways did more to

erty.

The Alma-Ata Declaration declared health as a basic human right. To advance toward the ambitious goal of **Health for All by the Year 2000**, it proposed a radical and potentially revolutionary approach to meeting all people's basic needs. This was called Primary Health Care.

Primary Health Care was conceived as a comprehensive strategy that would not only include a people-centred approach to health services, but would address the social and political factors that influence health. In recognition that change comes from organised demand, it calls for strong community participation, accountability of health workers and health ministries to the people, and social guarantees to make sure that the basic needs – including food needs – of all people are met.

Although Primary Health Care was a radical new concept for most ministries of health, for years many of its practices had been implemented by non-government community-based groups and by a few, exceptional governments that gave high priority to people's basic needs. China's approach to community health care, featuring 'barefoot doctors', had provided much of the basis for the design of Primary Health Care.

However, for most governments and health professionals, comprehensive Primary Health Care as conceived at Alma-Ata was too revolutionary. To those in positions of power, the idea of **giving ordinary people more control over their health and lives** sounded dangerously leftist and subversive.

So very soon after the Alma-Ata Declaration, high-level health 'experts' began to systematically extract the teeth of Primary Health Care and to convert it, at best, into a means for extending conventional, top-down health services into underserved areas.

Strategically, there have been **three major watersheds** that have undermined and dissipated the radical essence of Primary Health Care. The first was the introduction of Selective Primary Health Care in the early 1980s. The second has been the push for Cost Recovery or User-financed Health Services, introduced in the late 1980s. And the third is the **take-over of Third World health care policy by the World Bank** in the 1990s.

All three of these monumental assaults on Primary Health Care – Selective PHC, user-financing and the Bank's take-over – are a reflection of dominant socio-political and economic trends. So to put these interventions into context, let us first take a brief look at the underlying macro-trends.

As we know, the decade of the 1980s was a p[eriod] of global recession and retrenchm[ent] of conservative powers. By the beginning of the 1980s, high level 'development' strategies had begun to backfire. The Big is Beautiful model of development, pushed in the 1960s and 1970s by huge loans from the North, had made poor countries more dependent on the global market, with its ruthless ups and downs. The rise of large-scale indu[stry], by replacing labour-intensive p[roduction] with energy-intensive industr[y], had intensified pre-existing inequities. In rural areas, big agribusiness concentrated farmland into large holdings, causing a massive exodus of landless peasants into mushrooming city slums. But in the cities, big factories had replaced millions of workers with machines. Unemployment, poverty, homelessness, hunger, and crime increased. And the growing unrest brought more repressive measures of social control. Even in countries that experienced so-called 'economic miracles', like Brazil, real earnings of workers drastically declined. While the rich got richer, the poor got poorer. More trickled up than trickled down. In sum, for vast numbers of people, 'development' really meant 'underdevelopment'. It brought deteriorating living conditions and denial of basic rights.

'Structural Adjustment' policies

But troubles were just beginning. By the start of the 1980s, as a result of the giant development loans from Northern banks, poor countries were faced with a staggering foreign debt. Huge interest payments offset any benefits from economic growth, and Third World economies began to falter. Anticipating disaster, the banks got scared and withheld new loans. As a result, scores of countries went into a fiscal tailspin. Some announced that they simply could not pay. The Northern banks, with billions of dollars in loans to poor countries, were worried sick.

Then the World Bank and International Monetary Fund came to the rescue. They gave 'bail out' loans to allow poor countries to keep servicing their debts, and to promote economic recovery.

But there were strings attached, namely 'Structural Adjustment' cies. Adjustment measures wer signed to 'stream-line' poor co economies, and to bind them into national trade accords that favo business and 'free market' inter the North.

Structural adjustment has u included the following measures

- cutbacks in public spendi
- privatisation of governme terprises;
- freezing of wages and free prices;
- increased taxation, espe sales taxes
- increase of production – i ing food – for export rather than consumption.

As so often happens, these h handed 'austerity' strategies hit th hardest. Budgets for health, educ and food assistance were ruth slashed, while bloated military e ditures were left untouched. Lik public hospitals and health centre turned over to the private sector, p their costs out of reach of the Falling wages, higher prices, food city, and increased unemployme to government layoffs, all joined t low-income families into wors poverty.

The overall results of adjus have been hotly debated. In som dle-income countries it appears t helped stabilise the economies, alt the human and environmental co main in question. But in many poorest countries, adjustment a to have caused even greater eco stagnation.

In spite of overwhelming ev to the contrary, at first the World flatly denied that structural adju has hurt the poor. More recent Bank has conceded that adjustme have caused 'temporary hardshi low-income families, but tha 'austerity' is necessary to restor nomic growth. Ignoring the his record, the Bank still seems to thi by helping the rich get richer, th efits will somehow trickle down poor.

But the evidence is stron structural adjustment, linked to th conservative, neo-liberal trends cent years, has caused far-re setbacks in the state of world he

The World Bank in its publi ments consistently points out th the past 30 years Third World hea steadily improved. However, th

ports shrewdly omit or downplay the fact that **in many countries improvements in health have slowed down or stopped since the beginning of the 1980s.** Indeed, in some countries rates of under-nutrition, tuberculosis, cholera, and other indicators of deteriorating conditions, have been increasing. And in a few countries, mortality rates appear to be rising.

In spite of all the talk of development aid and poverty relief, in the 1990s more than $50 billion net flows each year from the poor countries to the rich. Today, the income of the richest 20% of the world's inhabitants is 140 times as great as that of the poorest 20%. And the gap between rich and poor has grown 30% wider in the last 10 years. According to the UNDP, one quarter of the world's people do not get enough to eat.

It is in this context of unfair global economic policies and structures that we must look at the three major strategies that have contributed to the disempowerment of Primary Health Care.

1. Selective Primary Health Care

No sooner had the dust settled from the Alma-Ata Conference in 1978, than top-ranking international health experts in the North began to trim the wings of Primary Health Care. They asserted that, in view of the economic recession and shrinking health budgets of poor countries, a comprehensive or holistic approach was unrealistic. If any health statistics were to improve, they argued, high risk groups must be 'targeted' with a few carefully selected, cost- effective interventions. To implement this new strategy, called Selective Primary Health Care, children under age five were 'targeted' in what became known as the Child Survival Revolution. (Some critics call it a counter-revolution.) Two 'low-cost, low-resistance' health technologies – Immunisation and Oral Rehydration Therapy – became the 'twin engines' of Child Survival.

Child Survival quickly won enthusiastic high-level support. For those in positions of privilege and power, it was politically safe. It prudently avoided confronting the economic and political causes of poor health, and left the *status quo* comfortably in place. No wonder so many health professionals, governments, USAID, and UNICEF, all jumped on the Child Survival bandwagon. Even the World Bank – which had previously put little investment in health – began to

The disappointing impact of Oral Rehydration Therapy(ORT) could have been avoided by teaching families to mix home-made drinks.

But technological solutions – while sometimes helpful – can only go so far in combating health problems whose roots are social and political. Not surprisingly, therefore, the Child Survival initiative has had far less of an impact than predicted. Between 12 and 14 million children still die each year, and most of their deaths are related to under-nutrition and poverty.

The disappointing impact of Oral Rehydration Therapy (ORT) can be traced, in part, to structural adjustment. The damage might have been avoided if ORT had been promoted by teaching families to mix home-made drinks, which would help foster self-reliance. But unfortunately, WHO and UNICEF have strongly promoted factory-made 'ORS packets', creating dependency on a manufactured product outside the control of families and communities. At first ORS packets were distributed at health posts free. But when health budgets were slashed through structural adjustment, health ministries were pressed to charge for the distribution of ORS packets. This meant, in some countries, that poor families with earnings of less than half a dollar a day, were expected to spend up to a third of their daily earnings on a single packet of ORS.

When we consider that **under-nutrition is the main predisposing condition leading to death from diarrhoea**, it is easy to see how the social marketing campaigns that induce poor families to spend their limited food money on commercial ORS packets can actually be counterproductive in terms of lowering child mortality.

And if the commercialisation of ORS is not enough, the hatchet job that structural adjustment has done on wages, health services, and food subsidies provides the final *coup de grace* for millions of hungry children. And so, in poor countries today, one of every four child deaths is still caused by the vicious cycle of under-nutrition and diarrhoea.

Of course, in addition to the continuing debt crisis and adjustment poli-

contribute to the high incidence of death from diarrhoea. Bottle feeding, for example, is still unscrupulously promoted by multinational producers of infant formula, despite the International Code and IBFAM boycott. Studies in several countries show that **the death rate from diarrhoea can be over 20 times as great in bottle-fed as in breast-fed babies**. UNICEF estimates that the unethical promotion of bottle feeding contributes to more than 1.5 million infant deaths a year – up 50% from the estimate five years ago.

2. User-financing and cost-recovery schemes

The next big set-back to Primary Health Care has been growing pressure to make disadvantaged people in poor countries pay for the cost of health services.

To make the conversion to user-financing or cost-recovery schemes more palatable, often they are promoted as a way of fostering self-reliance and community participation.

One of the biggest promoters of these user-financed community health services has been UNICEF. Its so-called Bamako Initiative now functions in many African countries. While UNICEF has some reservations about the Initiative, it argues that in today's hard times it sees no better alternative. In the 1980s cutbacks in health budgets resulted in the closure of many rural health posts, largely for lack of medicines. UNICEF recognised that people want medicines and are willing to pay for them. So, through Bamako, consumers are charged enough for medicines to keep the health post functioning. A positive feature of the Bamako Initiative is that only essential drugs are used. Also, in some of the community-run health posts, participation is active and enthusiastic.

But many such user-financing schemes have some serious – and perhaps life-threatening – drawbacks. Just because poor families are **willing** to pay for medicines does not mean they are **able** to pay for them. As with ORS packets (which are included as essential medicine) poor families will often spend for medicine the money they need to feed their sick children... And they may even pay for more medicines than are needed. When health posts are largely financed through sale of medicines, the temptation for health workers to over-prescribe is considerable.

Because the poorest families get sick most often and [illegible] medicines, they may carry more than their share of cost for the health post. While Bamako has provisions to charge less to families who are very poor, such 'safety nets' work better on paper than in practice.

Reportedly, in some areas the Bamako Initiative has given good results. But studies in some countries have shown that **when cost recovery has been introduced, utilisation of health centres by high risk groups has dropped.** In some cases the incidence of illness – including sexually transmitted diseases – has increased.

Whatever their immediate impact, the introduction of these cost- recovery schemes has disturbing implications. Placed in historical perspective, **when a health system begins to saddle the poor with the burden of its costs, this is a great step backwards.** It means that health care is no longer a basic right. During most of this century society has made gradual if halting progress toward 'human rights for all'. With a push from the Left, people gradually accepted the concept of proportional taxation: those who have more pay more, so that the community as a whole can guarantee that the basic needs of all people are fairly and adequately met. In short, there has been a gradual trend toward a spirit of collective responsibility, toward recognition that the well-being of each is linked to the well-being of all, and that sharing is more fulfilling than greed.

In the epic struggle between equity and greed, since the early 1980s, humanity has in some ways regressed. The conspiracy between big government and big business has undermined democratic process, and given almost free reign to powerful market forces. Main stream economists promote a so-called free-market system – that is, a market system free of democratic controls – that seeks unbridled economic growth, regardless of the human and environmental costs. The United States seeks to impose its Greed Centred Development model on the entire world. Yet poor people in USA have been trampled by the same powerful market forces and adjustment policies that have widened the gap between rich and poor in the Third World. Progressive taxation is being systematically undermined as the government gives bigger tax breaks to the rich and raises taxes for the rest. Ten years ago, one in seven children in the USA lived in poverty; today it is one in five. And since the early 1980s, public services [illegible] tally cut. In response to the grow rates of homelessness, desperation, st children, and crime, the governm does not provide more public servi or a higher minimum wage, but rat more policemen and jails. In the gr American spirit of 'self-reliance', disadvantaged must care for themselv

And so we see that the Bama Initiative and other cost-recov schemes in poor communities – wh perhaps the only alternative in face of unjust social order – are consistent w the neo-liberal 'free market' forces t are trying to free the owners of markets from their social and ethi responsibility.

3. The World Bank take-over of health policy planning

The World Bank tells us that it h turned over a new leaf and has come recognise that real development mu take direct measures to eliminate po erty. But the way it is going about it, o wonders if the Bank would not pref simply to eliminate the poor... or at lea the children of the poor. Certainly pop lation control – or rather, 'family pla ning' – is nigh on its agenda.

The World Bank has so consis ently financed policies that worsen th situation of disadvantaged people th we must question its ability to change i course. **Perhaps the most effective ste the World Bank could take to elim nate poverty would be to elimina itself.**

In recent years the World Bank ha become increasingly involved in Thir World health care and health policie The Bank's 1993 World Developmen Report is titled 'Investing in Health'. A better title might be 'Turning Health int Investment', for the Bank takes dehumanisingly market-oriented viev of both health and health care. Its chill ing thesis is that the purpose of keepin people healthy is to promote economi development.. but I can't help feelin that the Bank has it backwards. Wouldn' it make more sense to say that th **purpose of economic development i to promote health?**.... What are we ants?

The Bank has worked out an elabo rate scheme whereby it tries to measure the value of each person (that is to say the **dollar** value) by what it calls 'Dis ability Adjusted Life Years' or 'DALYs'. But I can't discuss all that because it is so foreign to my way of thinking.

urgent need to overcome poverty and to guarantee that the health needs of all people are met. It quite rightly criticises the persistent inequity and inefficiency of current Third World health systems. And it echoes much of the Alma-Ata call for community participation, self-reliance, and health in the people's hands.. so far so good.

But on reading further, we discover that under the guise of promoting an equitable, cost-effective, and country-appropriate health system, the World Bank's key recommendations spring from the same sort of market-friendly, structural adjustment paradigm that has exacerbated poverty and been so devastating to the health of the world's neediest people.

According to the World Bank's prescription, in order to save 'millions of lives and billions of dollars' governments must adopt 'a three pronged policy approach of health reform:

1. Foster an enabling environment for households to improve health.

2. Improve government spending in health.

3. Promote diversity and competition in the promotion of health services.'

These recommendations are said to reflect new thinking. But stripped of their Good Samaritan face lift, and reading the 'fine print' from the text of the Report, we can restate the policy's three prongs more clearly:

1. Put the responsibility of covering health costs back on the shoulders of the poor... in other words, fee for service and cost recovery through user financing.

2. Reduce government spending on health by drastically reducing services from a comprehensive to a very narrow, selective approach... in other words, a new brand of Selective Primary Health Care.

3. Turn over to private, profit-making doctors and businesses all those government services that used to provide fee or subsidised care... in other words, privatisation of most medical and health services.

Thus we find the new health policy is little more than old wine in new bottles: a rehash of the conservative strategies that have systematically derailed Comprehensive Primary Health Care, with elements of structural adjustment to boot. It is a market-friendly version of Selective Primary Health Care com-

Through elaborate statistical studies, the Bank has selected those interventions calculated to be most cost-effective in increasing 'Disability Adjusted Life Years' of productive work to advance the national economy. How the community - or even host country - is supposed to participate in (or even understand) this extreme form of globally computerised planning remains vague.

What can I say, except that all this is very scary. And it is dangerous because the World Bank, with its enormous money-lending capacity, has almost god-like clout. It can force poor countries to accept its health care blueprint by tying it to loan programmes, as it has done with adjustment.

Dangerous implications

The commercial medical establishment has celebrated the Bank's new World Development Report as a 'major breakthrough' toward a more cost efficient health care strategy. But many health activists see the Report as a disturbing document with dangerous implications. They are especially worried that the Bank will impose its recommendations on poor countries that can least afford to implement them.

It is an ominous sign when a giant financial institution with such strong ties to big government and big business bullies its way into health care. Yet according to the British medical journal, *Lancet*, **the World Bank is now moving into first place as the global agency most influencing health policy,** leaving the World Health Organisation in a weaker second place.

It is urgent that all of us concerned with the health and rights of disadvantaged people become familiar with this World Bank Report, with the harmful unrealistic policies are likely to do and whose interests they are really designed to serve.

Successful approaches to Primary Health Care

As we have seen, Primary Health Care as conceived at Alma-Ata has run into serious problems. This is no surprise. A revolutionary approach to health care requires a revolutionary process in society as a whole. In that context, a few countries have been relatively successful in introducing Primary Health Care. Nicaragua under the Sandinistas intro-

Care, with remarkable improvements in health. Cuba, since the Revolution, has taken a very comprehensive approach which guarantees to meet the basic needs of all people for housing, education, health care, and food. As a result, Cuba has health statistics equal to that of the Northern, industrialised countries.

Unfortunately, however, many countries that have opted for people centred development, in defiance of the development paradigm that favours big business, have been subject to relentless attacks and terrorism. For this reason their health care programmes – and improved health of their people – have been hard to sustain.

Nevertheless, hundreds of grassroots groups and movements around the world have kept a liberating approach to Primary Health Care alive, often against great obstacles. Activists realise that, in the long run, the health of our planet and its people depends on far-reaching social change.

Conclusion

I have given this talk as a protest – or 'URGENT ACTION ALERT' – warning that the global power structure, spearheaded by the World Bank, is poised for the final death blow to Primary Health Care, so that the health systems of poor countries will fall in line with what we might call *the McDonaldisation of Global Development.*

On one thing the World Bank is certainly right: **Achievement of a healthier society requires the reduction of poverty.** But the changes needed to overcome poverty will never come from the Bank nor the powers it represents. They can only come from the bottom up. In last analysis, the social transformation needed to bring Health for All turns on the ability of a worldwide coalition of grassroots groups and concerned world citizens to bring the global power structure under control.

I close with the conclusion of the International People's Health Council:

Health for All can only be reached through a united grassroots struggle for **EQUITY, ACCOUNTABILITY, and PARTICIPATORY DEMOCRACY.**

The struggle for health is a struggle for social justice. ◆

The above talk was delivered in Belgium on December 1994 by David Werner at a seminar organised by Medicine for the People, Medical Aid for the Third World, and International People's Health Council.

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COVER

The economic crisis, structural adjustment and health care in Africa

When African governments turned to Structural Adjustment Programmes to overcome the economic crisis and recession facing their countries in the 1980s, one of the principal casualties was health care. These policies resulted in severe cuts in government spending on the infrastructure that supports improvements in health and nutrition. They also undermined women's traditional support role in the promotion of health care in society.

Health care: The colonial legacy

UNTIL recently the state has been the largest provider of medical care in Africa. State involvement in health originated during the colonial era. Originally designed for the purpose of serving the European population, health care was eventually extended, often through forced therapy, to the indigenous population to defend against the spread of infectious diseases. Some colonial governments provided maternal and child health services which they saw as a Christian act of charity. Competing European churches of different denominations often ran these services, sometimes with government support. Health services were mostly curative, urban-based and available to Europeans and African elites. The health system was also dependent on personnel, supplies and technology from the various colonial home countries.

This system, inherited by African countries at Independence, was rarely modified. The retention of colonial structures has had important consequences for the hopes of general improvements in social welfare. These hopes have been thwarted as African elites (who stepped into the shoes of the colonialists) cultivated privileges for themselves. The elites inherited the colonialists' exclusive facilities, including their medical facilities. These exclusive health care privileges have been documented. In Zambia a complete renal unit was imported and installed at Lusaka Hospital to enable a permanent secretary to return from England for continued treatment at home. Overseas treatment for African heads of state and top functionaries is another dimension of this exclusivity. For example, in spite of prove health service Nigeria's president General Babangida went to Paris for a full month of medical care in 1987.

The legacy of the colonial system has perpetuated a serious maldistribution in health care. Whereas 70% of the African population is rural, health and services and other amenities are available mostly in urban areas. Consequently, there are significant differences between urban and rural health conditions. Infant mortality in rural areas is, for instance, often 2 to 5 times as high as in urban areas, while life expectancy is lower by 3 to 5 years.

Reversing the gains: effects of the economic crisis on health

In the 1950s, 60s and 1970s, African countries made substantial progress in health care delivery. In the 1970s, in particular, relatively high prices for Africa's export commodities and low international interest rates made possible substantial increases in health spending by African governments. Health-related projects were among the many development projects which were established during this period, and increases in the number of health professionals on the government payroll also occurred. With this development of health care infrastructure, rates of death and illness declined and general gains were made in the health of African population. However, while there were dramatic improvements in some health care indicators like the Infant Mortality Rate, it was not always clear how evenly distributed these improvements were within countries, communities, or even within households. Also, while significant improvements were made in the treatment of some diseases and the prevention of others, and corresponding improvements in the quality of life for survivors.

In the 1980s, this progress, problematic and uneven though it often was, began to unravel. The early 1980s saw large drops in the national incomes of African countries as the prices of their export commodities fell to record low levels. At the same time, the demands on this income were increasing. Dramatic increases in international interest rates made debt repayment a problem of crisis proportions for many countries. Other pressures on this income came from a variety of factors: military equipment to sustain local wars or participation in superpower conflicts, the personal greed of corrupt officials in government or international corporations. Another factor was the natural expectation of Africa's growing populations that the level of government services and economic development opportunities they experienced would continue to improve to eventually match those of industrialised countries in Europe and North America.

This economic crisis triggered a corresponding crisis in health care and health in Africa. This crisis was exacerbated by the structures of underdevelopment and the legacy of colonialism in African societies. These structures made African health systems heavily dependent on imported medicines and supplies, as well as medical technology. When foreign exchange became scarce as a result of the economic crisis, imports, including those needed to sustain the health care system, were severely reduced. In addition, the unequal distribution of medical facilities regionally within countries and between cities and rural areas, as well as the privileged access of a limited few to expensive hospitals, have further exa

Structural adjustment and health care

In the 1980s African governments were faced with economic crises and recession, domestic political discontent and tremendous international pressures to meet foreign debt obligations. As a result, many African governments either chose or were forced to adopt structural adjustment policies. These policies, which were initially intended mainly to improve the adjusting country's international financial balances, later grew in scope and complexity. They were supposed to bring about the restructuring of different sectors of the economy, including that of health services, and to allow for a better approach to problems of poverty, as well as to support political reforms which many Western donor countries were simultaneously encouraging. However, in the areas of health and health care in Africa, structural adjustment policies have not had the hoped for positive effects. Instead, African countries have experienced increasing numbers of babies with low birth weights, increasing rates of death among young children, an increase in the incidence of infectious and poverty-related diseases and increases in HIV infection and AIDS. Worse yet, the severely eroded health care systems in most African countries are increasingly ill-equipped to respond to these problems.

Eroding the health care system

The effects of structural adjustment on health and health care has been to exacerbate rather than fix the problems created by the economic crisis. This has happened in several ways. First, through an erosion of the health care system. Structural adjustment has imposed strict limits on government spending, and many governments have seen little reason not to make the necessary savings through cuts to the social sectors. As a result, government spending on health care has dropped dramatically in countries adopting structural adjustment policies. For example, Ghana's expenditure for health care dropped 47% between 1978 and 1988, while that of Cote d'Ivoire decreased by 43% over the same period.

These cutbacks, combined with the increased influence of private initiatives, has led to an erosion of governments' ability to implement a coordinated health care system. In many African countries private sector delivery of health care has often resulted in the undermining and draining of resources from the public sector.

Within the health care budget, it has been politically much easier to cut spending on supplies and facilities rather than salaries. So nurses, doctors, medical assistants and birth attendants found themselves working in run-down buildings without equipment or medicine, and often without an adequate supply of water or electricity. Where savings were made in salaries, this occurred mostly because salary levels were not increased to keep up with inflation, so that their real value eroded. Frequent delays of weeks or months in the payment of these salaries also eroded their value in situations of high inflation. These conditions contributed to the exodus of health professionals to other countries.

Exacerbating poverty

Structural adjustment policies have resulted in increases in poverty and a reduction in food security at both the national and the household level. In its recently released report *Implementing the World Bank's Strategy to Reduce Poverty*, the World Bank acknowledges that, even using the most optimistic projections for regional economic growth, poverty in Sub-Saharan Africa will continue to grow worse during the 1990s, as it has throughout the 1980s. The deepening of poverty in Sub-Saharan countries is an essential feature of structural adjustment. As one of the economists involved in the recently released Organisation for Economic Co-operation and Development (OECD) study of structural adjustment and equity comments:

'...it does not prove optimal to alleviate poverty during the first three *years of the adjustment period. Some redistribution does take place in years 2 and 3, but it is in favour of the rich or middle-class... The poverty reduction policy becomes optimal only when the economy starts to recover in year 4... Optimality is not achieved in redistributing to the poor.. either in current income or in productive assets during the first three years of adjustment because of the very large opportunity cost of investment during those years.*'

Recent suggestions by the World Bank that properly designed structural adjustment programmes can help to alleviate poverty are misleading on several grounds. First, the recommended changes to structural adjustment programmes generally involve the addition of a special programme to mitigate its costs, both for some groups of poor people and for politically volatile groups like laid-off civil servants. These programmes require funds from other countries, since resources within an adjusting country are desperately needed for debt repayment and for investment. However, in a climate of global recession and political conservatism, there have been reductions rather than increases in the foreign aid and loans available to African countries.

Second, the process of structural adjustments is taking longer than expected in African countries, so the increase in poverty it generates is not a temporary problem of transition which can be easily fixed. In stead, adjustment-enhanced poverty is becoming a serious long-term predicament in African societies where poverty was a significant problem even before the economic crisis and structural adjustment. Third, the idea that a little additional external money can be devoted to a compensatory programme to help the poor while no significant changes are made to the process of structural adjustment itself, is a contradictory one. It becomes an attempt to 'eradicate poverty while, at the same time, working within and often strengthening the very structure of... relationships that generate and reproduce it' in the first place.

Undermining food security

Efforts to promote food security are also undermined with the implementation of structural adjustment policies. A recent study carried out by the Organisation of Rural Associations for Progress (ORAP) in Zimbabwe illustrates how structural adjustment policies exacerbated the agricultural problems in the country which were already severe due to the drought.

As part of the drive to boost exports, the government raised producer prices for export crops such as tobacco, cotton and cut flowers, inducing many farmers to abandon maize production. The government also sold off its surplus grain as part of its adjustment programme. As late as February 1992, when the extent of the drought and impending crop failure was clear, the Grain Marketing Board was still exporting grain.

honouring the World Bank/IMF requirement that it balance its books. Once a surplus maize producer, Zimbabwe ran a deficit of one million metric tonnes in 1991. In 1992, more than half the population required food-aid assistance.

Abandoning infrastructure

Structural adjustment policies have had a negative impact on health because they have involved extremely severe cuts in government spending on infrastructure that supports health and nutrition improvements. This includes spending on water supply, sanitation, roads, national and local food storage facilities, as well as education and communications infrastructure that allows the spread of new information about health and health care.

Environmental degradation

Structural adjustment policies diminish the possibilities for good health because they hasten the deterioration of the natural environment in which people must live and from which they obtain resources to provide for their well-being. SAPs call for increased exports as a way of increasing foreign exchange earnings. Many African countries depend on the export derived from their natural environment – timber, cash crops, fish, etc. The resulting acceleration of commodity production is not ecologically sustainable. The destruction to the environment associated with this export-led growth strategy is not accounted for in GNP calculations and the loss of future productivity is disregarded. Reductions in government spending, privatisation and liberalisation also leads to the lack of enforcement of environmental laws and the removal of regulations to protect the environment. By intensifying poverty, structural adjustment policies have also forced people to move onto marginal lands to overuse scarce resources in order to survive.

In Ghana, timber exports were rapidly accelerated as part of its adjustment programme. As a result of these policies, Ghana's tropical forest area is now just 25% of its original size. Widespread deforestation is resulting in regional climatic change, soil erosion and large-scale desertification. Women have lost an important source of food, fuel and medicines that they had harvested

Women, health and structural adjustment

Gender relations denote the composite of ideas and practices concerning the relationship between men and women. These ideas and practices have an impact not only on the health of women but on the health of families and communities. Because historically women have been assigned the task of caring for the family, any policy which undermines women, undermines the health of families.

For a long time, women in Africa have been placed under stress by the gap between their economic responsibility and their access to resources. Structural adjustment exacerbates this gap further, not only in terms of resources but also in terms of stress, time and health. As Ingrid Palmer warns,

If the gender bias, the weakest link in sub-Saharan economies, is not resolved, these economies may have an absolute advantage in no product and a comparative advantage only in lines of production based on the super-exploitation of women and a demand for children's assistance.

Structural adjustment programmes also seek to shift production from non-tradeables, which are goods and services produced and consumed within national boundaries, to tradeables, which are goods and services intended for the international market. There is an underlying assumption that no difference exists in the ability of men and women to survive the transitional cost of making this switch, and that men and women have equal access to resources and to markets. But this is not the case. The switch from non-tradeable to tradeable production involves a relocation of many activities from the paid to the unpaid or underpaid economy accomplished through the labour of women. As a result, the ability of structural adjustment programmes to meet their objectives, may be won at the cost of a longer and harder working day for women. This cost will be invisible to the macro-economic policy makers because it is unpaid time. But the cost will be revealed in statistics on the health and nutritional status of such women.

Women's ability to promote health and nutrition for themselves and their families is conditioned by income, access to resources, and their level of education. In Africa, adjustment pro-

tural adjustment policies involve a duction in real wages to increase resources which can be devoted to vestment for economic restructuring for debt repayment. Women, alre receiving lower and less regular inco than men, have seen their small inco further diminished. In cities and tow formal sector employment for wo is increasingly limited under structu adjustment policies, so they are for into lower-paying and less produc informal work.

With reduced income, Afri women have to spend more time e ing extra income for the family, hun for bargains, making and mendin home rather than buying. The increa demands on their time limit that av able for health and nutrition-related tivities. Moreover, women have incr ingly become responsible for taking of sick relatives thereby adding m responsibilities to their already he burden. This leaves them with litt no time to take adequate care of th selves further diminishing their health and consequently of their f lies.

The negative impact of struct adjustment on women is not an e remedied oversight, as is someti suggested. Women's labour is act an important factor in the adjustr process. It is women who are expe to make up for the loss of governm services in health and education thr the increased care of sick family m bers and increased responsibility children unable to attend school. I case, savings at the level of the nat budget are illusory ones, gained on shifting costs from the monetise non-monetised parts of the econ through unpaid and underpaid fe labour. Women are also under incre pressure to make up for losses t family income by taking on addit paid work, by providing additiona paid labour to income-generatin tivities organised by male family m bers, or by carrying out their ow come-generating activities. At the time, women face greater difficult their role as household managers, income and available time diminish tive to the cost of obtaining good services necessary for the family, ing daily crises of consumption.

The above is an excerpt from ***Beyond Adju****.* ***Responding to the Health Crisis in Africa*** *(p 28) published by the* Inter-Church Coalition on

The World Bank's vision of health: a critique

The model of health care for developing countries promoted by the World Bank in its *World Development Report 1993* is a deeply flawed one. The proposed system of health care is a two-tiered one, which is commercial in inspirations and profit-motivated in orientations. As such, it constitutes a further assault on the principles of universality and equal access.

THE *World Development Report 1993* offers a model of health care for the developing world. Since the health and livelihood of citizens around the world are very closely linked to the policies which the World Bank promotes, a critical analysis of the World Bank's health proposals is essential.

Investing in Health proposes a vision of health care for developing countries based on a set of assumptions about the way health care is currently provided. First, government spending in developing countries is disproportionately skewed toward the more expensive tertiary sector, that is for hi-tech, hospital-based, curative care. Second, public health systems in poorer countries are inefficient; private health care delivery is of a higher quality. Third, the pursuit of pro-poor adjustment policies can help to maintain cost-effective health expenditures.

The Bank's specific policy proposals include the following:

- Reduce public expenditures on tertiary facilities, specialist training, and interventions that are not cost-effective.
- Finance a set of public health interventions dealing with infectious disease control, environmental pollution, etc.
- Ensure financing of a package of essential clinical services for the poor.
- Promote private finance of all clinical services outside the essential package, with government regulation of the private sector.
- Encourage private suppliers to compete both to deliver clinical services and to provide inputs such as drugs to both the public and private sectors. Domestic suppliers should be protected from international competition.

The vision of health promoted in the *World Development Report 1993* falls far short of the most basic requirements for a health care system. It proposes a two-tiered system of health care which is commercial in inspiration and is distorted by an undue emphasis on privatisation and the profit motive. In essence, the report urges poorer countries to cede most health care to the private sector, leaving governments to provide basic primary health care for the poor and to try to regulate the private sector.

The World Bank's vision of health

There are several problems with these assumptions and proposals. First, the contents of the basic health care package for the poor are extremely limited. Since the poor are more vulnerable to disease and injury than the rich, and are more likely already to be suffering ill-health, they are trapped in a vicious cycle. Their access to adequate health care depends on their ability to participate in the economy, but their present ill-health makes full participation difficult, if not impossible. A second problem relates to the World Bank's assumption that in providing a basic health care package for the poor, governments will be committing themselves to a modest expenditure for a relatively small part of the population. In many sub-Saharan African countries, more than half of the population lives in poverty, and the numbers of the poor are rising rather than shrinking. In such a situation, a modest expenditure targeted at a small, easily-defined group of people in poverty is neither a realistic nor an adequate response to a crisis of health and health care.

While the World Bank's emphasis on primary health care is positive, it is also selective. It targets individuals for immunisation or micro-nutrient supplements, but does not take adequate account of the close relationship between Targeted remedial programmes for children such as immunisation or food packages, as outlined in the *World Development Report*, are not adequate because they are not linked to the improvement of peoples' economic, political, social and physical environments. Ignoring the broader dimensions of ill-health and focusing instead on addressing only their symptoms does not embody a holistic and comprehensive vision of health.

A two-tiered health care system

While the World Bank agrees that health care is a basic human right, its policy prescriptions treat it not as a right but as a scarce commodity to be allocated according to ability to pay. This assumption leads to a division of communities and societies into two classes of people: the 'haves' who can afford to pay for a privatised, profit-driven health care system and the 'have-nots' who will have to content themselves with a bare minimum of treatment in the public health care system.

The World Bank's vision also involves a division of rich and poor countries. In the Bank's view, the rich countries are to do health research, develop health care technologies and manufacture drugs, while the poor countries must, as far as their means allow them, remain consumers of these health products.

In effect, the World Bank is promoting an international health care system based on the American model. And yet, as the *World Development Report* itself points out, the US has the most inefficient health care system in the world. It accounts for 42% of total global health care expenditures, while making up only 2% of the world's population. Even so, more than 37 million

As a result of Structural Adjustment Programmes, governments have been forced to cut back on spending on health clinics.

health care.

The World Bank's prescriptions for health care constitute a further assault on the principle of universality and equal access. Their report argues that, 'The main problem with universal government financing is that it subsidises the wealthy who could afford to pay for their own services, and thus leaves fewer government resources for the poor.'

Arguments like these form an integral part of the neo-conservative doctrine which, over the past decade, have been used to dismantle social programmes around the world and replace them with user-pay, privatised two-tiered systems. The premise for this change is seductive: why should the rich receive the benefits of universal programmes if they can afford to pay for

guarantees minimum care for the poor and makes those who can afford it pay for these services. What is sacrificed, though, is the principle of universality. The result is a health care system which will provide one level of health care to those who can afford it and a far inferior standard of health care to some, but probably not all of the poor. The principle of universality is subverted in favour of profit-driven schemes. This is especially problematic in countries where those in poverty constitute a large percentage of the population.

There are proven alternatives to the approach advocated by the World Bank, such as ensuring that richer members of society pay their fair share of taxes, which would preserve the principle of universality and ensure an adequate level

Research and training

The *World Development Report* also argues for a shift of poor countries' priorities away from health research and the training of health personnel in favour of primary health care. While this recommendation seems sensible, it masks a disturbing reality. This reallocation of expenditure will continue to erode the fragile and important base of research and training in poor countries. It is estimated that during the 1980s more than 30,000 professionals have left Africa as a direct result of the abandonment of state support for basic research and teaching.

Rather than abandoning these people and their work, it would be better to consider ways to support research and training institutions appropriate to the health and health care needs of African countries at either a national or regional level. If such measures are not taken, indigenous research and training will continue to be turned over to private, profit-driven Northern health institutions. These institutions are not accountable to anyone other than their shareholders or boards of governors. They will thus be likely to perpetuate current biases in health care towards biomedical definitions of health problems, as well as toward the health problems of white, well-to-do men.

Privatisation

Rather than deal with the root causes of ill-health, more money goes from most African governments into private health care than to public and mission health care put together. Almost half of the doctors, nearly all pharmacists and many nurses and midwives in African countries work in the profit-based sector and establish themselves in large cities.

In the scenario proposed by the World Bank, with the private sector responsible for individual cure and the public sector responsible for collective

integration of preventative and curative health care.

Privatisation and the shift of government expenditure toward primary health care also includes a call for non-governmental organisations and churches to become more involved in the provision of health care. This can only be viewed as a short-term, stop-gap measure. It will lead to greater fragmentation in health policy as well as considerable variation in the quality and availability of health care. It also results in greater assymetry in the maintenance of information systems which threatens the ability to provide quality health care. Long-term national health planning, regulation and coordination become extremely difficult, if not impossible. Reduplication of services and the inefficiency of several bureaucracies are another result of this approach.

Cost recovery and user fees

The *World Development Report 1993* promotes the introduction of user fees for basic health services. User fees and cost recovery are the foundation of the World Bank's proposal for health care financing in developing countries. The World Bank argues that, 'since patients are already paying for supposedly free or low cost health care, new user fees, when accompanied by a reduction in indirect costs and improved services, may increase utilisation.' In a context of high unemployment, soaring prices and growing poverty this strategy only increases inequities in access to health services and effectively closes off access to adequate health care for the poor.

According to the World Bank, the justification for this trend lies in the fact that a developing country cannot afford free health care and education. Therefore, through user charges, the population should pay for a significant part of the care with private enterprises playing a much greater role. Governments implementing structural adjustment programmes are forced to cut back their allocations to health care and seek compensation by giving more room to private initiatives and donors as well as introducing large fees for patients.

The transformation of health care into a privatised, user-pay system thus constitutes another assault on both the physical welfare and the basic human dignity of the poor. Evidence about the health care systems of a number of African countries challenges the World Bank's claims. For example, since the introduction of user fees in Zimbabwe, there has been a dramatic drop in the number of hospital visits. Fewer babies are being delivered in clinics and hospitals in the rural areas while the number of women dying in childbirth in Harare has doubled since the introduction of the structural adjustment programme in 1990.

Women, girls pay dearly

The World Bank's system of health care not only pits richer against poorer members of society, it also forces families to decide which of their members are to receive treatment. It is in this regard that the inequity of this system of health care for women is clear. Since women and girls presently receive fewer resources in many families, they are more likely to be further discriminated against if health care resources must be rationed. As a result of declining incomes and rising expenses for basic necessities, many women and girls have also been forced to reduce their intake of food, which only increases their vulnerability to disease and accident. In addition, women are mostly likely to have to take on the additional work of caring for sick family members when professional care is unaffordable.

The *World Development Report* does offer up the solution that better education for girls will improve the general health of families and communities. However, this recommendation not only papers over the serious problem of gender inequality, it also overlooks the greatest threat to the health and well-being of women, and of entire communities: poverty. The *World Development Report* does, to its credit, affirm the close link that obtains between poverty and health. It also recognises the appalling levels of violence against women throughout the world as a dominant health issue. What the report fails to do is make the link between poverty and the failure of the World Bank's economic policies.

The proposals contained in the *World Development Report* do not address the single greatest factor contributing to the health care crisis in the South. The debt crisis remains the largest single threat to health currently facing the global community. In addition, many countries have been compelled to adopt structural adjustment programmes (SAPs), which have had a devastating

the majority of their citizens. Structural adjustment undermines the ability of states to allocate resources towards either health care or self-reliant development, and instead turns these resources towards the export sector and debt servicing. How can poor countries possibly give either resources or attention to health care when significant amounts of their scarce capital continue to be siphoned off by Northern banks, G-7 governments, the International Monetary Fund and the World Bank? The reduction of public investment due to SAPs has also affected the ability of countries to maintain and develop infrastructure in water and public sanitation. In its 1989 document entitled *African Alternative Framework for Socio-Economic Recovery and Transformation*, the United Nations Economic Commission for Africa warned against the cutbacks in social spending as a debt-servicing strategy: 'Reductions in budget deficits must not be accomplished at the expense of expenditures on the social sector, ie, education, health and other social infrastructure.'

Promoting an unhealthy planet

Structural adjustment policies also result in serious constraints on efforts to promote better health through more environmentally responsible development policies. The promotion of toxic waste exports to poor African countries by the former Chief Economist of lthe World Bank, Lawrence Summers is an example of this. His recommendation was not an aberration, but rather the logical extension of a structural adjustment agenda which forces countries desperate for foreign exchange to sacrifice the health of their citizens by exposing them to the unwanted waste of Northern countries.

The World Bank's own internal review of its project lending, conducted by W Wapenhans in 1992, points to an alarming 37.5% failure rate. The same report notes that the worst-affected sectors were in water supply and sanitation where 43% of the projects were said to have 'major problems' and in agriculture, with a rate of 42%.

The World Bank continues to lend money for projects which harm the environment and which do not directly involve the people who will be directly affected by them at every step of the

As a result of privatisation, maternity wards in many African countries have suffered a depletion of midwives, nurses and other staff.

Conflict of interest

It is the poor who are being forced to pay, through cutbacks in health spending and through reductions in their living standards and physical well-being for the irresponsible lending and borrowing that occurred during the 1960s and 1970s. During the 1970s, World Bank lending to developing countries increased five-fold at the same time as it was actively encouraging banks and Northern governments to increase their lending. In spite of very clear indications that this lending was unsustainable, the World Bank continued to increase its lending as well as encourage Northern banks and governments to do so.

During the 1980s, the World Bank effect bailing out commercial banks, Northern governments, the IMF and itself by using funds earmarked for development assistance for debt servicing. The servicing of the growing debts owed to the World Bank and the IMF is another problem. An average of 45% of African countries' debt servicing goes for multi-lateral debt. The need to service this debt has directly contributed to the dismantling of health care systems.

The solution advocated by the World Bank in the 1980s has been to encourage indebted countries to increase exports of their primary commodities. Rather than solve the debt problem, this strategy only exacerbated it as the oversupply of commodities led to plummeting prices. The 'solution' to the debt

fact became the cause of further indebtedness. The World Bank refuses to accept its share of responsibility for contributing to and exacerbating the debt crisis. It could do so without difficulty given that it has amassed over $13 billion in profit over the past decade.

As the world's largest development institution, the World Bank must take responsibility for its contribution to the growing poverty and declining health of the majority of the world's people. A thorough review of the World Bank's development, environment and lending record is urgently required. The Bank must be called to account for its disturbing legacy of bad loans to corrupt leaders, failed projects and flawed development policies. The World Bank must also accept its share of responsibility for contributing to and exacerbating the debt crisis by cancelling the debts owed to it by the poorest countries and channelling these funds towards social sector transformation and growth.

Ensuring universality and equal access

Comprehensive health care should be seen as part of an overall development strategy to combat poverty and promote self-reliance. The provision of adequate health care depends upon a commitment of public resources. This vision can be realised only if governments, health services and donors support a process that will ensure a democratic system of health care which guarantees universality and equal access.

This vision cannot be seriously considered in the context of diminishing resources for the social sector and the privatisation of basic social services. At the heart of these trends is the problem of international indebtedness and the implementation of orthodox structural adjustment programmes. These have been the most important factors contributing to the deterioration of health care systems not only in Africa but as part of a global trend.

Efforts to address the HIV/AIDS crisis in Africa must be part of a comprehensive national plan at all levels of health care. An adequate response to the HIV/AIDS crisis cannot be mounted in the context of shrinking national budgets owing to debt servicing or a frag-

system.

The failure of top-down development methods to eradicate poverty and improve the living conditions of the poor in African nations has led to demands for and adoption of participatory initiatives to strengthen the power and welfare of people. Such initiatives rely on the sharing of power and scarce resources. These include efforts by social groups to control their own destinies and the opening up of opportunities from below. This approach has bolstered community involvement in the design, execution and management of development projects and resource management. It has led to increased benefits and efficiency in the provision of social services, especially those related to health, nutrition, education and income generation. Included in this vision is the reaffirmation and support for indigenous healing systems and the integrity of indigenous health knowledge and practices.

These community-based efforts can only succeed where health care is accorded primacy at the national level. A comprehensive national health care policy framework can only emerge where there is continuous consultation with patients, health-care practitioners and policy-makers at all levels. This entails a massive reshifting of resources away from the private sector and towards the public sector. The allocation of secondary and tertiary care to the private sector, as the World Bank proposes, will only lead to a further skewing of health care which favours the rich. Secondary and tertiary health care have to be integrated and become part of a comprehensive basic package that is made available to all citizens.

We favour a democratic, community-based, comprehensive vision of health care where communities are given the power and the tools to reduce problems of ill-health, problems which are intimately related to the economic and social patterns of their society. Promoting democratic health practices would mean placing the definition and control of health care in the hands of those who use the services. This will mean that people, especially women, will not be treated as the targets of health campaigns, but as members of society with equal political rights, social status, and economic value.

The basic elements of a democratic health service would include:

- Equitable distribution of food, services, and free curative medical care to women, children and men of all social classes in rural and urban areas.
- Support for community-based health care initiatives which give all members of a community control over decisions involving their health and livelihood.
- Affirmation of and concrete support for indegenous health care knowledge and practice.
- Support for and promotion of food security. In particular, the production of food crops for domestic consumption must be given priority over commercial production of export crops. The redistribution of land is another important component of food security, as are a more equitable and appropriate distribution of agricultural services and inputs to small farmers, especially women.
- Support programmes which would enable groups to overcome poverty such as housing development, literacy training, improved education and skills development programmes for the poor.
- Programmes to combat family violence and sexual inequality.

An integrated health care system

There is a need to build health care facilities to serve rural communities. Such facilities must be intergrated into the secondary and tertiary care system and must not be compromised by making the poor carry an unfair burden of the costs while enabling urban elites to avoid sharing the benefit of advanced medical technology.

In addition, medical education which has tended to produce clinical specialists needs to be revised to train generalists as well. Such generalists must be familiar with rural health problems and prepared to work in teams of public health professionals under conditions of scarcity in rural areas. Community rather than economic concerns should be the motivating force behind the operation of these health care teams. Ideally, such teams should function within a transformed political structure, but realistically, they would need to cope with the limits imposed by existing national and local institutions.

Transnational pharmaceutical corporations represent another area of neglect in health care strategies for poor countries. These corporations operate lowed to amass widfall profits through monopoly pricing. For example, prices for drugs can be lowered through legislation as Germany did when it reduced the reference prices of drugs for health plans to those of generic brands, using pharmacological properties as the basis for grouping and pricing drugs. This forced transnational pharmaceuticals to reduce the price of their drugs to the level of generic brands.

Transnationals must be more closely monitored in both rich and poor countries, and made more accountable to the customers they purport to serve. This would include imposing higher taxes on the profits made by pharmaceutical corporations and channelling these funds into national health care systems. Stiff penalties should be imposed on unscrupulous companies that dump expired drugs and con duct dangerous tests of new medications in poorer countries. Medicines which benefit all people, and which are derived from the genetic stock which is the heritage of all humanity, should not be controlled by private interests. The shining example of Dr Manuel Patarroyo's donation of a malaria vaccine to the World Health Organisation serves as a model of solidarity and true concern for the well-being of the world's inhabitants.

Comprehensive health care should be seen as part of an overall development strategy to combat poverty and promote self-reliance. The provision of adequate health care depends upon a commitment of public resources. This vision can realised only if the governments, health services and aid donors support this process of change.

What African countries need now is a commitment from our governments and from development agencies like the World Bank to support **their** efforts to develop and implement **their own** comprehensive health care programmes where people not markets take priority.

Promoting democratic health practices would mean placing the redefinition and control of health care in the hands of those who use the services. By doing so, the majority of people, especially women, will not be treated as targets of health campaigns, but as members of society with equal political rights, soial status, and economic value. ◆

The above is an excerpt from ***Beyond Adjustment: Responding to the Health Crisis in Africa*** *(pages 30-42) published by the* Inter-Church Coalition on Africa

DOCUMENT

Declaration of Alma-Ata

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

The Alma-Ata Conference in Kazakhstan in progress.

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

II

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

III

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

IV

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

V

Governments have a responsibility for the health of their people which can be fulfilled only by the provision of adequate health and social measures. A main social target of governments, in-

world community in the coming decades should be the attainment by all peoples of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life. Primary health care is the key to attaining this target as part of development in the spirit of social justice.

VI

Primary health care is essential health care based on practical, scientifically sound and socially acceptable methods and technology made univer-

lies in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing

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

VII

Primary health care:

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

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

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

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

5. requires and promotes maximum community and individual self-reliance

ganisation, operation and control of primary health care, making fullest use of local, national and other available resources, and to this end develops through appropriate education the ability of communities to participate;

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

7. relies, at local and referral levels, on health workers, including physicians, nurses, midwives, auxiliaries and community workers as applicable, as well as traditional practitioners as needed, suitably trained socially and technically to work as a health team and to respond to the expressed health needs of the community.

VIII

All governments should formulate national policies, strategies and plans of action to launch and sustain primary health care as part of a comprehensive national health system and in coordination with other sectors. To this end, it will be necessary to exercise political will, to mobilise the country's resources and to use available external resources rationally.

IX

All countries should cooperate in a

sure primary health care for all people since the attainment of health by people in any one country directly concerns and benefits every other country. In this context the joint WHO/UNICEF report on primary health care constitutes a solid basis for the further development and operation of primary health care throughout the world.

X

An acceptable level of health for all the people of the world by the year 2000 can be attained through a fuller and better use of the world's resources, a considerable part of which is now spent on armaments and military conflicts. A genuine policy of independence, peace, detente and disarmament could and should release additional resources that could well be devoted to peaceful aims and in particular to the acceleration of social and economic development of which primary health care, as an essential part, should be allotted its proper share.

* * * * *

The International Conference on Primary Health Care calls for urgent and effective national and international action to develop and implement primary health care throughout the world and particularly in developing countries in a spirit of technical cooperation and in keeping with a New International Economic Order. It urges governments, WHO and UNICEF, and other international organisations, as well as multilateral and bilateral agencies, non-governmental organisations, funding agencies, all health workers and the whole world community to support national and international commitment to primary health care and to channel increased technical and financial support to it, particularly in developing countries. The Conference calls on all the aforementioned to collaborate in introducing, developing and maintaining primary health care in accordance with the spirit

Science and ethics in the NORPLANT trials

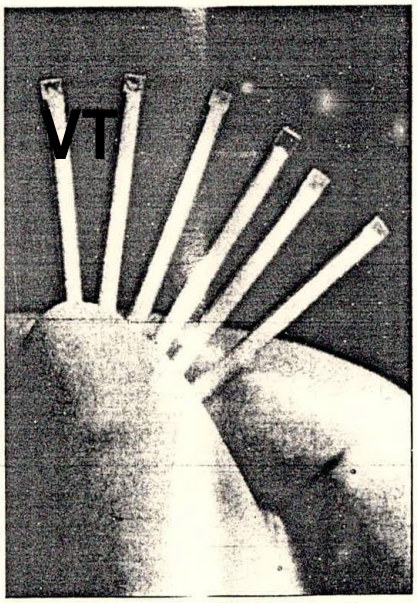
Safety trials are being conducted in India on NORPLANT, the implantable hormone contraceptive developed by the US Population Council. The way the trials are being carried out, however, raises serious questions.

Kalpana Mehta

WALK in to the Family Plannning clinic at the Safdarjung hospital and you are greeted by two posters of NORPLANT, the five-year implantable hormonal contraceptive invented by the Population Council of the USA. The counsellor takes great pains to explain to you all about this new contraceptive costing Rs1,800 received from the US. Six white match-sized capsules comprising this contraceptive are stuck on the poster – so that women can see it for themselves. But neither the counsellor nor the doctor on duty bother to inform women of the minor hitch - NORPLANT is not as yet an approved method for contraception but is undergoing trials in the country. Women who agree to use NORPLANT will in fact be participating in the Phase III trials of the Indian Council for Medical Research which will establish the safety and effectiveness or for that matter the lack of it for Indian women.

While the inventor, namely, the Population Council, lists out a number of side effects which include spotting, amenorrhea,menorrhagia, metrorrhagia, ovarian cysts, mastalgia, weight gain, dermatitis, acne, hair loss, hirsutism, headache, nervousness, nausea, dizziness, change of appetite, depression and other mood changes, infection, itching or pain at the site of implantation, our researchers reassure women that NORPLANT is perfectly safe, ('You may suffer some bleeding disturbances but we can easily take care of them') in complete disregard of the fact that there is no treatment for these disturbances.

Of course this irrational therapy is not confined to India alone but is rampant in almost all countries where this miracle device is in use, ranging from Finland to Indonesia. 'Only a hundred devices have been sent to us and even our own staff is queueing up for them,'



NORPLANT capsules... designed to prevent pregnancy for up to five years.

The doctor on duty first screens two women based on their reproductive status including age and parity and possible inclination to seek a contraceptive for full five years. She then sends them for routine examination and a pap smear. It is a bit late in the day and the concerned doctor refuses to take the smear. The women persist saying that they need to get the test done on the same day because they have been asked to get NORPLANT inserted the next day. 'But the result of the smear will be available only after two weeks,' says the doctor. The women rush back to the Family Planning clinic a bit confused. The doctor on duty reassures them that it is not necessary to wait for the results. Now the unsuspecting volunteers are truly worried – why all this testing if it is not needed?

are dissuaded that 'these contain hormones and will ruin your uterus. Why don't you go for the Copper T?' by the very doctors who promote NORPLANT as being safe. IS THIS ETHICAL?

Ethics apart, what is the rationale for all the promotional glossies that have been printed already by the Ministry of Health and Family Welfare or for that matter the video on NORPLANT insertion, all of which make NORPLANT seem like an ideal contraceptive? How has the Ministry decided that NORPLANT trials will prove to be a safe and efficacious device for Indian conditions? Are these trials being conducted to determine the side effects among Indian women or are they a ritual exercise meant to give a scientific facade to a political decision? Or are the trials meant to pacify the joint front of women's organisations which has demanded that NORPLANT not be introduced in India.

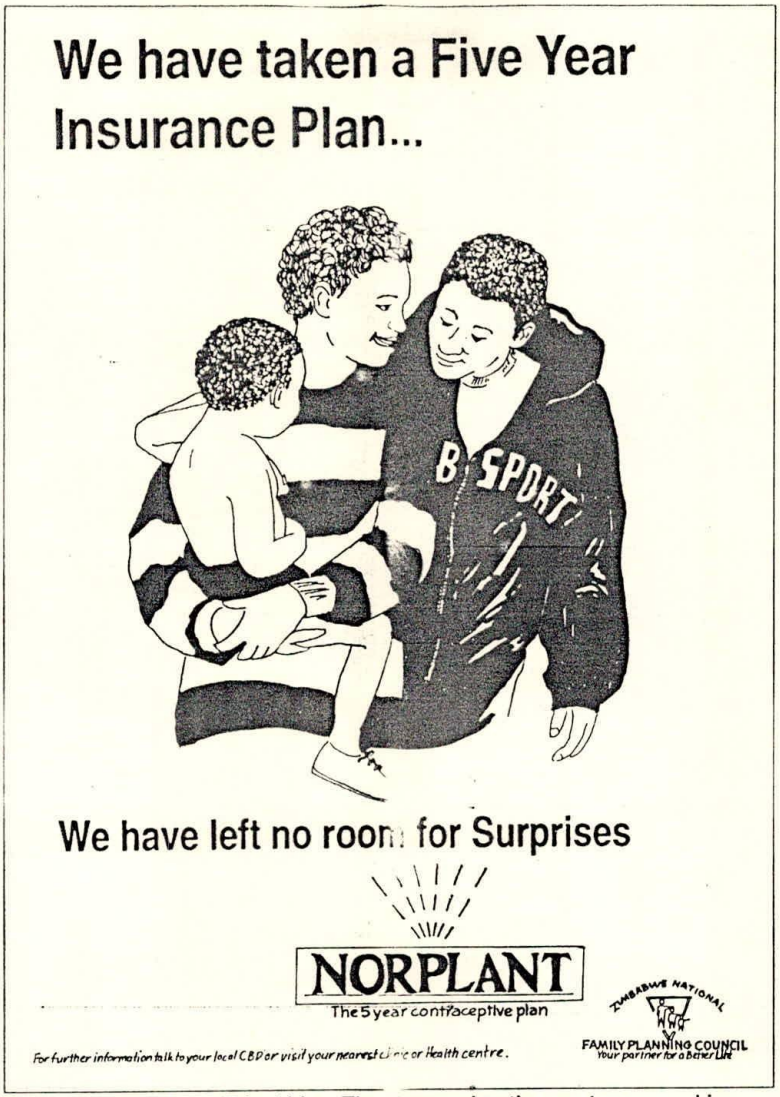
Time and again NORPLANT approval in the US is cited as a ground for the safety of this device. But a cursory look at the National Drug Approval before the US informs the reader that the US application was made so that it would be easy to obtain approval from drug authorities in the Third World.

In 1991 I happened to attend a meeting called by the Indian Council of Medical Research and the Ministry of Health and Family Welfare where they revealed their plans to go ahead with NORPLANT introduction without carrying out the Phase III trials. They sought the support of women's groups to go ahead. This was not surprising because at that stage only a few women's groups like Saheli, Chingari and Stree Shakti Sanghathana had raised their voice against introduction of unsafe contraceptives and the abuse potential of contraceptive technology.

NORPLANT as a contraceptive

tablishment ideally, second only to sterilisation. Once motivated a woman could be forgotten about for five years. Not only was the question of safety being ignored but also the actual proof of abuse from the country of origin ie the US.

In India the contraceptive had not even undergone the necessary clinical trials which would have answered the question of effectiveness, side effects and adverse reactions among Indian women. NORPLANT administration also requires sophisticated screening and monitoring systems which were then non-existent in the country or were fast being dismantled. This had already been proved in the case of another version of NORPLANT where for a large number of cases contact was lost altogether. Non-removal at the end of the effective period could subject these women to the life-threatening condition of ectopic pregnancy.



Promoting NORPLANT in Africa. The above advertisement was used in Zimbabwe.

On these premises a broad coalition of women's organisations and health groups came forward to say a resolute 'no' to NORPLANT. While their position on the suitability of this device for Indian conditions was not accepted there was no denying that Phase III trials were a must. The Indian Council of Medical Research thus admitted before the National Commission for Women that it would carry out a Phase III trial instead of the proposed post- marketing surveillance of 20,000 women. A sample of 1,000 women was then drawn up and this trial was initiated in July this year at ten medical colleges.

There are a number of problems with the way this study has been designed and also with its implementation. First and foremost NORPLANT is not being offered as an experimental method but as a choice among many other methods. While the study aims to see the acceptability of the method among young women, this is not even built into the design of the study. Hospitals are, in practice, putting pressure on women with two children to adopt sterilisation or to opt for IUDs instead of offering them a choice including NORPLANT. Women who opt for NORPLANT are to be provided with health cards so that they can get good medical care for all their problems - an inducement which can hardly help if one of the objectives is to assess the relative acceptability of the device. Similarly targets have been set for NORPLANT recruitment but not for an overall limit for the study biasing counsellors to push NORPLANT among eligible women. Similarly, the researchers are not fully informed of the side effects by the research protocol. Serious side effects which include ovar-

for that matter hea disease are abser from this protoc even though they hav been reported to occu with a fair regularit among NORPLAN users in other studie

A recent evalua tion in Indonesi suggests that as man as 11% women re ported symptoms c heart disease while o NORPLANT. Th Population Counc suggests that ovaria cysts have occurre among nearly 10% c the users even thoug it does not provide in formation on the per centage which re quired surgery. Th research protocol c ICMR suggests tha the study could b discontinued if life threatening side ef fects were discovere but for most India women heart attack would mean loss c life given the low ac cess to health care The logic of carryin out research to fin out what is alread known escapes one.

Medical researc cannot be done in dis regard of social and infrastructural rea ity. Research is justified if there exist a possibility of finding a superior solu tion to an existing problem NORPLANT fails to meet this require ment for women. Time and again fig ures of maternal mortality are quoted a a defence for introducing contracep tives. But death rate from NORPLANT use sans medical facilities to treat fo side effects would itself surpass the ex isting rate of maternal mortality NORPLANT has an effective life o five years, is not recommended for lac tating women and yet is being promote as a spacing method. Which woma would be advised to space her childre by seven years?

NORPLANT the world over has record of abuse possibly surpassed onl by the vasectomy drive in India durin the emergency. While in the US it ha

authorities such as judges and welfare workers who want to ensure that women on parole and welfare do not reproduce, in Indonesia it has been used without even informing women that it can be removed before five years are over.

US approval at any rate is no guarantee for safety. There is no comparison between healthy North American women and their average Indian counter parts. There is no comparison between emergency medical assistance or for that matter in product liability laws. Or do we propose to follow the example of Indonesia where insertion (and hence screening and surgery) is carried out in facilities which lack examination tables, running water and electricity?

Promoting a positive image for NORPLANT in Indonesia.

We are now aware that HIV virus spreads also through heterosexual intercourse. Experts suggest that India is on the verge of an AIDS epidemic. In this context it is important to note that NORPLANT provides no protection against HIV and is likely to contribute to the spread of the virus because of the surgery involved. The Population Council makes a ludicrous suggestion that NORPLANT should be used for contraception but a condom should be used against HIV. Why not dispense with the implant because a condom can take care of both requirements?

Of course the side effects listed in the official literature occur among women who have been screened for contraindications including pregnancy, liver disease, hypertension, heart and clotting disorders, cancer etc. No one knows how other women will respond.

Not allowing research to take place labels women's organisations as being anti-science. But surely quest of knowledge cannot be at the expense of human beings. And at any rate what is scientific about trying to do away with research before introducing a new drug? Or for that matter what is scientific about printing promotional literature in advance of the research? Or for that matter what is scientific about researching into products which will only increase human misery?

Before starting research the appropriateness of technology must be assessed. The ability to deliver services safely depends on the quality and reach of the health care system. Even if it were possible to deliver a particular technology the costs arising out of the cost of delivery, cost of screening and monitoring, cost of training the personnel and above all the cost of morbidity likely to result from the side effects must be weighed against the benefits of providing additional choices to women ie, how many women would have an unmet need satisfied and hence the concrete benefits from the method. These estimates are invariably available because most contraceptives undergoing trials in India are in use elsewhere. It is important to state that in a family planning programme like ours, the abuse potential of a contraceptive (which means how it can be forced upon women) is a critical factor in approving contraceptive methods even for research.

In today's context, only a method which has the potential to serve contraceptive needs of men or women better and costs the exchequer less than the other methods while providing protection against HIV and with a lower potential for abuse can be logically cleared for clinical trials. But this logic could be applied if the trials are meant to serve the cause of science and humanity.

Not only does the question of choice of new methods have to be answered through research but some other enquiries with respect to existing methods are in order. Bleeding disturbances associated with injectables and implants are brushed aside as minor inconveniences without scientific basis and it has taken thirty years to even initiate research on this subject. Similarly while the stress is on the promotion of spacing methods many methods have not been tested sufficiently for return of fertility, return of the ability to bear healthy children and the likely impact of invasive methods on breastfed infants. Long-term follow-up of subjects which is essential to determine the carcinogenic potential of hormonal contraceptives among women and their children is absent. Is this scientific?

Medical researchers never tire of talking about the cafeteria approach. But what recourse is available to sexually active women who are not living within the confines of marriage? Why does research always model itself on a long-standing couple relationship where a woman is constantly exposed to the risk of pregnancy when this is akin to taking a daily dose of aspirin to prevent a headache? It is well known to all, that ever increasing migration from rural areas would mean that even married women need contraception for sporadic and spontaneous sexual intercourse. Yet little research is aimed at this segment. It is equally well known that a large proportion of Indian women are anaemic and yet no research is aimed at methods which do not entail increased bleeding losses, with the exception of immunological contraceptives which put more at stake than the present hormonal methods.

In fact, it can safely be asserted that research on contraceptives is akin to endless packaging of old wine in new bottles - most of it is aimed at finding new delivery system for synthetic hormones for continuous contraceptive protection while safety questions are left unanswered. And increasingly even this research is being dispensed with as has been the case with the approval accorded to Depo Provera last year and the promotional literature on NORPLANT and Cyclofem. ◆

Kalpana Mehta is a health activist in India.

Com H 3

The case of the nuclear human guinea pigs

Recent revelations that US government agencies, private corporations, hospitals and universities have subjected pregnant women, newborn infants and mentally retarded children to secret radiation experiments have sent shock waves throughout the world.

US OFFICIALS say they are a long way from compensating the thousands of human guinea pigs subjected to secret government radiation experiments following World War II.

'People don't want to get caught with something that could be a multi-billion-dollar thing,' an administration official told reporters. 'There's just not loads of money to go around.'

The comments appear to contradict those made by Energy Secretary Hazel O'Leary, who has led the government's inquiry into the experiments. She said on television that victims should be compensated.

'Many have suggested, and I tend to agree personally, that those people who were wronged need to be compensated,' O'Leary said in the 28 December interview. 'I am appalled by what was done,' she said. 'Clearly standards were used that should never have been approved.'

800 people involved

The experiments involved exposing people to, and injecting them with, doses of radiation without their informed consent. The extent of the experiments is still unknown and new reports surface almost daily. O'Leary said some 800 people were involved.

Government agencies, private corporations, hospitals and universities conducted the experiments from the mid-1940s to at least the mid-1970s on pregnant women, newborn infants, mentally retarded children, native Americans, and prisoners, among others.

The Atomic Energy Commission, the predecessor of the US Energy Department which oversees the country's nuclear programme, managed most of the experiments.

O'Leary's suggestion of compensation was the first time the government has taken the lead in offering payments to survivors of nuclear tests.

But the Bill Clinton administration will not immediately change course, according to official Spokesman Jeff Eller has said on 10 January 1994, that the White House was still a 'long way' from committing to compensation.

High-level task force

The administration has, however, announced the formation of a high-level task force to investigate the scope of the radiation experiments, including how many people were used as guinea pigs and if they should receive compensation.

The scandal over the experiments began in December 1993 when a New Mexico newspaper reported that 18 hospital patients were injected with high concentrations of plutonium between 1945 and 1947.

One woman was reportedly monitored for 35 years without being told what had been done to her. The paper said another subject's body was exhumed 31 years after burial and sent to a government laboratory in Chicago for further tests.

More revelations of the experiments surfaced as researchers dug through thousands of newly declassified documents released by the Energy Department. The media also investigated local reports of abuse.

The *Boston Globe* reported in early January that more than 30 mentally-retarded children were fed radioactive foods as part of a 10-year study in the 1940s and 1950s. It said the experiments were performed at Harvard University and the Massachusetts Institute of Technology and supported by the food company Quaker Oats.

In another case in the late 1940s, hundreds of pregnant women in Nashville, Tennessee, were reportedly given radioactive iron to study its effect on the development of the child. The stu found higher than normal cancer rat among the children born.

Newborn infants were also su jected to tests. In one study, 235 we reportedly injected with radioactive i dine, apparently to see how the thyro gland works. The results were publish in the 1950s and 1960s.

At the time of the experiment officials acknowledged they risk criticism for not telling people what w being done to them. One official likene the experiments to those of Nazi docto at the Buchenwald concentration can during World War II.

Buchenwald touch

'If this is to be done in humans warned researcher Dr Joseph Hamilto in a 1950 memo, 'I feel that those co cerned in the Atomic Energy Commi sion would be subject to considerab criticism as admittedly this would hav a little of the Buchenwald touch.'

But the studies enjoyed the suppo of government agencies, universities ar hospitals, including the National Aero nautics and Space Administratio (NASA), the US Public Health Servic Columbia University and the Universit of California.

Government researchers also co ducted experiments in prisons. I Washington and Oregon, reports sa 131 prisoners had their testicles expose to radiation to see what effect it woul have on sperm production and to fin out how much radiation was necessar to make them sterile.

The Clinton administration's ne task force, comprised of representative from all major government agencie will seek to answer lingering question and see if experiments involvin chemical and biological weapon were also performed on unwitting sub jects. – *IPS*

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SECTION T

CULTURAL COMPONENTS OF BEHAVIOURAL EPIDEMIOLOGY: IMPLICATIONS FOR PRIMARY HEALTH CARE

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Abstract—In this article we discuss the association of culturally linked behaviour and epidemiology: that patterns of disease are significantly related to cultural sets of normative beliefs and behaviour. The literature on this is vast and includes much of what is written under the headings of Medical Anthropology as well as, for example, Cross-cultural Psychiatry and Medical Geography. A comprehensive review is obviously impossible, but as this is presented primarily as a background paper, basic issues are raised, and related to examples from the literature, to stimulate discussion. The article is divided into four subsections which give an indication of our focus: (1) culture, disease and illness causation; (2) utilization and provision of health resources; (3) health, illness and normative socio-political and economic behaviour and (4) primary health care, community participation and culture—implications for the future.

INTRODUCTION

We need only read Fabrega's 1974 volume *Disease and Social Behavior* [1] and scan its 30 pages of references to be convinced that behaviour and disease prevalence and incidence are interconnected. It is clear that people's behaviour affect agents, hosts and environment to either increase or decrease the risk of a whole range of diseases and ailments. It is this which we understand as behavioural epidemiology, the study of patterns of morbidity and mortality of various groups which may be associated with particular behaviour (e.g. it has been found that smoking behaviour is, epidemiologically, associated with higher rates of lung cancer for smokers than for non-smokers).

There are many reasons why we behave as we do, but much of what we do, and how we do it, is culturally determined. We may agree with Landy that, "... almost every facet of human behavior seems to be either modifiable or impressively influenced by cultural factors" [2]. Culture has many definitions, but most would agree that it is a set of beliefs and behaviour shared by a specific group. Thus by the very fact of our belonging to such a group, as we all do, we all have been socialized to accept certain values and behaviours as normative.

Even if we argue that no culture is static, with some being particularly fluid, and that acculturation and multiculturism, not to mention cultural imperialism, have relevance in most parts of the world, we are all undeniably influenced by cultural norms, be they those of dominant and/or of the sub-culture in which we live. It may be that the culture of our youth is different from the one we live in as adults both because of change over time and because we may have moved from one culture to another, but this does not minimize the influence of culture, though it does signify dissonance.

Since the publication of Benjamin Paul's *Health, Culture and Community* [3] in 1955 and Steven Polgar's major article, "Health and Human Behavior: areas of interest common to the social and medical sciences" [4] in *Current Anthropology* in 1962, the connection between culture and epidemiology has been clearly established. It is now widely accepted, not only by social scientists but also by a substantial number of health professionals that patterns of disease are significantly related to cultural sets of normative beliefs and behaviour. It is now no longer considered strange that anthropologists work in medical schools or with health services programmes as it was less than 10 years ago.

More recent volumes such as Landy's, 1977, *Culture, Disease and Healing* [2] and those published in the "Comparative Studies of Health Systems and Medical Care" series edited by Leslie [5] since 1978 and those in the "Culture, Illness and Healing" series edited by Kleinman [6] which began in 1981 are but a few of the more well known of a vast literature which convincingly makes the connection between culture, behaviour and epidemiology (e.g. [7–14]). The current prominence of this connection does not imply that it is a new discovery. It has been recognized and expressed by medical philosophers and practitioners from Hippocrates [15] to Virchow [16] and, more recently, Dubos [17, 18] and Engel [19]. The rediscovery is connected with a growing disillusionment with the disproportionate prominence and pre-occupation

The views expressed in this article are those of the authors and do not necessarily represent those of the institutions with which they are associated.

with the technological and biomedical aspects—the technological fix—of health and illness. This does not imply a disregard for the value of biomedicine but rather a recognition that it may be faulted for having become but a partial healing process.

Most of what is known as medical anthropology and much of the literature of such fields as cross-cultural psychiatry, culture and personality, and medical geography can be related to culture, behaviour and epidemiology. It would be unrealistic to attempt a comprehensive review of such literature. Rather, we want to present a few examples of this relationship and, as this is written as a background paper, to raise some issues which may serve to stimulate discussion. We have done this under four basic headings: (1) culture, disease and illness causations; (2) utilization and provision of health resources; (3) health, illness and 'normative' socio-political and economic behaviour and, in conclusion; (4) primary health care, community participation and culture—implication for the future.

First a word must be said about measurement, however, and about the care which should be taken in drawing conclusions from comparative cross-cultural morbidity and mortality statistics. 'Obvious' differences may not be as obvious as they first seem. The quality of health statistics is not uniform throughout the world; the reliability of statistical records varies considerably. In some countries national health statistics are based upon reports from less than 25% of the health facilities. Emphasis on what is recorded and the categories used also vary from country to country.

It must also be remembered that, especially in developing countries, a significant proportion of 'illness events', and causes of death, are not included in the statistics at all since they are unknown to the official health system. There are usually no records of ailments receiving the attention of traditional practitioners, for example, or of those dealt with through self care. Even where medical pluralism is practised, as it is in most places throughout the world, where health care is sought from the orthodox as well as from a number of other health resources, the problem persists. The complications arise both because of multiple resource use for the same ailment as well as from the tendency to use one rather than another health resource because of the character of a particular ailment.

The epidemiological pattern which emerges from the morbidity and mortality statistics recorded by the official health system, therefore, may be both misleading as well as incomplete. This is not to say that cross-cultural epidemiological comparisons can not be made but rather that specific comparative studies which do not only rely on available (regional and national) statistics may be needed before conclusions can be pronounced about the associations between cultural characteristics and specific epidemiological configurations.

CULTURE, DISEASE AND ILLNESS—PATTERNS OF ILLNESS CAUSATION

It is widely acknowledged that a great deal of human behaviour is directly hazardous to one's own and other's health. Although many practices linked to ill health are a matter of personal choice or preference, for the most part they are socially condoned within a given cultural context. Excessive alcohol consumption, for example, with related morbidity and mortality, is primarily a problem culturally confined to non-Moslem societies.

In a broader context, industrial–technological progress initiated in the Western world may be regarded as health-hazardous behaviour, in which environmental pollution, as well as direct contamination by carcinogenic agents, is essentially condoned by its very presence.

The crucial importance of diet to one's health is widely accepted; today, in the West, the concept of 'you are what you eat' has developed to the point of fanatic fadism—in which specialized, exclusive diets purported to be health promotive, compete with one another for followers. There are, however, dietary practices which can be directly associated with various illnesses [20, 21]. This is in addition to those associated with malnutrition caused by specific deficits in food resources [22].

A number of practices, associated with specific cultures, have been noted for their deleterious effects on health; the practice of female circumcision [23], particularly the practice of infibulation, is significant for the attention it has received not only as a health but also a feminist issue. Some practices are more indirectly linked to ill-health; the performance of uvulectomies on newborns in Northern Nigeria, for example, has been linked to high incidence of early childhood anaemia [24]. Another example is that of unilateral breast-feeding, in which an increased risk of cancer in the unsuckled breast has been evidenced [25]. The occurrence of what has been called 'culture-bound syndromes' which are said to be culture-specific, should also be mentioned although their etiology is not clearly established [26, 27]. In both developed and developing countries, specific behaviour as well as cultural context, are influential in determining health status (see, for example [28–34].

Hypothesizing that lifestyle—or culturally influenced behaviour—is a major determinant of community health, a rural subsistence community (Papua New Guinea) and an urban industrialized society (Australia) have been contrasted regarding such features as physical environment, social situation, human relationships and parameters of health and patterns of disease. The former community, seen as self-reliant, socially cohesive, whose members are well adapted to their physical and social environment, were free from major degenerative cardiovascular diseases, with little overt psychiatric illness, but with a heavy burden of infectious disease and marginal nutritional status.

On the other hand, the highly industrialized community lacks social cohesion and depends heavily on technologies of production and discourages direct relationships between its members and their physical environment. The price for containment of infectious disease, diminished infant mortality and extended life expectancy would seem to be increased levels of degenerative disease and disease from psychological stress. The authors conclude that health, in its fullest

sense, is not the prerogative of any one type of society [35].

The well being of a family may be influenced in most societies by the degree to which the female carries out the usually unpaid role of nurturer, and provider of physical and emotional comfort. In the industrialized West, the woman's burden of a 'double workload' when she is wife and mother as well as a salaried worker is one she shares with most women in rural developing societies. Common to both is the lack of value placed on the non-paid work women carry out. Paradoxically for cultures predominantly defined by men, the concept of motherhood holds high status, but the toil of mothering is largely unacknowledged. Misogyny is perhaps not too harsh a term to describe cultural attitudes in which not only is little value placed on women's work within the home, but unequal value is placed on work outside the home as well, by lower salaries, fewer opportunities for advancement, etc.

The preference for male babies has been documented in several cultures, where property and status are male sex linked. A most recent example of female infanticide is seen in China, where the one-child-family ruling has led families to sacrifice first born daughters to allow them a 'second chance' for a son. So concerned has the Chinese government become that special allowances have now been made to permit some families more than one offspring.

Cultural change and health

Culturally influenced psychological stress is not only of concern to members of highly industrialized Western societies, where stress related morbidity and mortality have been well documented. Cultural transformation has also been studied as it has affected patterns of illness in various groups. Coronary heart disease, hypertension and cancer as well as a number of other diseases have been found with greater incidence among people who have migrated from one culture to another [36–38]. The patterns of illness may change due to diet, physical environmental factors as well as to socio-psychological phenomena of cultural change and stress related to adaptation [39–41].

Differing levels of physiological stress have been related to cultural change and the extent to which acculturation has been undertaken. Reaction to culture change, either short-term or over generations, has been noted to follow a *U*-curve, with intermediately acculturated immigrants exhibiting higher levels of stress than either high or low contact groups [42].

Rapid socio-cultural transitions, brought about in primarily subsistence economy societies by post-war contact with Western culture, have caused transformations in economic structure and dependence, in demographic shifts, as well as in traditional communal life styles. In Micronesia, this transition has seen suicide rates among adolescent males increase in epidemic proportions; the phenomenon has been suggested attributable to the post-war social change in Micronesia, in which the communal village level of organization has largely disintegrated [43]. Also, comparatively higher incidences of high blood pressure have been found among males in more modern, urban areas in Micronesia [44].

One hypothesis suggested by Cassel [44], based on comparative studies of blood pressure levels, holds that low pressures occur in societies with a coherent value system which remains relatively unchallenged in a generation, but migration to a society with a different value system could lead to dissonance, resulting in sustained elevation of blood pressure. The other hypothesis emphasizes physical factors, caloric intake, physical activity, body build, salt intake and the presence of parasites and diseases which could influence blood pressure level. However, both hypotheses could be associated with modernization and migration [45].

High levels of modernity and acculturation have similarly been found to influence higher rates of coronary heart disease (CHO); in a study of Japanese-Americans, the most traditional group had a CHD prevalence as low as that observed in Japan, whereas the group which was most acculturated to American culture had a 3–5-fold excess in CHD prevalence [46].

Implications of psychological stress on health

Although the mortality rate world wide is greater due to disease, comparative rates of suicide may be indicative of the level of psychological stress in a society, as well as of the relative lack of socio-psychological support in situations of personal distress. Compared with figures from the British Isles, the real rate of suicide is twice as high in Denmark, for example [47].

This difference is surprising, perhaps, due to the latter country's highly developed health and social welfare system, which optimally provides security from poverty and untreated illness. The security may not provide support, however, but in fact may be regarded as an alienating and patronizing safety net of caretaking for those who have not met the high standards of health and socio-economic status set. State provisions of homes for the elderly have expanded as the extended family has diminished, leaving many elderly virtually alone; indeed the highest rate of suicide in Denmark is among the older citizens, although the rates among younger people, and younger women especially, is increasing.

The alarming fact that younger people in many societies today experience the ultimate breakdown of psycho-social support networks and resort to suicide may also be linked to a society's lack of opportunities for mobility—for changing environment, 'starting over' and finding new inspiration or support. In the United States the 'go West young man' phrase can clearly be seen adhered to in its high level of mobility and varied opportunities (we have already noted some of the negative effects of this constant transition, but it also has its advantages). As a side comment, it is notable that the majority of those committing suicide by falls from the Golden Gate Bridge in San Francisco are reported to have jumped off the West side.

UTILIZATION AND PROVISION OF HEALTH RESOURCES

What do people do when they become sick? Obviously, the reasons for the choices depend on the type of ailment and on a great number of other factors.

They are also related to, and influenced by, culture. Specifically, they may be linked to beliefs about etiology and to more general concepts of health, illness and appropriate treatment which differ from culture to culture (much has been written on this and some of the more recent literature includes [2, 48–55]). The consequences of these choices, the different processes, types and timing of treatment, can be related to outcome and thus, epidemiologically to prevailing patterns of disease. There are many accounts, for example, of beliefs about appropriate treatment for certain afflictions which contradict what is considered medically sound by allopathic practitioners—not that they have always been found to be correct.

Definitions of disease and illness also vary from culture to culture and if what 'we' think of as disease is not considered as such (nor considered an illness) but rather as a normal phenomenon [56], attempts to combat it would also be expected to be non-existent or minimal. In Malaysia, for example, Heggenhougen was directly told by several villagers that it was impossible for people not to have worms, and that if they did not have them something would be wrong with them. Numerous such examples can be found in the literature which consider it normal to be afflicted by a variety of, what we would call diseases. Kleinman *et al.* [53] among others [1] have clearly discussed such differences in definitions and have emphasized the distinctions between disease and illness. These differences are relevant not only for decisions to engage in, or seek, treatment or not, but are also pertinent regarding the practitioner–patient interrelationship, subsequent compliance and outcome.

Only a few years ago the World Health Organization's estimate claimed that traditional medicine is the primary health service resource available for up to 80% of the population in the rural areas of many countries [57]. Self care and the considerable knowledge and assistance of people themselves must of course not be forgotten, be this in rural areas of developing countries or elsewhere. Increasingly, however, at least some form of alopathic health services are available to most people; the value of allopathic medicine is widely recognized, albeit more for certain afflictions that for others. But this recognition does not necessarily mean that allopathic medicine is always the preferred choice of treatment. Quite often medical pluralism is practised [58, 59]. Different resources are used either alternatively for different ailments and/or multiple resources are used at the same time, serially or intermittently, for one ailment. Such treatment practices could have both positive and negative outcomes.

The position of the afflicted within a particular cultural group, the accepted sick role and the relationship of the larger group and of health professional to the sick is significant to the health of the individual and often to the group at large [60]. Included here are concepts of stigma and status and accepted long- and short-term rehabilitation practices. Types of illness behaviour and the behaviour of others to the ill person obviously relate to choice of treatment, to the quality of the immediate, practitioner–patient therapeutic process, to compliance and to the overall rehabilitative process which can be significantly related to outcome (see, for example [50, 61]).

The interaction between practitioner and patient is crucial. It is a process which could be a positive 'therapeutic alliance' [62] but at least within the Western medical paradigm, the interaction often takes place between people of unequal power across a considerable cultural gap. The quality of this interaction—of the immediate treatment process—can be related to rates of compliance to treatment regimen [63–65]. This relationship and the consequent quality of compliance and subsequent outcome can in turn be related to culturally determined concepts of health and illness which may be shared by, but which often are different for, practitioner and patient.

Steffensen and Colker [66] have reported on a particularly interesting study which "provides evidence that absence of shared concepts between practitioner and patient may impede even willing compliance". In other words, patients do not comply because they do not understand what the practitioner is talking about. The study involved a matched group of Australian Aboriginal and North American women who heard and recalled two stories incorporating Aboriginal and Western conceptions of illness and treatment. Both groups showed an equal ability in recalling the story relevant to their own culture *and* an equal inability to recall the story relevant for the other group's culture. Significant also are differences in manifestation, presentation and description of symptoms including response to, and admission of, pain by members of different cultures [67–74].

Health education attempts to influence people to do something they are not now doing or to make others stop or change what they are doing. It is recognized that it is necessary to promote cultural change. The provision of health education, and its impact as reflected by how people react to it, is a factor concerning both disease incidence and prevalence. The rigid, hierarchical approach of some health education must be examined, as it assumes a medical cultural imperialism in which the Western allopathic medical model is superior.

Much of the technical and biomedical aspects of allopathic medicine is effective and is clearly recognized as such by most. It is the character of the treatment process and the lack of communication, despite the conversations held, which constitute the problem. And here, allopathic medicine may have something to learn from traditional medicine [75–78]. This is another vast subject and Engel [19] is but one of the most widely quoted critics of the prevailing bio-medical model, suggesting that the character of the medical system(s) itself should also be changed.

Reasons for choices

The decision to use, or not to use, a particular treatment resource, or a multiple of resources, necessarily depends upon availability and accessibility. Of equal importance is the acceptability of these resources. How does a system, and/or its practitioners, relate to particular patients? Do patients and their families have confidence in the practitioner? Are they at ease within the therapeutic setting? Do they believe the practitioners properly understand them? Do patient and practitioner speak the same language

—both literally and figuratively? In short, do they belong to the same culture, and if not, can they overcome and communicate across the cultural barriers?

Annis [79], for one, has argued that the reason people—in this case Guatemalan Indian peasants—do not use the available allopathic services is more because they lack drugs and equipment than because of any cultural barrier. We agree that this is a significant reason and lack of drugs and equipment is the norm in rural areas throughout much of the developing world. As stated above, we further agree that most people, be they peasants or nomads, recognize the significant efficacy of much of allopathic medicine, but we still maintain that despite availability of a well stocked health centre its use may be considered unacceptable because they may be too great a cultural distance between patient and practitioner and because of such factors as racism and arrogance—this certainly is the case in Guatemala. These factors, in addition to drugs and equipment, are significant for quality of care.

Choice depends on culturally instilled normative concepts of health and illness and on what is felt to be appropriate treatment. It also depends on the patient's, and/or his family's, etiological perception about the particular ailment in question. Much of the vast literature on this is well known and need not be expanded on here (see, for example [2, 48, 80–82]). Let us but mention two sets of binary concepts—the hot/cold or yin/yang perceptions about illness, food and medicines, and what we may call the how/why perceptions about etiology—both of which may be related to choice, treatment and to outcome.

The division of foods, illnesses and medicines into hot/cold, or yin/yang categories is evident in a great number of cultures and is well documented particularly in the medical anthropological, but also in the more general public health, literature. As illness is often conceived of as dissonance, or imbalance, between these binary forces within the body it is felt important to restore harmony by reinforcing the element (hor or cold) which has become depleted. Thus a cold illness should be treated by what is considered a hot medicine or aided by a hot food.

Many people are concerned not only with how they became ill—the host/agent inter-relationship considered biochemically—but also with why they became ill. They are not only concerned with, for example, the biomedical inter-relationship between agent and host but also with the more spiritual or social aspects of illness. many ailments are, of course, considered as purely naturalistic, but others are also seen in a different light. Most people are aware that they fell ill because of, for example, a snake bite or even because of a mosquito bite—what we refer to as the 'how' of an affliction—but many are also often concerned with, "why me?" And with "why me, at this particular time?"

Voodoo, charms and spiritual aspects of illness of various kinds may be of utmost importance to many patients. Illness may also be seen as a sign of wrong doings or sins. The dissonance to be balanced is then not only within the body, but also outside. The relationship with others, or even with 'the gods' or the ancestors may be seen as faulty, and if it is, then a treatment process which aims to restore harmony within the family, the group, or between man and the ancestors or gods may be considered of equal, or greater, importance than the biomedical treatment of the physical disease. And if such treatment does not take place—if this 'why' aspect of an illness is not attended to—stress will remain: the patient will remain uneasy or dis-eased.

We know well enough the powerful inter-relationships between attitude and feelings and physical health—the inter-relationship between mind and body [83]—to recognize the deleterious effects of not paying attention to this 'why', whether we believe it to be 'superstitious' or not. In many ways, reality becomes what we perceive it to be [61, 84, 85]. In this light the use of allopathic health resources may be seen as a necessary, but not always as a sufficient, treatment process. One reason for the frequent preference for traditional over allopathic treatment is precisely because traditional medicine tends to pay greater attention to this aspect of healing. If an ailment is considered to be predominantly of a supernatural nature, biomedical treatment whether by allopathic or traditional herbalists, however, will be secondary.

Consequences of choices

The choice of treatment we make, or are urged to make, is usually, but not always, made in the expectation that it will be to the benefit of ourselves or an ailing relative. However, the choice of treatment may have either positive or negative consequences, or both. Leaving aside the positive for the moment, let us concentrate on the negative consequences and on how choices, and timing, of treatment may affect patterns of diseases.

Before mentioning treatment choices for what we would call actual disease and illness we must also consider the consequences of a number of culturally determined practices, or medical interventions, such as infibulation, uvulectomies, cutting of so-called plastic teeth and the like which are done both for social and for their potentially disease preventive effects (see, for example [23]). Similarly it should be mentioned that the perhaps too frequent and accepted practices of tonsillectomy and coronary bypass surgery may be unnecessary and could have negative medical as well as economic consequences.

A common complaint of allopathic practitioners (and especially of the few who are ethnocentric and who do not fully understand the concept of 'acceptability') is that because patients first seek help from traditional practitioners, or practice self-care, they delay too long in finally arriving at a health centre or a hospital. Many of these 'cases' which could have been cured, die because they arrived too late. And why do they arrive too late? In addition to the reasons mentioned previously, another is that hospitals and even health centres have become known as places people go to, to die. Because people hesitate as long as possible before going, the chances that people will die when they finally do go increase—it is a vicious circle.

The capability of many traditional healers in treating a number of ailments must be questioned; but it is not always clear if the rate of iatragenesis is greater

for traditional healers than for allopathic practitioners. The multiple use of different health resources is also a cause for concern since these do not necessarily complement each other but may be in conflict especially if a patient receives and takes medicines from more than one source at the same time.

Rehabilitation and behaviour toward the afflicted

It is evident that the illness behaviour of the afflicted—how s/he behaves and/or is allowed and expected to behave by her/his cultural group—is important relative to the choice of treatment, the quality of the therapeutic process and to the eventual outcome. How the family, the larger cultural group and various health personnel treat the sick both in terms of acute affliction and relative to rehabilitation and degree of integration within the group for chronic patients, is also important. The literature point to a great deal of cultural divergence of such behaviour which is epidemiologically relevant.

Do family and friends tend to isolate, ignore or shun the sick or do they closely comfort and care for and associate with the afflicted? Depending on the ailment, both extremes of such behaviour could have negative effects for either/or both the patient and those with whom he is in contact. Does this depend on the type of ailment? In many cultures in both developing and developed countries leprosy and STD, for example, carry a stigma. They are diseases which are often considered the results of sins or ethical and social misconduct. Will such ailments be kept secret and treatment avoided or delayed? What of those with other ailments such as polio, or the mentally retarded, the neurotic and psychotic? How are they treated or cared for by the communities in which they live? Are some confined? Are others ignored and left to suffer in poverty and starvation for want of being able to support themselves? Are boys better cared for than girls? The answers will vary from culture to culture.

Two specific examples may be mentioned: studies of psychological support in illness and rehabilitation found that cultural attitudes regarding personal responsibility for illness in Sweden influenced the quality of care received by hospitalized patients. Comparing Australian and Swedish health professionals, it was found that differences in the quality of patient care were attributable to the Swedish health professionals' stronger belief in personal responsibility for health. This belief was found to influence the health workers' perceptions of patients as less attractive and less deserving of care. Conversely, the Australian health workers, more highly trained in a psycho-social approach to patient care, were found to assume that their patients' illnesses caused emotional distress and that they were in need of support. The study concludes that the cultural values of health professionals may influence the outcomes of interactions between patients and practitioners [86].

Psychological support and maternal attitudes have been found to critically influence the outcome of rehabilitation efforts provided for children suffering from malnutritional diseases. A study of Ugandan children treated for kwashiorkor and marasmus found a higher rate of successful rehabilitation among those children whose mothers were **actively** engaged in stimulating, playing with and holding their children during hospitalization. The children whose mothers ignored their cries for attention and cared fared much more poorly, and in many cases the rehabilitation efforts were totally unsuccessful. The fact that familial support and caring during illness influences the outcome of rehabilitation is not questioned. What is, is the extent to which cultural factors determine the implementation of the psychological resources necessary to provide for successful rehabilitation.

The Western model and its accompanying cultural norms have been accepted or enforced throughout the world. In addition to economic constraints, the character of this medical orientation is also inappropriate in a great number of situations in both developed and developing countries. It is not the optimal approach required to achieve the stated goal of better health for the total population. This inappropriateness is now widely recognized, at least in theory if not in practice, and one reaction may be related to the promotion of primary health care.

HEALTH AND 'NORMATIVE' SOCIO-POLITICAL AND ECONOMIC BEHAVIOUR

We have mentioned the potential consequences to health for those individuals who by and large accept and carry out their culture's normative pattern of behaviour. Here we intend to discuss culturally determined behaviour on a slightly larger scale and the consequences this may have both for the health of members within as well as outside the boundaries of a specific culture [87]. Related to this is cultural imperialism—both within and across national boundaries, which imposes the normative behaviour of one cultural group onto another. Regarding both of these concepts we recognize, though, that cultures are not static and that because of cultural diffusion, transmission and international communication it is not always easy to distinguish specific cultural boundaries.

Our concern here is with political, social and economic behaviour—policies and practices—which are either accepted, or at least recognized by people as the 'normal' socio-political and economic practices of the cultural group to which they belong. This concern includes such basic issues as racism, exploitation, the greed/profit motive where the end justifies the means, aggression and war.

Development, business practices and health

The accepted behaviour by major cultural—national or other corporate—groups of intervening in the internal affairs of such countries as, for example, Afghanistan and Chile, or in Central America, certainly having dire consequences for the health of the people in those countries [88]. Accepted industrial and business practices can be directly linked to the extermination of Amazonian Indians and to the persecution and ostracism of indigenous fourth world populations in all parts of the world. Also in Scandinavia, there have been infringements against the same people—the so-called Lapps—which though perhaps not as drastic as elsewhere in the world, may certainly be linked to their state of well being. This

relationship has been amply documented by, for example, Survival International and in the scores of publications of the International Work Group for Indigenous Affairs (IWGIA)—established by a Scandinavian anthropologist—in Copenhagen [89].

The consequences of development, when pursued, as it quite often is, in purely technical and economic terms, are of utmost importance to the health of vast numbers of people throughout the world. As well as having positive consequences development can also be associated with ill health which results from poverty and life in urban slums, from migration and from the stress of so-called modernization as mentioned earlier. Their is also an enormous literature on this and here we can do little more than allude to the epidemiological significance. By mentioning these issues within this article we may be accused of including everything under the term 'culture'. But, perhaps because we agree with the earlier statement by Landy, we do believe that development policies nd industrial and business practices reflect culturally determined and accepted norms of behaviour and should therefore be central to the consideration of culture and behavioural epidemiology.

The magic of science, technology and so-called development seem to have entirely won the day in much of the world. Technicians are at a premium with *affect* seen as a 'commodity' of little value. The accomplishment of the possible, rather than of what is considered valuable, has become a guiding principle. The creations of Daedalus have taken on a life of their own and like Icarus, unmindful of the warnings, we are borne away, riding ever onward, to 'progress' binging destruction to our environment, to our fellow men, and 'unwittingly' (?) to ourselves. Wordsworth's poem is certainly much more apt now than at the beginning of the last century.

> The world is too much with us: late and soon
> Getting and spending, we lay waste our powers;
> Little we see in Nature that is ours;
> We have given our hearts away, a sordid boon (1806).

Apartheid, racism and health

South Africa is unquestionably the most outstanding example of a country where the normative socio cultural behaviour of one powerful group is detrimental to the health of a significant number of others. The recent WHO publication *Apartheid and Health* [90] and the previous *Apartheid and Mental Health Care* [91] clearly point to the detrimental significance of the normative racist behaviour of the dominant white cultural group for the health of South African Blacks.

Racism is a fact of life not only in South Africa but in countries throughout the world. It is inherent in the cultural make-up and culturally transmitted normative behaviour patterns of dominant and subservient groups and sub-groups. The situation of Sri Lanka is but one case in point. The 'accepted' behaviour of Ladinos towards Indians throughout Latin America, of whites towards Aborigines in Australia, and the covert, and often overt, racism in, for example, North America and England are but a few additional examples.

The health status of the United States is relatively low compared to many other industrialized countries. A major reason is the considerably lower overall health status of Blacks than of whites [92, 93]. Racist behaviour inescapably contributes to this difference. Considering health in terms of psychological and social as well as physical well being, we need not even read the considerable literature on the effects of racism, such as for example, *Black Rage* or the works of Fanon [94, 95], to realize that racism is a health hazard. Littlewood and Lipsedge's [96] work on racism and the behaviour toward, and of, aliens—the outsider, the 'different person'—and their health consequences is most relevant.

Sadly, we must also admit, both in terms of economic exploitation and of racism, that slavery and the sale of people, particularly children [97], into servitude, including prostitution, is not a thing of the past but occurs in many places throughout the world where it is an accepted way of life. The practice may not be the ideal, or stated, cultural norm, but it is certainly the actual and observed normative behaviour which for various reasons exists largely unchallenged.

Psychiatry as social control

Psychiatry, with its power to stigmatize, has been blamed for maintaining the *status quo* for the elite in dominant Western cultures. Those who are the outsiders, be they religiously, politically, racially or socio-economically different, have been classified in terms of psychiatric disorders, as a means by which to contain them as separate, unequal and sick. So-called deviant behaviour is essentially socially defined, reflecting the balance of power in society; it can be defined as anything which is considered a problem by a group powerful enough to do something about it. Medical labels have been assigned to problems, which are essentially of a social origin. A theory which maintains that deviant behaviour is the result of mental disorders, together with a definition of deviance which reflects the prejudices of the socially powerful, forms a considerable weapon for social control [98].

In the United States, the lower socio-economic status groups predominate in psychiatric hospitalizations and in being prescribed psychotropic drugs; do the poor have greater mental disorders *per se*—or do their problems arise from poverty, impotence and fear, and is treatment of their deviant behaviour an attempt to pacify, control and camouflage; rather than attend to the social imbalances which lead to 'deviant' expressions of frustration and rage? An historical example of how 'deviant' behaviour and subsequent psychiatric labelling follows the norms or prejudices of the predominant social group, is the 19th century mental disorder 'drapetomania', characterized by the 'inexplicable' and irresistable urge of slaves to run away from their owners [96].

War and aggression—children of the nuclear age

Aggression and war are commonplace. The predominance of the military–industrial complex is a fact of life in most countries. The appropriations of major portions of national budgets for military hardware is normal behaviour throughout the world. Such expenditures leave less for other sectors which more directly and immediately promote and support

health. We are all familiar with the comparisons of how many days of required food could be supplied to the total world's population from the funds used for one day's military expenditures. It is not always convincing to be told that the considerable military stockpiling is for defence, preservation of life and maintenance of health. The argument that the possession of a gun leads to its eventual use is as coherent as that which claims it prevents others from using theirs [99].

The health consequences of an actual war are, of course, obvious (see, for example [100]), but the preparations for war, or the build-up of defences, also have direct and indirect consequences for our health. Yet, from generation to generation in most cultures throughout the world we take it as a fact of life. And now, the nuclear age. We can blow ourselves up numerable times over. Yet *we* can not cry, "Stop the world, I want to get off". How do we stop the treadmill; how do we stop the insanity of escalation? How can we become, or remain, sane or healthy, in an insane world [101]? How can health be achieved when in so many cultures normative, accepted and transmitted behaviour is in so many ways antithetical to health? (Yet, to be abnormal in insane societies is also not necessarily health promotive.)

In a nuclear holocaust there is no first aid, nor does 'last aid' [102] seem particularly pertinent. Whether it makes sense or not to escalate nuclear stockpiling in the name of maintaining peace through a sufficient deterent, and ignoring for the moment the results of the actual use of these weapons, the effects of growing up in a world, in a culture, where expenditures on nuclear weapons, and where their potential use, is a reality is directly related to our health. Alienation, fatalism, anomie and addictions of various kinds are but a few of the associated consequences. Being children of a nuclear age produces stress which, whether acknowledged or suppressed, seriously affect both our mental and physical state of health (see, for example [103] concerning research which is beginning to be carried out on this subject).

The issues we have attempted to raise here are akin to the concerns expressed by Gellhorn, the keynote speaker of the 1983 Social Science and Medicine Conference [104].

PRIMARY HEALTH CARE, COMMUNITY PARTICIPATION AND CULTURE—IMPLICATIONS FOR THE FUTURE

It is clear that we believe that the sets of normative behaviour of dominant socio-cultural—corporate/national—groups influence not only patterns of health of adherents of those cultural norms but the health of sub-cultural groups within and of cultural groups without.

If we are at least partially correct, what are the implications for the future relative to efforts for improving health? What are the implications for primary health care (PHC) which, in theory at least, is being universally accepted as the guiding concept for improved 'health for all by the year 2000' (HFA/2000)? PHC is by now familiar to most and need not be described in detail [105, 106] other than that it is conceived of both as a set of specific activities and as a general concept which should influence the character and the kinds of efforts to be undertaken to achieve the desired aims. It is this second understanding of PHC which is more pertinent to our discussion.

PHC implies a reaction against the limitations of an exclusively high-tech, bio-medical orientation (often arrogantly and ethnocentrically executed) and accepts an encompassing definition of health. The concept of PHC is one which quite clearly recognizes the cultural behavioural determinants of health and the significance of a culture's prevailing economic and socio-political normative behaviour.

We believe, that if taken seriously, PHC will necessitate significant changes in the behaviour of individuals, and overall changes in the cultural make up of communities or nation states. These are changes which go beyond those usually thought of as falling within the health sector [107, 108]. The central position of health education, as part of the specific activities of PHC, is a concrete example of the perceived need to bring about cultural change. We feel, however, that most health education efforts are considered in too limited a way—without denying the positive effects this may have. We suggest that the wider conceptualization of health education should include proposed changes within the culture of the dominant health professionals and of dominant national groups.

Some of the reasons for this belief have already been stated. Two additional examples may be mentioned:

(1) The 'Physical Quality of Life Index' [109] shows that health status is not necessarily associated with overall GNP or total wealth of a country, but rather with the distribution of resources and benefits within it. The examples of Kerala State in India and Sri Lanka which have much higher PQLI ratings and specific health status statistics than countries with higher per capita GNPs are well known [110].

(2) Belmar's recent findings, though apparently still limited to Latin America, show a strong correlation between level of democracy and health. "If this is found to be generally true, it will have profound implication for health policy and planning experts who now tend to focus on technical medical care and public health measures more than on societal context" [111].

Community participation is considered a cornerstone of PHC. This is, of course, translated in many ways, from merely carrying out prescribed activities, dictated from on high, to a truly equitable co-operation in the planning, implementation and control of efforts which are believed to be of benefit to an individual's and a group's physical, social and psychological well being. At best, what could be implied and attempted is the practice of democracy and social justice.

The kind of changes which community participation may call for, and which is implied by an encompassing definition of health education, however, may not be particularly appreciated by dominant individuals or groups since it may call for changes in their behaviour as well as in that of peasant and tribal communities. One specific example of the rejection of community participation health promotion efforts

is that of Paulo Freire's work in Brazil; originally supported by USAID, finding was cut off and Freire exiled as his conscientization programme with peasant groups heightened their socio-political awareness to an extent found threatening to the existing regime. The normative behaviour of dominant groups will not be easy to change, yet if they remain as they are, we maintain, they constitute a major obstacle to the achievement of PHC goals.

PHC efforts may therefore face significant resistance which will impede its success [108]. This is quite clearly pointed out by Werner [112, 113] and many others. This is not to say that many non-threatening changes can not take place which will have significant positive health consequences, but this should not blind us to the necessity for more basic changes to attack the underlying causes responsible for the perpetual occurrence of specific diseases. We should also remember that the provision of certain curative services (and the encouragement of only limited changes) may even camouflage and divert attention from the necessity to deal with these more basic changes.

In closing, it must be said that it is impossible to create a blueprint for a 'new society', or an Utopian culture, where behaviour optimally supports and promotes our own and other's health. History is full of accounts of the disastrous consequences of dictatorial attempts to enforce 'the ideal society'. We believe dogma, no matter how comforting and health preserving, is no solution. We agree with Audy and Dunn that, "We do not know nearly enough to plan societies; but we do know enough to see a number of hazards and harmful processes and to plan constructively for improving the quality of the individual, a process that starts well before birth or even conception" [114], and we believe that the quality of the life of the individual depends to a great extent on his culture. But if it is culture which is the problem and makes us sick, or at least contributes to our ill health, then is not cultural, as well as individual therapy required [115]?

We believe there are certain basic ideas which in theory have legitimized societies for centuries, namely, freedom, justice, equality and fraternity to name but a few. It is appropriate to evaluate these declared philosophies in the light of actual normative behaviour. And since we do inevitably live in Toeffler's world of 'future shock', where 'the only constant is change', the task becomes also to establish harmony, balance and rootedness in spite of perpetual transition.

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