APPENDIX to Second Gulbarga Report of 2001

Sabu George
Jan 04,2001

NEEDS EXPRESSED BY DOCTORS

BIDAR Dt.

1. Want Registers for ANM, PNC, EC, Delivery + other Registers
2. Require Family Planning Case Sheets
3. OPD Charts
4. Dhobi Charges to be raised to ensure clean clothes
5. Malaria Workers want TA

Basava Kalyan Taluk

1. Want Water Supply in Kittur PHC. The ZP had diverted the motor for this Centre to some other place.
2. At least one vehicle per 2 PHCs. Presently problematic to even supplying drugs to PHC due to lack of jeeps.

Divisional Joint Director of Health, Gulbarga

Request a diesel car to replace the present 20 year old petrol car

Bidar District Hospital

1. Incubator
2. Pulse Oximetry
3. Warmers
4. Phototheraphy Units
5. Pediatric cots (Saw several donated by Doctors)
6. Dormitory Building for the Hospital
7. Sweet Drinking water (present is hard)
8. Money for providing diet to in-patients — of taluk hospitals / CHCs / P

5/11

Bagalkot Field visits

FIRST BAGALKOT REPORT OF 2001

January 5, 2001; Written in Trivandrum & revised at Bangalore

Sabu George

Time Spent and Places visited

Spent a total of 7.5 days over two visits in Bagalkot District in connection with the First Pulse polio immunisation of 2000-1 (in end November and 2nd week of December). Went to 4 taluks. Met DHO, several senior Medical Officers at the taluk Headquarters including 2 Taluk Medical Officers and few Health Education Officers. Visited villages in the 2 most backward taluks of the Bagalkot District-Hungundu & Badami. Crossed the District border and visited 2 border PHCs in Raichur to assess the usually neglected borders of remote areas. Also met the District ICDS Programme Officer.

The significance of the Bagalkot visits is that it builds on the earlier visits (August) and therefore we have more than a one time cross sectional glimpse of the Health System. Doctors were more forthcoming despite the fact that the meetings occurred in the context of the Pulse Polio.

Taluk Hospital

The Badami Taluk hospital is being renovated under KHSDP. The new Block construction started belatedly unlike the few other Hospitals in the better off Taluks of the District that were completed. The Senior Doctor complained that already the proposed wing has been downsized. An X-ray room and another room has been removed from the original plans due to lack of funds. The wall tiles will only be upto 2 feet instead of the proposed 6 feet. Only after the construction is over will we know what else will be eliminated. The old building was small and in bad condition.

Medical Officers: Corruption

The "new" Medical Officer I met in August apparently is no longer there. A Minister's son-in law has been appointed at the PHC. Apparently he rarely visits the PHC.

The "old" Doctor I met last time was absent at the PHC both the times I went. He was out on field visits to monitor Pulse Polio. However, he met my friend from the Sugar Mill who went on the following day and complained of corruption at the top District level. Medicines are being sold privately and he is having problems with the District authorities in this regard. He

wanted public spirited individuals like us to take up this corruption. This Doctor has an unusual ~~in his previous~~ background (see my August Report). He had just taken over the PHC that week. He had promised to stay in the PHC quarters as soon as it was repaired by the Panchayat. This visit he was still commuting 3 hours each way but since I could not meet this time, find out why he was not staying.

The District Health Officer

Shocked to know that the DHO did not know about the current situation of Poliomyelitis cases from the Polio Surveillance System. He read it from the newspaper that there are now 6 wild virus cases and all in Northern Karnataka. I had contacted the Southern Surveillance In-charge thru Prahalad just before I left for Bagalkot. As this information is useful to motivate the Sugar mill volunteers to reach out to every unimmunised child left by the Government.

The DHO was unaware that there are another 4 more cases in Karnataka which are called Compatible ones. I mention this as vertical systems like WHO polio surveillance though largely dependant on the routine health delivery systems inevitably get a life of their own. Thus they do not communicate and share the information with even the District Officials. The continued persistence of poliomyelitis is also a reflection of the inadequacies of the WHO Polio eradication strategy to understand field realities as much as of the routine health system to reach out to every child. Just flooding vaccine around in repeated massive campaigns was presumed to be adequate to eliminate polio (last year some of the Northern states had six rounds).

The DHO said that the Health Minister is largely interested in the Government Hospitals and not that much on the primary health care infrastructure. He informed that the Commissioner of Health had a meeting of the Belgaum region's DHOs in November at Bijapur.

Pulse Polio Immunisation

Received excellent cooperation from the District and taluk Doctors this year. In the beginning of the last year (May 1999) it was lukewarm, though they wanted the Sugar Mill just to provide them money for hiring jeeps and buying food for the Booth staff. I had met the DHO on a second Saturday evening. Despite being a holiday he took me to his Office and called up all the 4 Taluk Medical Officers to remind them about the involvement of the Somaiya Sugar Mill workers, Field staff, volunteers and Somaiya Nursing College students. Gave me several thousand doses of vaccine, primarily to cover children of Maharastra migrant labour who cut

sugar cane in distant fields (away from villages) for the many mills who procure cane from the Jamkhandi and Mudhol taluks. The Officials are feeling the heat from the top. All the six wild virus poliomyelitis cases are in Northern Karnataka (2 each in Koppal, Gulbarga and 1 in Raichur & Bagalkot).

Clearly there was fatigue in the field as there seems to be no end to Polio campaigns. For last several years the Government had been promising that it was the last time and polio would be eradicated. The DHO told me that it was difficult for him to get jeeps requisitioned for 3 days from the other Departments. I had received no such complaint last year from him. All the posters this year mentioned only one day for both the rounds though the Government was actually committed to 3 days for completing pulse polio immunization. In at least two taluks the teachers did not participate in the first day. Note last year they were involved in all the four rounds.

In one Raichur PHC, I found booths closed by 2 pm on the first day. All the reports from the sub-centres had arrived before 3 pm at the PHC. Either the PHC staff are very efficient or that they were indifferent to the goal of polio eradication. Yes villages are nuclear and that there are hardly any field huts in this region and therefore attaining complete immunization is easy. But some families work in fields miles away and therefore the likelihood of ensuring complete immunization by 2 pm is probably unlikely and the chances that the workers would traverse miles on the next two days for a few isolated children dispersed away in fields is remote. I wish I am wrong but repeatedly I have found children left out in distant villages over the last 5 rounds in 4 taluks.

The ICDS System

I had met the District Programme Officer of the ICDS. She said neither her nor the Assistant Director of WCD have got their jeeps. Mr. Kanti, the Joint Director in charge had earlier told me that the Jeeps for the newly formed will be given. When I met Mr. Kanti this week in Bangalore he said had asked UNICEF Delhi to supply jeeps. This matter needs to be followed with the ICDS Director as it might many months before the Jeeps do reach the new Districts. (To be brief- Note previously in September, Mr. Kanti had given me another version). Irrespective of the fact that whoever pays for the Jeep (UNICEF or GOI) it is important that the jeeps be arranged soon. Too often there is cynicism and indifference to the well being of the child at the sub-Director levels in the ICDS Directorate. It may not be as bad as in the Health

Dept. Another instance, the previous Assistant Director of Gulbarga WCD and presently a Deputy Director in WCD told me this week, that there is no hope that children in the 3 Blocks of Gulbarga will be fed everyday (Presently they are only fed officially only half the time- I have been to a village where feeding was disrupted for a whole month). Every body at the District CEO, DC, ZP and at the State level- Director, Secretary are aware of this sad fact. Crores of rupees have been diverted from children's food to other heads with or without the connivance of the Panchayats, WCD, Planning or Finance Departments over 3 years. In characteristic bureaucratic style everybody blames somebody else. The Gulbarga DC said that the CEO should take the initiative with the Panchayats. But a little later the DC said that he would do exactly what the CEO would do- be indifferent to diversion from children's food. He acknowledged that PWD Contractors, Doctors who have strong lobbies have their self-interests protected while the Anganwadi workers who are the weakest suffer. The only thing on which all the officials agree both in Gulbarga and in Bangalore is that this remains unresolved as the Northern people are not empowered to protect their rights. Note this remains a problem of largely of Northern taluks.

I spoke to the Programme Officer of Bagalkot to identify neglected and remote villages of Badami as she had served there for 6 years. Also enquired of Hungundu taluk. Offered to take her in a jeep to Hungundu villages on the Pulse day as she had no Jeep. She wanted to be in Badami as her boss was likely to be in Hungundu. She described the Assistant Director as a serious person. I had not met the present AD after he had joined Bagalkot.

Raichur District Border villages

Visited 2 PHCs in the border. Situated in Lingsur Taluk. Villages in this remote area alternated between Raichur & Bagalkot Districts. The first PHC was in a small village Sajalagudda, and except for a Nurse who had the Polio vaccine nobody else was there. Running water was there. Most of the rooms were kept locked. The Nurse had a key bunch of 20 keys or so and took time to find the Doctor's Office key. The Doctor's room was dusty. No Doctor has worked there for the past 6 years. In about 6 km on the Bagalkot side there was a PHC. The adjacent PHC in Raichur was only 2 km away.

In fact, I did not even realize that the Building was a PHC till a School Employee told me later. The local villagers had directed me to this Hospital but it looked tiny and was deserted apart for a dog. I had taken it for a Sub-Centre and thought the lonely Nurse was there because it

was the Pulse Polio day. I was looking for a place for the hungry Bombay Nurses (who came for Pulse Polio immunization) to have lunch at 2pm.

The second PHC I visited was a relatively new building and appeared clean. The PHC is situated deep inside the village, far from the Main road of the village (to the locals- the PHC was out of the village). Nagral PHC had no quarters and no vehicle. There was no approach road and garbage heaps had to be crossed to reach the PHC. I was there before 3 PM. Only two men staff were there. One ANM died and this has remained vacant. The Doctor had gone away to his house in the village. Has been there for over 5 years. Started as a Contract Doctor. Was told that there are 100+ patients every day. Though there was a village overhead tank just in front of the PHC , the Centre had no running water. About six months ago a new Water Sump, overhead tank (Sintex) and a pump were installed. But the contractor ran away without connecting the pipes. The PHC undertakes sterilization only once a month.

It is sad to see that in a PHC where there is water there is no Doctor and where there is a Doctor that PHC does not have running water. Should it take 6 months to get the pipes connected when everything else has been installed?

The very location of PHCs is arbitrary. I believe it is helpful to do a survey of where the PHCs are literally redundant- ie., that other PHCs are nearby and the PHC village is small & isolated, and therefore unlikely to attract a Doctor. Such PHCs merely increase the numbers without actually contributing to enhancing the health status of the population.

Costs

Several days over two hundred kms were covered. The entire costs- local travel, travel to Bagalkot etc., exceeding eight thousand Rupees were not met by CHC.

Gulbarga Field visits

SECOND GULBARGA REPORT OF 2001
Nutrition, Epidemiology etc.

January 4, 2001; Written in Trivandrum & Bangalore
Sabu George

Nutrition Related

1. **Assessment of Iron status of women after delivery**

Thelma observed that Hemoglobin of the mothers were not being measured soon after childbirth. In the current situation where the iron status of both women and pre-school children are poor; assessment and where required supplementation; at every instance when women are at hospitals is necessary. Supplementation at the post-natal stage will improve the iron status of the anemic and iron deplete women and also improve through breast milk the status of iron deficient children. Note the iron levels of the mother immediately after birth depends on her pre-pregnancy levels, diet and on the extent of blood losses during delivery. Thus better quality of obstetric care has a role in averting reduction of iron levels of a certain proportion of women.

The proposed hemoglobin assessment and supplementation should be made mandatory at all PHC's and Govt. Hospitals.

2. **Birth weights**

At the CHC the birth weight data was suspicious as almost weights were rounded off to 500 grams. Several of the weights were 3.5 kg and one even 4 kg. The weighing balance had 50 gram sub-division. This indifference to recording birth weights accurately is common. Even in Kerala where over 95% births take place at Hospitals, trends on birth weights are not available because of negligence in recording weights properly. As presently, Karnataka is in a steep phase of increase in institutional deliveries, attention to recording birth weights can help us to obtain good baselines on low birth weight incidence. Birth weight is one of the most sensitive indicators of maternal nutritional status.

NATIVE EPIDEMIOLOGY: Gulbarga District Hospital Statistics

Surprised to find a detailed Annual Report of the District Hospital for the year 1999. The statistics have been compiled with pride by the Medical Records Officer and the Hospital Staff.

RJ
7/1/01

Even a graph has been drawn. At one level the Report provide comprehensive information on utilization of the beds, services and by whom.

Obviously, I looked for the existence of gender bias based on other knowledge, visits etc. This data again confirms gender discrimination. For instance the number of boys using the Hospital as inpatients are nearly 50% more than girls (1558 boys vs 1082 girls). This could not be ascertained for out-patients as there was no disaggregation of children by sex. Just like in Bangalore, Gulbarga women of marriageable age are several times more likely to be burnt to death then men. This is likely to be the pattern over the last ten years (in the graph there is no age disaggregation; only sex distribution). This excess risk for women is not occupational but due to social causes as we know elsewhere from Bangalore, Dharwar, Mangalore etc. Therefore the modern evil of dowry deaths is also present even in the most backward part of the State.

Not surprisingly almost all the sterilizations are on women (603 vs 2). Disturbingly, the number of cataract surgeries done was only 346. Note that there is at least one Ophthalmologist among the senior Medical Staff. Gross underutilization of Ophthalmic facilities is obvious even when one looks at the OPD numbers. There is evidence that the hospital birth information is probably credible. As seasonality is seen in the current year and the patterns are consistent over the years.

Another useful purpose these statistics serve is to set up targets for improvements over the next few years. Credible targets are extremely important for motivating the system to perform better. It needs to be kept in mind that the Health & Family Welfare system have a terrible record of manipulation in the country. In the routine health information system-Family planning, immunization, mortality data have been cleverly made up for decades. Therefore even to have reasonable estimates for targets has sometimes been difficult.

Targets have become common in developmental planning for about 3 decades. They were borrowed from Management practice. Initially targets were pious dreams – mere statement of intentions and too general. For instance, the 1974 World Food Conference had the goal: "Within a decade no child will go to bed hungry, that no family will fear for its next bread, and that no human being's future and capacities will be stunted by malnutrition". Regrettably targets are often chosen without much thought. This defeats the very purpose of targets- to mobilise public support & generate political will, and to raise resources. I deliberately elaborate on this as some of the targets in the HNP Draft Proposal are problematic (For instance the MMR estimate

is absurd- Such figures will only spawn fraud). Given the sad reality that many past targets have not been achieved in Karnataka and therefore such elusive figures are not likely to be taken seriously. As Maxwell has said about food security targets- Targets have been repeatedly set, repeatedly not achieved and repeatedly, so to speak repeated. This would be true of Karnataka targets for the child. Therefore, I hope we will have credible targets that are achievable in a definite time period. We cannot use targets like slogans ('Health for All').

Measles Immunisation and ANMs

When Doctors were asked about Measles immunisation coverage the general response was that children are all fully immunised. This was the same response during the last visit. The independent Survey data like RCH reveal that coverage is poor. Therefore measles immunisation is not taken seriously. In the Border Area District areas (some specific taluks of the Gulbarga region) the DJD is planning to organise special efforts to improve coverage. It is worth monitoring to see how much of the promises made at the visits will be implemented over the next year.

In Bidar there were 30 vacancies of ANMs (total of 234). The shortage is not as acute as in Gulbarga but the challenges are formidable. As the ante-natal coverage is among the lowest in the State as per the RCH Survey.

Conclusion

Our visit in December was a short one. Merely a day in each District. Thanks to the support of the DJD and the DHO Bidar we accomplished a lot. That Thelma being a Task Force Member helped in getting attention of the Officials. The DC & CEO gave time.

This visit was largely confined to Hospitals and meeting District Officials. Thus complementing the earlier visit where I went to several distant villages and met Nutrition Staff at various levels. Krishnan, Thelma and myself ~~we~~ have practically covered most of the taluks of the large Gulbarga District. Due to lack of time we were confined to the Southern part of Bidar District.

We were informed that the local MLA took interest in the Taluk Hospital in Basava Kalyan taluk of Bidar. The Health Minister has improved the functioning of the Gulbarga District Hospital. Perhaps, we can enlist the support of interested MLAs to improve the Public Health System and resist the Bank influenced privatisation of the Government Health Infrastructure.

For Dr. Kapur

Gulbarga Field visits

FIRST GULBARGA REPORT OF 2001

Version dated January 2, 2001; Written in Trivandrum & final revision in Bangalore

Sabu George

Note

From this report onwards observations of both the visits would be included for brevity (Sept & Dec). Nutrition and Epidemiology related matters will be in a separate report.

Details of the Visit in December

Thelma and I spent one day each in Gulbarga and Bidar Districts. Had discussions with the Divisional Joint Director of Health, Gulbarga region, DHO Bidar, Gulbarga's CEO, Deputy Commissioner and City Commissioner. Primarily visited Government Hospitals including District Hospitals and 2 Taluk ones in Bidar. One PHC and CHC was reviewed by Thelma. Visited the Hyderabad Karnataka Development Board Office. Briefly met with Medical Missionaries Dr. Abraham and the Salins Family at Aurad village, Gulbarga and Bidar city respectively.

Note that the DJD came with us to the PHC at Kamlapur in Gulbarga District near the Bidar border. Kamlapur was chosen as it was on the way to Bidar. The DHO Bidar received us at the Border and was with us till 9.45 pm. The specific Hospitals visited were decided largely by him (Thelma indicated that she wanted to see a CHC & the District Hospital).

Hospitals

The physical condition of the majority of the hospitals visited was pathetic. The Basava Kalyan taluk hospital is an exceptional one in that the Chief Doctor (26 years service) took genuine interest in serving people. The very ambience of the Hospitals and the number of patients present were indicative of the interest the concerned Doctors took in their Government job. The Gulbarga District Hospital has over 750 beds and is even larger than the Hubli Hospital. We reached the Bidar District Hospital at about 9.15 pm and saw two Doctors in there. Malnutrition, diarrhea were seen in the District hospitals. The specific needs expressed by the Doctors will be reported in a subsequent report.

All PHCs in Bidar have Doctors. The 5 vacancies are being filled by the DC. In a few days they will be on duty. The DHO wants sanction for direct recruitment of Nurses in Govt. Hospitals.

Drugs did not seem to be a major problem. There was supply despite lack of adequate vehicles for distribution to every PHC. The KHDSP apparently dumps the Drugs into taluk Hospitals without ascertaining what the particular needs are. Thelma enquired and found that Pediatric Doses of TB drugs were unavailable at all the Hospitals.

In construction of new Buildings the concerned Engineers do not actively involve the Doctors in the Planning and Execution.

In the CHC we visited the Construction was going on without the least concern for patients admitted. They had no toilets or water.

In all the sub-District Hospitals we visited we were informed that they got only a few cases of TB every month unlike in St. Luke's where they see 2 new cases every day. TB hardly could be a St. Luke outreach area problem. Either the Govt. Doctors are not recognising TB or the patients are unhappy with the treatment provided.

The neglect of DJD

Nobody had told me either in Bangalore or in Gulbarga in September about meeting the DJD. Note I met the CEO, DC and other medical officials at the District . All referred me to the DHO only and not to the DJD. Dr. Pranesh appeared to be serious about his responsibilities. A native of Gulbarga had spent 17 years in Raichur. Did know several of the good Doctors I met in my last visit. He lamented about his serious limitations. He is provided with a 20 year old petrol vehicle. Other Divisional Heads have vehicles that they can requisition. He has no powers to purchase even a battery. To get sanction from the Director in Bangalore can take a year.

The diversity of controls of Hospitals was evident in Gulbarga. The District Hospital is under the DME as it is a teaching Hospital and thus the DJD has no responsibility for the largest Hospital in his region.

Of course, DJD was not pleased with the bossism of the IAS Officers. They take decisions without understanding the Health System. When Thelma asked how the present Commisioner and Secretary are- They are better as they listen.

He said under the Border Area Scheme they are going to initiate measles immunization. They have received disposable syringes for this purpose.

DC , CEO & Municipal Commissioner's Perspectives

The Doctors and IAS views of the Health System were of course different. These are well known. Nevertheless, the IAS perspectives will be critically reviewed in a separate report. Certainly there was some truth in the concerns expressed by the Doctors but clearly there is a real lack of will on the part of the majority of the Doctors to get the Health system functioning properly. The Administrators have rightly attributed this indifference to the private practice of the Doctors. The DC highlighted the fact that Health Dept. is unique among Government Departments in that majority of its vehicles are never in working condition. Most Doctors do not stay in their PHC. They do not maintain the Hospitals. There is little discipline among the Doctors. No surprise that they have found that even Compounders practice and the ANMs take bribes. The Government should ban private practice and provide compensatory allowance for the Doctors to improve the functioning of the Health System. There does not appear to be financial decentralization in the Health Dept. The Medical Officers claim that they have no financial powers. While even a Gram Panchayat Secretary spent two lakhs a year. The DC believes that the Doctors can utilize the Panchayat System if the Doctors actively work with the members. The Medical Officer at the PHC should be given an Annual Maintenance Grant.

There are only 3 Laprascopic Surgeons in the Gulbarga District which has a population of 35 lakhs. Nobody at the top levels monitor the functioning of the Doctors at the PHC and taluk level. Specific directives should be issued so that sterilisations are done every week rather than once a month. All those who have received Post Graduation should be mandated to participate in sterilizations. All PHCs should conduct institutional deliveries. Careful monitoring of each Centre is required. The Health Department should give priority for these areas as it gives to Pulse Polio.

There are few Lady Doctors and he is now giving priority for their recruitment. He felt that the Training provided to the Panchayat members is routine. 100 people are called for a session and are made to listen to 4 to 5 long speeches. Smaller groups are required for meaningful interaction.

The CEO said that the Contract Doctors do not have powers to take action against erring officials. Felt that in-service training of the Contract Doctors in public Health is important. Asserted that there is money with the panchayats for maintenance. All the Doctors had told that this was a problem. The CEO said that there was 5 lakhs per GP and that Doctors should take the initiative. Corruption cannot occur without the connivance of the Doctors, therefore blaming only the Panchayats is not fair. Informed that a young ZP member, Sherin Prakash from Sedam is himself a Doctor- Lecturer in the Medical College.

The urban areas are not under the CEO. They come under the DC. There are 3000 Self Help Groups including that promoted by DWCRA. These could be used for health promotion activities. The Group Insurance Programmes of the GIC etc. could be used to provide better economic security for the poor by covering some Health care needs.

The Municipal Commissioner did not appear knowledgeable about health matters. Was unaware of Mahila Samakya. Claimed that Malaria did not exist. But said that they were fogging insecticide regularly. The Gulbarga Municipality covers 5 lakh people. 32 slums exist including 10 unregistered ones. There are 5 to 6 other Municipal towns and 3 town panchayats in Gulbarga District. IPP8 has not yet started. Sanctioned and will function from January. The DC will recruit Staff for 7 Health Centres and 1 male and female Doctor. He said that the IPP bosses do not take our suggestions. They impose what they like.

The major health problems he saw were lack of health care for slums and no Hospital waste management for the City. There are more than 50 Clinics and Hospitals in the City. He said a Delhi based NGO- Environment Education Centre under one Suresh are planning a Waste Management Programme. This is funded by the State & Central Govt. and will start in 6 months. The Hospitals have to pay for collection, disposal and incineration. The Health Cess collected by the Corporation is given to the State Govt. Acknowledged that there are many street children but no organisation working on this issue

Medical Missions in Bidar: The Salins Family

I was very keen on meeting with Dr. Salins as I had heard of them from Dr. Benjamin. The Doctor couple are Vellore alumni and evangelical Christians. By the time we finished with the Bidar taluk hospitals it was 8 pm. After dinner at DHO's house, went to Dr. Salins's house. Dr. Christopher Salins and his wife Dr. Sushila served in hospitals in Karnataka for 3 years and

finally came to Bidar in 1969. Served only 2 years in the Methodist Hospital as they were removed for their evangelical zeal. Then established the Good News Society Hospital in the City. They do Leprosy rehabilitation and also urban & rural outreach work and run a rural hospital. Dr. Salins has done several thousand Cataract surgeries with Lions. Their daughter has specialised in Ophthalmology and has done research on diabetic retinopathy. The exemplary devotion of the Salins family has kept their Hospitals and outreach work going for three decades in Bidar. They had to close clinics in adjacent towns of Maharastra and Andhra due to lack of Christian Doctors. We were informed that the old Methodist Hospital in the city has been revived by a Doctor couple who joined recently.

Like Dr. Abraham, we could talk about the isolation of Salins (see earlier Gulbarga report). But this also reflects on others in the Community Health sector, who have not taken the trouble to get them involved in active partnerships to further the health status of the people in the most remote parts of Karnataka.

Learnt that Xerophthalmia in pre-school children remains endemic in the rural areas in Bidar.

Roads are more important than Health for the HKD Board

The Hyderabad Karnatak Development Board was constituted in 1991 and the 39 MLAs from the 5 Districts of the Gulbarga region are members. This gives the local MLAs effective control over the large Budget. Annual budget is of the order of 100 crores. Proposals for projects directly emanate from these members. Thus construction activities like Roads & Irrigation get overwhelming importance while Health receives a low priority. Such priorities are because of the profits for local level politicians. The DC said funds for Roads are available from multiple sources- MLA's fund, MP fund, Panchayat allocations etc. and therefore does not provide money if he can for roads from sources under his control.

Told that Flourosis is a problem in some parts of Koppal, Gulbarga and Raichur.

Rationale for the HNP and for World Bank money

The Hospital facilities are grossly inadequate in the Gulbarga region. For instance, the Bidar District Hospital has less than 30 beds for women after delivery. Several of the existing Hospitals are dilapidated. Therefore given that the State is spending almost all its resources on Irrigation and Power there is no choice but to seek World Bank money for the benefit of the

poor. The eagerness of the State Health officers is understandable. The Bank officials are also keen on lending to Karnataka. Therefore, we have to be extremely determined to ensure that the project priorities are decided on the basis of the people's needs rather than on the current ideological predilections of the Bank. Similarly, we do not have to oblige ambitious World Bank staff who often distort projects to test favourite hypotheses so as to further their personal careers. These concerns are not theoretical. Rather, this was very evident in the recent mission of the Bank to Karnataka in November.

Hopeful Future for the poor and the disadvantaged

The only affordable hope for the poor is the Govt. System for health care and public health. Therefore, we have to resolutely oppose the privatisation of the Health Sector. The institution of the user fees has resulted in reduction of the Out Patients at the Bidar District Hospital (1100 to 700). There is need for a detailed study to assess the consequences of various kinds of user fees to the poor in the most backward region of the State. Uniform policies for the whole state in these matters may have to be challenged as it would most adversely affect the least empowered sections of the Karnataka population.

At the same time we have to get the Government Health structures to be more responsive to the people (importantly increase access, coverage, equity and quality). This is the challenge for the proposed HNP Project. Just as in the earlier field visits to the Districts, this time also we found dedicated Doctors working under adverse circumstances in isolated areas. Identifying such exceptional individuals, motivating and supporting them is one way to strengthen the existing system. The optimal functioning of few sincere Doctors in an otherwise indifferent Government Health infrastructure can make a difference in the long run to empower some people to demand similar quality standards in more Government hospitals.

It is of utmost importance that CHC strive to build networks in each of the backward Districts to safeguard the interests of the poor. Sincere Government Doctors, well meaning private sector practitioners, non-fundamentalist Christian medical missionaries, good NGOs etc., can be the partners. Obviously, such alliances require a lot of nurturing to fructify (just the organisation of the State PHA was a herculean effort). This World Bank project process should be used to create and foster such alliances. Cells and individuals have roles; but only collective

efforts of organisations and alliances can take on the forces of privatisation; particularly when the State is more than willing to accept World Bank's prescriptions.

Towards a holistic understanding of the Gulbarga region

The present visit covered the Health sector while my earlier visit focused on the Anganwadi sector. We still have not touched upon the District or Taluk Panchayats. The hostility of both the Health Department and the WCD staff to the Panchayat Raj is well known and we were repeatedly told by the Doctors and the CDPOs about their difficulties with the local Panchayats. Panchayat Raj has been blamed for interference in appointments and transfers; corruption, nepotism, non-functioning of the Departments etc. The inadequate democratisation of the society in this backward area is well known but still we need to meet with the elected representatives to know their side of the story. For instance the Gulbarga DC said the Health Department just does not want to be accountable. If the Doctors did their work, then they would have less problems with the Panchayats.

Our impression of the Northern region after field visits is much better then the scenario which was painted from the South. Things are not hopeless in the North and much better than what we were led to believe. If improvements in the staffing and infrastructure do take place in the next two years in the Health and Nutrition sectors then this itself may reduce the differentials in the Health indicators over the next five years between the North and the South.

I believe an unexplored area that remains is the prejudice against Gulbarga people in the South of the State. Social backwardness, including a pernicious feudal past of course creates cultural stereotypes but does that explain the prejudice of even well meaning officials and Doctors? We have been told that the same officials who do well in the South fail to do well in the North. The Northern people are lazy and do not work hard! Even the extreme climate has been blamed for the underdevelopment.

The political causes of backwardness need also to be understood better. Right from the 1950s Northern Karnataka had its share of political power. Chief Ministers like BD Jatti (from Savalagi, Bagalkot); Veerendra Patil (Chincholi, Gulbarga) etc. were from the North. The great Nigilinjappa himself had to go to the North when he was defeated from South to enter the Assembly. Several times the Gulbarga region had large number of Ministers. Two senior ministers from Gulbarga- Dharam Singh and Kharge, representing disadvantaged castes have a

nearly three decade uninterrupted tenure in the Assembly. Influential Congress stooges like CM Stephen, Sonia etc. who would not have won elections elsewhere from the South have used the Northern Karnataka people to further their political careers. Now that CHC has given priority to North Karnataka perhaps it will make some efforts to better understand the political economy and social history of this neglected region. Health is Politics and therefore this larger project is necessarily related to the task of enhancing the well being of the Northern people.

We need to be analytical, retaining humaneness, + kindness, + being wary of being judgemental or arriving at quick conclusions.

I think this is important. We have some earlier reports on Karnataka and Districts by CHFCE. This should be identified and those on Gulbarga Division could be updated. SDRs Bihar background note was strong on Political Economy. Perhaps AP could add this dimension while SG and SKK must also begin to collect information during interactions as SG has done here!

? SG writes about CHC as if he is outside of it. Every good idea / insight he gets that will help the problem analysis should be worked upon by himself as part of the CHC team.

REPORT ON VISIT TO GULBARGA DIVISION ON 21-22nd DECEMBER 2000

PHC GOBBUR (AFZALPUR TALUK, GULBARGA DIST)

The PHC is located on the main road itself 25 Km from Gulbarga (map attd). The PHC covers a population of 288442 in 21 villages. It has 8 Sub-centres –Gobbur, Havenur, Bidamer, Chowdapur, Chinamgera, Banderwal, Hassergundagi, Sagnur (30 Kms away) with 8 ANM's all residing in these villages. Old building with many patients in attendance on time of visit (1130Hrs). Has three doctors- Dr Nagendra (since 7 1/2 years living in campus, belongs to Mandya Dist), Dr Premalatha (since 8 yrs living in campus) both present , and Dr Vijayalakshmi (5 1/2 yrs shuttles daily from Gulbarga) who was away at the sub-centre (where I met her also). On an average OPD attendance 50-60 patients mostly fever, URTI, LRTI and Dysentry. During the month of November, 2049 OPD patients treated and 37 inpatients (tubectomy, delivery, post-cataract surgery) and during October 1760 OPD and 41 inpatients were treated. Electricity erratic , average 3-4 hrs cuts. Stand-by generator available (kerosene run, 1988 vintage, Honda).

Family planning achievements during the year –155 tubectomies and 140 IUD insertions (performed by all three though only Male Dr trained).Cataract operations done by visiting Eye surgeon –12.Two AFP cases reported (Sangapur and Sagnur- both negative). 170 deliveries in the year. Whole year 90 cases of malaria (Pv 80, Pf 10) 1999 130 cases (Pv 124, Pf 6). Total 7 cases of TB, 1 sputum positive being treated at DTC. Others on TZ only. Filariasis one positive.

One Mahindra jeep (IPP III, 1983 vintage) on road.

Training –Dr Nagendra underwent the following training

CSSM trg	one week	1995	RHWTC,Gulbarga
RCH trg	one week	1997	"
FP trg	two weeks	1998	" (learnt tubectomy himself)
Mgment(IPP IX)	two weeks	1999	"
Admin trg	-	1999	Nazir Ahmed Rural Trg Centre Mysore.

Feels all this training is required but with better resource persons. Also feels the necessity for CME's.

Private sector- No MBBS doctors available locally, but 7 BHMS practicing in his area. Two medical shops function at Gobbur and Chowdapur.

Drug supplies- All medicines from Taluka stores now since two years (earlier from Dist.) Slight short supply in this PHC (all other PHC's/CHC's visited had adequate quantity).Supply is twice a year (60% and 40%) apart from FP drugs and vaccines which are indented monthly. Kit A and Kit B are directly issued to sub-centres. Under RCH only four SC's repaired 3 yrs back. Two SC's (Hassergundagi and Chowdapur) do not have own building and functioning from ANM's rented house.

Voluntary Agencies- SOSVA (3yrs back from two villages) now 8 villages . Only link workers keep in touch with ANM's in RCH activities.

Anganwadis- 28 AW's; visit 8-9 AW's monthly (3 monthly all to be covered) CDPO/Supervisor contacts.

During rainy season, the accessibility of the villages to the PHC is almost nil due to mud roads which are only accessible by bullock carts / tractors.

Monthly / Quarterly meetings of gram panchayats are held and the MOs attend (5 GPs)

The PHC has 3 HW (M) against 8. Telephone is available.

IMPRESSIONS: This PHC seemed to have been informed of our visit and appeared to give a conducted tour. The MO even wore a lab coat. Since it has two LMOs, one could be deputed to PHC Atanur.

SUB CENTER CHERANGERA

Was located about 15 kms away from the PHC Gobbur. The LMO Dr. Vijaylakshmi, ANM Uma and HW (M) P.R. Diradhar were available. The SC building was good but had no electricity supply to the non-living portion. The ANM had managed to get an illegal connection to her residence portion. There were 52 cases registered for ANC of which 36 had yet to deliver out of 2525 population. There was no BP apparatus available. Kit A & Kit B were available and well stocked with RCH medicines. The HW (M) only has to collect 22 slides for MP every month and chlorinate 2 GP wells.

IMPRESSIONS: Furniture, electricity and water should be available at the SCs. The duties of HW (M) needs to be well defined.

ANGANWADI – CHOWDAPUR TANDA

Met AWW Shivleela and helper Thipamma. The AW had 68 children registered of which 18 were below 1 year of age, 20 between 1-2 years and 38 were 3-6 years. Average attendance was 20 per day. The AW functioned between 9-12 pm only and the children had left when I visited at 12:30 pm. Twice a week energy food (60 gram, one handful) is given to the children. Mothers also collect for the other children. There were no toys, no registers, no medical kit, no weighing machine. Growth chart was poorly maintained. Nice building. Doctor had last visited on 18th October and done medical check up. ANM had given immunization to 8 children and 2 mothers on that day.

IMPRESSIONS: The AW was typically of what we had expected.

PHC ATANOOR (AFZALPUR TALUK) GULBARGA DISTRICT

PHC located on main Afazalpur –Chandapur road and at one end. Another PHU now updated to PHC Revoor with three sub-centres (Dr. Raghunath Kulkarni) taken over some of the villages from this PHC.

Only one doctor, Dr. Shivakumar K Manakar, who lives in the village in a two roomed house (pays Rs.400/- rent and gets HRA of Rs. 222/- per month) was employed on contract basis 5 years back and confirmed only one year back. (Contract salary Rs. 4000-6000, regular salary 7400 basic consolidated Rs. 10,400/-). Doctor belongs to Gobbur.

PHC building in good condition and compact design, built by HKD Board under MLA fund (approximate 24 lacs) in 4 Acre land. No water source as bore-well failed after 6 months. One hand-pump located nearby. Building does not have meeting hall or mortuary.

PHC covers two villages – Bhoganahalli and Sidanur and covers a population of 14,185 through 3 sub-centres at Atanoor, Malabad and Chinchur. Two ANMs and two HW (M) (One ANM on deputation). All ANMs residing in the villages. Requirement of LMO felt to handle the female patients. The gram panchayat of Atanoor village has all women members and has hence been requesting for an LMO (which could be easily deputed from Gobbur). The PHC has no vehicle, no generator and electricity is erratic. The average OPD attendance is 40 patients.

FP operations carried out are 73 / 116 (November). IUD – 76 /125. 156 deliveries have been conducted in the PHC by Jr. HA (f). 72 have been home deliveries under trained Dais and only 19 deliveries have been by un-trained Dai. Average around 30 deliveries per month. The Doctor has undergone adequate training courses but feels the requirement of Tubectomy and MTP training.
There are 5-6 PPs in the area with BHMS /BAMS degrees.
Adequate supply of medicines with almost all antibiotics and no shortage of different categories of drugs. (Supplied twice a year 60%, 40%) Family Welfare indent as required. No problem at sub-centres also.
There has been an epidemic of 36 cases of GE in one and a half months in Siddanur village of which 4 were positive for Vibro Cholera. There have been 9 cases of Pv + malaria and no sputum + case.
There is a good labour room (without tiling) but no delivery table. Mattresses having a life of 1 –2 years only. There is a shortage of one pharmacist, one senior HI and two group D employees. There is no telephone connection.
Doctor was highly motivated and had a beautiful brief of the activities and statistics of his PHC which he has given to the visitor.
IMPRESSIONS: The_PHC seemed to be a model compact PHC and even the building could be the type of pattern for further constructions. Dedicated MOs should be acknowledged and also contract service should be counted for their government service. This would help them in getting their speciality.

TALUK HOSPITAL (AFZALPUR)
Was located on the main road and has two doctors. Dr. C.V. Takkalaki – the Taluk Health Officer was supposedly away on tour and the other doctor Dr. Baburao Bellar had reported for duty only at 3 pm. Presently 30 bedded but has hardly a few beds on the verandah due to lack of space (supposed to be a 50 bedded hospital). Behind this building, is a beautifully constructed 12 bedded hospital under HKD Board which is under litigation since 5 years due to land encroachment. Recently IPP9 is looking out for land to construct a new hospital. Phone is available. Average OPD 70 patients per day. No admissions as no ward available. No toilet and no drinking water available. Drug supply adequate. Surprisingly has no posted supervisory staff since three years and only has deputed staff. Lab equipment satisfactory. X-Ray machine remained uninstalled for one full year finally installed two months back, worked for few days and is again non-functional. X-Ray technician available. Deep-freezer and generator available.
IMPRESSIONS: The situation the hospital seems to be contrived to avoid providing health services to the population who require it. Either the portion of the building encroaching on the private land should be demolished (loss of a few lakhs) or a few lakhs should be paid and out of court settlement done so that the building could be used by the hospital. The proposal to construct another hospital seems quite ridiculous. Posting of new set of staff could go a long way in reviving the collapsing hospital.

PHC ALMEL (SINDAGI TALUK, BIJAPUR DISTRICT, GOIP)
Three doctors were available of whom two are staying in the campus. Dr. S.S. Bajantri (1995), Dr. Preeti S.J., LMO (5 months KHSDP regular) and Dr. Savitri Kinigi, LMO

(2 years). Have full staff except for shortage of 2 ANMs and pharmacist post vacant since three years. Covers 8 villages through 5 sub-centres (Bomanahalli, Devangam, Kadni, Almel with two SCs and Mandanhalli which is vacant). Three HW (m) out of 6 available. PHC covers 34,000 population. Drug supply adequate, no standby generator, vehicle condemned and transferred out. Has 15-20 deliveries every month. Malaria + 2-3 cases per month. 11 Sputum+ cases of which 4 under RNTCP and 10 under NTCP. Has telephone. Has three gram panchayats of which Almel GP has one lady GP. Doctors regularly attend GP meetings every month. Regular anganwadi medical check-ups are carried out in the 21 anganwadis and CDPO meets regularly in the sector meetings.

Very old dilapidated building and roof leaking. Needs a new building urgently as doctors residing in the campus itself and sufficient 5 acre land available. Also has an ANM training centre in which 10 students are undergoing 4 month course. The hostel building has become unsafe so they are residing in one of the staff quarters.

There are 4-5 MBBS doctors and 9-10 others in the area with 6 medical shops close by.

Doctors have had reasonable amount of training but feel the requirement of skill based training in MTP, Tubectomy (including laparoscopic), anesthesia and medico-legal. Doctor states that he has done 30-35 autopsies during his 5 years of service.

IMPRESSIONS: The PHC has dedicated staff staying in the campus and yet no proposal to construct new buildings etc. are planned. Such PHCs should be given preference for all major construction work. Re-distribution of LMOs by deputation should be done so that no PHC / CHC / Hospital have more than one LMO. Training of all staff on MTP, Tubectomy, Medico-legal, is a must to enable them to function more efficiently.

PHU STATION GANAGAPUR – AFZALPUR TALUK

PHU upgraded to CHC – 4 years back.

Dr. Suresh W Nayak (6years 6 months) is the present MO in charge. Shuttles daily by Udayan Express from Gulbarga. Underwent training in management and orientation training under IPPIX. Assists in Tubectomy. Feels he requires training in Administration, Induction training and medico-legal training.

(Dr. M.S. Sangolikar now in CHC Nimbarga, Aland Taluk was earlier in this PHU for 10 years and lived in the campus.)

Has 3 SCs with 4 ANMs and 4 HW (m) covering 4 villages with about 10,000 population. One sub-cenrtre building ready but not handed over. All sub-centres have kit A and B. No lab Technician but microscope available. Adequate quantity of drugs available. 4 acre land available Average OPD 90-100,. 15-20 in-patients a month.FP 100 tubectomies achieved Malaria 6 cases per month. 6 Beds occupied with 6 Cases of tubectomy were seen.

Village water supply pipe line not adequate. No independent supply. Requires a bore-well. No generator, PHC Devangangapur 10 Km away. No phone, no vehicle

ANMs living in quarters

IMPRESSIONS: Water supply and electricity should be a priority for all PHCs, SCs, CHCs and hospitals. Communications like telephone and vehicle is a must to reach the SCs.

PHC DHANGAPUR-ALAND TALUK (Not visited)

Spoken to the MO, Dr. Satish Patil (2-1/2 Years contract basis). Has 4 SCs. PHC Building built under MLA fund 10 years back without plastering without electricity and water supply. But were asked to occupy the same and has been functioning from it since then. No repairs /additions / alterations possible since under controversy. Needs urgent attention. Located 5 kms from CHC Nimbarga.

IMPRESSIONS: The government should evolve a policy to overcome such technical snags and attend promptly to such functional PHCs rather than constructing in locations where no doctor seems interested to work.

CHC NIMBARGA (ALAND TALUK), GULBARGA DISTRICT.

Dr. M.S. Sangolikar DCh. As mentioned earlier was in PHU Ganagapur, now recently taken over the CHC. Shuttle daily from Gulbarga. (I collected all three doctors from the Railway Station at 5 pm and visited all the above three medical units).

Good building with 30 beds. No Doctor earlier for 2 years. In 4 acres campus with 6 quarters except for MO all other staff are residing in the campus. 3 wards, no vehicle, telephone available. Adequate medicines were available.

25-30 family welfare operations per month (only tubectomies), 32 malaria cases so far. GE outbreak in village Nimbarga Tanda with 35 none positive for cholera. Immunization adequate.

Beautiful operation theatre already available. One additional operation theatre and admin block seems to have been sanctioned under IPPIX. Requirement of X-ray machine. X-ray technician posted with CHC, presently under deputation out. No labour room available which should have been the priority. Lab technician with two microscopes also available.

2 cases of TB detected and treated from other PHCs. Daily OPD attendance 90-100.

Since large OT already exists, only needs slight improvements. There is however a requirement of labour room, admin room, post mortem room and X-ray plant.

IMPRESSIONS: It is typical of the CHC to have only one doctor and functioning only as a PHC since its upgradation 3 years ago. Plans to construct additional OT etc. has no meaning if no staff will be available to perform surgeries. The population also is too small to have sufficient surgeries.

YADGIR TALUK GENERAL HOSPITAL(GULBARGA)

Taluk Health Officer P. Vijayakumar Paediatrician 1991 was not available.

Dr. R.N. Katti Surgeon 1995 briefed about the hospital.

Dr. G.D. Hunkunti surgeon 1990.

Dr. Thenga Kulkarni LMO 1991

Dr. Neelamma LMO 2000

Dr. B.C. Patil Dental 2000.

Old 24 bedded hospital now shifted to new campus. Now supposed to be 50 bedded hospital since 1992 further being upgraded to 100 bedded hospital under KHSDP. Bed occupancy only 25-30 only tubectomy.

No anesthetist since 1992. Gynaecologist, Physician, Eye Surgeon post vacant. OPD attendance 250-300 daily. 2 MOs quarters only.

Mobile vehicle ophthalmic unit (van) off road since 1 year due to burst tyre. Tempo Trax of THO off road due to engine seize (lack of engine oil). Matador Ambulance on road.
Old X-ray machine functioning from old hospital 2 kms away. New X-ray machine maybe installed through KHSDP. X-ray technician and Lab technician available. No ECG machine available.
Malaria 500 slides per month examined. 190 positive of 5746 slides examined.
Operation Theatre in good condition with one working AC out of two. Used only for Tubectomy operations. One more OT sanctioned recently. Surprising since no major surgery performed since 10 years inspite of 2 surgeons being available. Also no cataract surgeries being performed and figure of operations carried out by Mission Hospital are reflected in the Government reports.
642 tubectomies performed (50-60 per month) including15 PHCs and 1 CHC covering a population of 3,29000 of which closest PHC is Mudnar 4 kms away and the furthest Kadechur 65 kms away. Adequate drugs are available.
Very old Dental chair available. Needs replacement.
IMPRESSIONS: This taluk hospital seems to have a very poor reputation with Doctors not available most of the time. Even the team from KHSDP which had visited went back without meeting anyone as they were offended as no one was available. Surprisingly the 2 surgeons only performed tubectomies in their long stint in the hospital. Construction of an additional OT seems ridiculous and a waste of money. Since they have a dental surgeon, it is logical that a good dental chair and equipment should be provided to improve dental services. Lifting of cataract surgeries statistics from the Mission Hospital nearby should be at some benefit to the NGO by providing lenses etc. The poor state of vehicles shows the lack of concern by the Government staff. The workload seems to be less for so many doctors and suggests that they are busy with their private practice.

HOLSTON MISSION HOSPITAL – YADGIR

Met Dr. M.C.Benjamin an eye specialist, who is the only doctor available in the hospital with a handful of staff. The hospital had 100 beds and basic specialists like surgery, medicine, Gynae, dental and eye earlier and was very popular. Since the locating of the Taluk hospital nearby, the clients have reduced as Government facilities are totally free. Also due to internal politics and poor management, the hospital has lost its capacity to be a good hospital. The hospital gets another eye specialist trained in IOL from Gulbarga city twice a month and performs cataract surgery. They have performed around 200 cataract operations. The hospital could be revived by support from the Government as it has excellent facilities.

OPEC HOSPITAL RAICHUR

Dr. M.B. Karkenewar, Addl.Project Officer, KfW and Addl Director & Spl Officer OPEC Hospital since 01 October 2000 was available and briefed about the hospital. Hospital was inaugurated on 18th October 2000 and two teams from NIMHANS (1 neuro-physician and 1 neuro-surgeon)& Jayadeva Institute of Cardiology (1 cardiac surgeon, 1 cardiac anesthetist and 1 cardiologist) were attached for one month. Subsequently only 1 team from Jayadeva is functioning at the hospital. Also two new MBBS doctors (one son of DJD Gulbarga) have been employed.

Super-speciality hospital with seven specialities- cardiology, nephrology, neurology, burns, orthopaedics, plastic surgery and dental. Has latest generation of equipment excluding MRI. One Lady Bio-medical engineer was available to show the equipment.
Has meager staff of 2 staff nurses, 1 clerk, 1 computer programmer, 1 pharmacist, 1 biomedical engineer, and 15 cleaning staff and 1 driver. Vehicle is from district hospital.
The operation theatres seem spacious but the doors do not close flush which is required in an OT. Also AC vents are being installed as an afterthought showing that user interface has not been taken into consideration.
Due to leaking roof of district hospital, about 100 beds are being transferred to this 350 bedded hospital. The project officer is due to retire on 1st March 2001. Work-load of the hospital has been only to work up the cardiac patients and further referral to Bangalore.
IMPRESSIONS: A beautiful 350 bedded hospital gifted by OPEC to the Govt for the poor people of Raichur and Gulbarga region. Due to inability of the State to run the hospital (reqd budget 10 Cr /annually approx) seems to be a deliberate hurry to privatize it defeating the very purpose of the gift. The very idea of keeping a low motivated person to oversee the functioning speaks volumes. Ideally the hospital should start functioning as a multi speciality hospital with all specialities like surgery, medicine, eye, ENT, dental etc. and then build up into a super-speciality hospital once its bed occupancy increases then automatically it can be reduced to only super-speciality beds. No attempt was made to train local speacilists in super speciality to cater to the local need. It would not be possible to sustain the hospital by importing specialists. Attempts should have also been made to rope in philanthropic organizations even IT industry to raise 10 Cr. Annually and run the hospital for the purpose for which it was originally designed.

To: SKK
27-11-
7/01/01

REGIONAL DISPARITIES – GULBARGA DIVISION & BIJAPUR DISTRICT

Some of the impressions regarding regional disparities in Gulbarga Division and Bijapur District after visiting the areas are outlined briefly below:
(I am not very certain that these observations would not be seen in other districts of Karnataka also).

Roads:- Roads from Gulbarga on the Gulbarga Afzalpur - Bijapur axis and roads towards Yadgir taluk and from there to Raichur and within Gulbarga district itself were of poor quality, uneven and full of deep pot holes. Further roads going into the taluks were made of stone and very uneven. Roads leading into the villages were basically mud roads and hence during rainy season the villages are inaccessible by regular mode of transport, which is practically for 3-4 months every year. This is quite in contrast to many of the villages in Uttar Pradesh (BIMAROU state) where grampanchayats have constructed brick roads to connect their villages to the main roads. These are long lasting and easily repairable by local labour / shramadhan. Also brick kilns are found all along the roads so bricks are cheap & easily available locally.

Transport:- Though state buses do fly on these roads they are infrequent and irregular. Predominant mode of transport are private Mahindra Jeeps which cover short distances of 5-20 Kms and charge individuals accordingly. These Jeeps are over-crowded (more than 10 passengers) but seem to meet the needs of the people. Even the supervisory staff including MO's / LMO's have to depend on this to visit SC's and villages where no transport is available at the PHC's (majority of them). At the end of the day these Jeeps are available at the villages and the MO's stated that they were used (without prejudice) to transfer serious patients to the nearest hospital, whenever need arose. During rainy season only bullock-carts and tractors could fly on the mud roads, otherwise villages were virtually cut off from all services.

Electricity:- Electricity was only available in revenue and a few other villages. Most of the PHC's had no electricity supply during the time of visit. The MO's stated that supply

was low voltage, erratic and with frequent unscheduled cuts varying form 2-8 hours a day.

Water Supply:- Most of the PHC's /CHC's /few taluk hospitals did not have a proper water connection and were dependent on the villages for their water requirement. They had locked up the toilets to prevent patients from using the same in the absence of water supply.

Epidemics:- During summer months out breaks of Gastro enteritis (many due to cholera) were common. PHC Gobbur (Afzalpur Taluk) had 27 GE cases with 1 positive for cholera this year (2000). PHC Atnoor (same taluk) had 36 GE cases with 4 positive for cholera within 1½ months in Siddanur village. CHC Ninibarga (Aland Taluk) reported 35 GE cases (nil positive for cholera) from village Ninibarga Tanda.

Communicable Diseases:- Malaria seems to be a major problem in these areas though under reporting is common. Raichur District is notorious for all types of Malaria is Benign mixed and Tertian Malaria, Urban Malaria, (cross-border) Migrant Malaria, Tribal Malaria and chloroquine resistant Malaria. PHC Gobbur had 90 cases of malaria (80Pv+10Pg) in 28,842 population of 21 villages (interestingly HW (M) at SC Chirangera stated that he was required to collect 22 slides for fever cases in a month under NMEP and chlorinate only two GP wells in his duties). PHC Atnoor had 9 cases of Pv in 600 cases of fever in which slides were taken (Population 14,185 in 9 villages)

CHC Nimbarga reported 32 cases of Malaria and other PHC's /CHC's and taluk hospitals reported 2-5 cases of malaria in a month (Gross under-estimate). Taluk hospital Yadgir covering a population of 3,29,000 from 15 PHC's and one CHC examines about 500 slides per month. They had 190 positive cases ~~amount~~ out of 5,746 slides examined.

Tuberculosis:-was hardly being detected and this is a major concern. Most of the PHC's /CHC's /Hospitals had detected nil to 10 cases of TB in the whole year. This is inspite of

the fact that all of them had 1-2 microscopes and lab technicians. Only two drugs for treatment of TB were available (INH and thiacetazone).

Buildings:- Some of the PHC's in Gobbur, PHC Almel (Bijapur district, Sindagi Taluk), Taluk Hospitals Afzalpur were housed in dilapidated buildings and definitely need new buildings. Many PHC's /CHC's and Taluk hospitals had good buildings and only needed electricity, water supply and few minor repairs / maintenance. However, ~~none~~ none of these were comparable to the excellent PHC /CHC buildings of many of the districts of Uttar Pradesh which I had visited (constructed under IPP III). Most of the PHC's /CHC's Hospitals were on 4 acres of land with or without boundary walls.

Private Sector:- Most of these districts did not have private MBBS doctors near villages or even in Taluks. A handful of quacks, BAMS, BHMS etc practiced in the taluks and this was corroborated by the handful of Medical shops in these areas. Nursing homes and specialist clinics were confined to the District Headquarters and many of these in Gulbarga & Raichur were of a high standard. (Hence I feel that task force could recommend that licensing of practioners of other systems of medicine should be more stringent and permission given for practice only at taluk & below levels.)

Position of Staff:- On the whole position of crucial staff at PHC's /SC's were adequate. Most of the staff were residing in the staff quarters or villages for long durations. Staff position in CHC's & Taluk Hospitals were very poor with CHC's being manned by single doctors and with deficiency of most technical staff.

Training of Staff:- Could determine only training needs of MO's. Most of them had underwent training for 1-2 weeks duration every year (especially under IPP 1X). However, they commented that the training was stereo-typed and unimaginative and hardly skill-based. They all felt the requirement of skill-based training in MTP, Tubectomy (including Leparoscopic) and Medico legal. (This has also been identified by RCH and other Trainers). Also need for CME's (atleast twice a year) and involvement of

Medical Colleges/ Consultants as resource persons at RHWTC's was felt would improve their professional knowledge & skills.

Medicines:- Except Gobbur PHC all the other centres were well stocked with drugs which are received from GMS through District / Taluk stores in two allotments of 60% and 40%. Also stocks received from other programmes especially RCH (kit A and B for SC's) ensured adequate stock of quality medicines.

Family Welfare:- Deliveries were being carried out in the PHC's as well as in the villages by trained and untrained Dais. . PHC Gobbur had conducted 170 deliveries and 155 Tubectomies (140 IUD insertions), PHC Atanoor 156 deliveries in PHC, 72 in villages with trained Dais and 19 with untrained Dais. They had done 73 Tubectomies and 76 IUD insertions. Vasectomy had a low priority. In fact a team from Regional office of H & FW had organised camps of non -scalpel vasectomy during the period of our visit in Gulbarga region and succeeded in conducting only 7 cases. Taluk hospital, Yadgir who had planned 4 cases could not get even one case. They conduct about 50 –60 tubectomies a month (642 during the year). CHC Station Ganagapur had conducted 100 tubectomies and CHC Ninabarga 25 – 30 per month.

Cataract Operations:- Conduct of cataract operations have been ~~discussed~~ dismal. PHC, Gobbur had managed 12 cases. Surprisingly, at Yadgir Taluk hospital no cataract operation was conducted and they only reflect the cataract operations conducted in Private Hospitals / Mission Hospitals locally. The Holston Mission Hospital had conducted 200 10L cataract surgeries by getting the Eye Specialist from Gulbarga city twice a month. The mobile ophthalmic van (matador) of the Taluk hospital was off road since 1 year due to a burst tyre.

Immunization:- Routine immunization seems to be going on in a passive manner with no extra effort to reach every infant in the village. There was adequate quantity of all vaccines in all the PHC's /CHC's / Hospitals visited and records maintained. Cold chain seemed adequate though many CHC's / PHC's had no stand by generator. (some of the

PHC's visited would not open the deep freezers for inspection to avoid loss of cold, which was appreciated). At one anganwadi visited (Chandapur Thanda under PHC Gobbur) 8 babies were given immunization including 2 measles and 1 booster dose and 2 pregnant mothers were given TT.

Taluk Health Officer:- Providing vehicles (Tata Sumo / Tempo Trax to THO's seems to be more a bane than a boon to the provision of health services. They were absent wherever we visited and feed back from the field indicate that they do not visit the PHC's CHC's as frequently as they should.

December 29, 2000

REPORT OF VISIT TO GULBARGA DIVISION – DECEMBER 2000.

Three CHC team members (TN, SKK, SG) who are part of the HNP team evolving the Karnataka Integrated Health Nutrition and Family Welfare Services Development Project proposal, with the Directorate of H & FW, GOK, spent two days, 21st and 22nd December, 2000, visiting health institutions in Gulbarga Division and holding discussions with Government officials and NGO's regarding the proposed project.

The visit was facilitated by the Commissioner, H & FW and coordinated and organised locally by the Divisional Joint Director of Health & FW, Gulbarga Division.

The team divided into two for greater coverage of field visits. Due to good organizational support from the DJD and local officials and members were able to visit institutions in Gulbarga, Bidar and Raichur districts and one in Bijapur district.

Visits made included:

1. PHC's

   a) Kamlapur, Gulbarga district.
   b) Gobbur
   c) Afzalpur
   d) Dangapur
   e) Almel, Bijapur district.

2. CHC

   a) Mannaekeli, Humnabad Taluk, Bidar district.

3. **TALUK GENERAL HOSPITAL**

   a) Humnabad, Bidar district.
   b) Basavakalyan, Bidar district.
   c) Yadgir, Gulbarga district.

4. **DISTRICT HOSPITAL**

   a) Bidar
   b) Gulbarga

5. **OTHER HOSPITALS**

   a) Raichur OPEC hospital.
   b) Gulbarga cancer hospital, (linked to Kidwai Institute o Oncology, Bangalore).

c) Gulbarga DTC (closed for lunch)

6. NGO INSTITUTIONS

a) St. Luke's Mission Hospital – rural Gulbarga (20 km away from town)
b) Bidar Methodist Hospital.
c) Mission Hospital, Yadgir.

Discussions held with:

1. Dr. A. Pranesh, DJD, Gulbarga Division.
2. Dr. Nimbur, DHO, Bidar.
3. Mr. Maheswar Rao, CEO, Gulbarga.
4. Mr. Lakshmi Narayan, DC, Gulbarga.
5. Hyderabad, Karnataka Area Development Board Official.
6. Municipal Commissioner, Gulbarga.
7. Doctors and some staff from institutions listed above.

Impressions, findings and suggestions for the HNP project.

1. Development of detailed strategies for the special package for category 'C' districts, through consultation with local officials from health and related departments is required and welcomed. It is preferable if a planning meeting is held in Gulbarga to allow wider representation. Officials there also feel that the meeting and its venue in Gulbarga would signify the importance given to the region.

2. The facility survey will need to be carefully and objectively carried out, with physical verification. Duplication of facilities, OTs has been noted. Different interpretations are sometimes given and certain items may be omitted by respondents, to suit their convenience, if not objectively done.

3. There are a number of people with commitment and enthusiasm in the region who need support and encouragement.

4. Vacancies continue to be a problem e.g. of ANMs in Gulbarga district. Bidar district is better placed. Recruiting more lady Medical officers may need to be a priority. There are 24 LMO's out of 100 in Gulbarga. However, data about their distribution in PHC's is what is important. Filling vacancies of common health personnel, will help improve access to health care by women and to better the performance in MCH and RCH, which is low for these districts.

5. The DJD reportedly has inadequate resources and powers, both financial and administrative. The DHO's, technically under him, are administratively under the ZP. Hence his role gets limited. For quality of care to be improved, supervision and accountability for all aspects of technical work will need to be stronger. The ZP does not have the capacity or expertise required to perform this role.

6. Quality of work was variable in the institutions visited. Illustrative examples are given.

6.1. In Humnabad Taluk General Hospital – There were hardly any patients. The only patients in one ward were a mother with a newborn child. Their bed had no sheet and the room was dirty. When asked for the chart – the baby was supposed to weigh 3 kg. On verification, it was 2.4 kg. We were later told that the wrong chart of a discharged patient was mistakenly shown to us, which indicated sloppy work, considering there was only one patient. The mother's hemoglobin, a routine investigation, was not done, though she looked pale. This level of care does not meet basic standards.

6.2. We were told that there were 400 out patients everyday in the above hospital. The registers recorded about 200 patients for that day. The column for diagnosis was filled mainly by symptoms of fever, backache, GBA (generalised body ache). Provisional and final diagnosis needs to be more professional, especially at this referral level, where specialists run the service. This database for any disease surveillance system is inadequate and would produce misleading results.

6.3. Hospital / health care waste management was a concept not understood or practised in any of the institutions visited.

6.4. Toilets were blocked in the CHC visited and environmental cleanliness was poor. All 3 doctors in the CHC were MBBS and 1 on leave was an Auyurvedic physician. There were no specialists as required at an FRU. However, they were enthusiastic and eager to learn. There were 3 people from one family with high fever, who had come in at about 4 pm that evening. By the time we reached a little after 5 p.m. blood smears had been done by the CHC laboratory technician and they were found to be positive for malaria (P.vivax). Treatment was being initiated. This CHC had weekly F.P. operations performed by specialists who come in. A number of post operative patients were admitted in the ward. Registers revealed a fairly larger out- patients load. The number of sputum AFB tests done was small, with very few TB patients on treatment. The doctors were keen to learn more about TB treatment and TB control.

They were also open to have a medicinal herbal garden in their vast compound.

6.5. The Basavakalyan Taluk General Hospital was efficiently run and very busy. The Gynecologist (LMO) was upto-date with all dimensions of work of the hospital, including the renovations being undertaken under KFW. There were a large number of patients at around 3 p.m when we visited. These appeared to be good teamwork among the staff. Records were well maintained. The institution looked more cared for and clean.

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POLICY BRIEF

COMH-71.

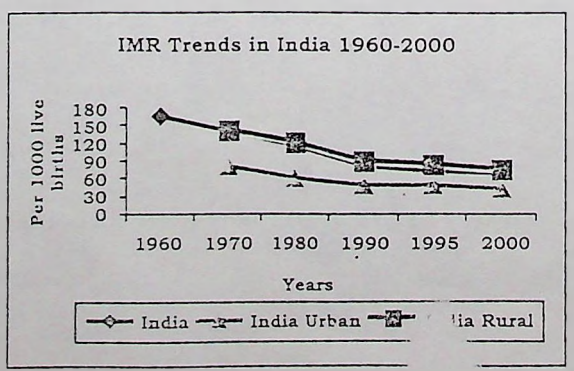
Save Public Health - Ensure Health for All NOW!
Make Health Care a Fundamental Right!

One of the best ways to judge the well being of the people of any nation is by examining the standards of health that ordinary people have attained. Healthy living conditions and access to good quality health care for all citizens are not only basic human rights, but also essential prerequisites for social and economic development. Hence it is high time that **people's health is given priority as a national political issue.** The current health policies need to be seriously examined so that new policies can be implemented in the framework of quality health care for all as a basic right. The following sections first take a look at the hard realities of people's health in India today, and examine some of the maladies of recent health policies. Next the availability of various resources, which could be utilised for an improved health care system is discussed, finally followed by certain recommendations to strengthen and reorient the health system to ensure quality health care for all. We hope these **recommendations will be incorporated by political parties in their election manifestos** for the upcoming general election as a demonstration of their commitment to public health. Jan Swasthya Abhiyan, a national platform working for people's health, looks forward to such a commitment from all political forces in the country.

How can India's health be shining when ...

- **Infant and Child mortality snuffs out the life of 22 lakh children every year,** and there has been very little improvement in this situation in recent years.[1] We are yet to achieve the National Health Policy 1983 target to reduce Infant Mortality Rate to less than 60 per 1000 live births.[2] More serious is the fact that the rate of decline in Infant Mortality, which was significant in the 1970s and 80s, has slowed down in the 1990s, (See graph below)

- **130,000 mothers die during childbirth every year.** The NHP 1983 target for 2000 was to reduce Maternal Mortality Rate to less than 200 per 100,000 live births. However, 407 mothers die due to pregnancy related causes, for every 100,000 live births even today.[1] In fact, as per the NFHS surveys in the last decade Maternal Mortality Rate has increased from 424 maternal deaths per 100,000 live births to 540 maternal deaths per 100,000 live births.[3]



- **Three completely avoidable child deaths occur every minute.** If the entire country were to achieve a better level of child health, for example the child mortality levels of Kerala,[1] then **18 lakh deaths of under-five children could be avoided every year.** The four major killers (lower respiratory tract infection, diarrheal diseases, perinatal causes and vaccine preventable diseases) accounting for over 60% of deaths under five years of age are entirely preventable through better child health care and supplemental feeding programs.[3] The most recent estimate of complete immunization coverage indicates that only 54% of all children under age three were fully protected.[4]

- **About 5 lakh people die from tuberculosis every year**[18], and this number is almost unchanged since Independence![19] 20 lakh new cases are added each year, to the burgeoning number of TB patients presently estimated at around 1.40 crore[2] Indians !

- India is experiencing a **resurgence of various communicable diseases** including Malaria, Encephalitis, Kala azar, Dengue and Leptospirosis. The number of cases of **Malaria has remained at a high level of around 2 million cases annually** since the mid eighties. By the year 2001, the worrying fact has emerged that **nearly half of the cases are of Falciparum malaria,** which can cause the deadly cerebral malaria. The outbreak of **Dengue** in India in 1996-97, saw 16,517 cases

and claimed 545 lives[8]. Environmental and social dislocations combined with weakening public health systems have contributed to this resurgence.

- Diarrhea, dysentery, acute respiratory infections and asthma continue to take their toll because we are unable to improve environmental health conditions. **Around 6 lakh children die each year from an ordinary illness like diarrhoea.** While diarrhea itself could be largely prevented by universal provision of safe drinking water and sanitary conditions, these deaths can be prevented by timely administration of oral rehydration solution, which is presently administered in only 27% of cases[3].
- Cancer claims over 3 lakh lives per year and **tobacco related cancers** contribute to 50% of the overall cancer burden, which means that such deaths might be prevented by tobacco control measures[2].
- Estimates of mental health show about 10 million people suffering from serious mental illness, 20-30 million having neuroses and 0.5 to 1 percent of all children having mental retardation[2]. **One Indian commits suicide every 5 minutes[5]!**

As a nation, today there is a need to look closely at the deep problems in the health system, rather than making exaggerated claims. There is a need to recognize the growing health inequities, and urgently implement basic changes in the health system.

With political will and people's involvement, ensuring good quality health care for every Indian is possible!

The growing inequities in health and health care are unjust !

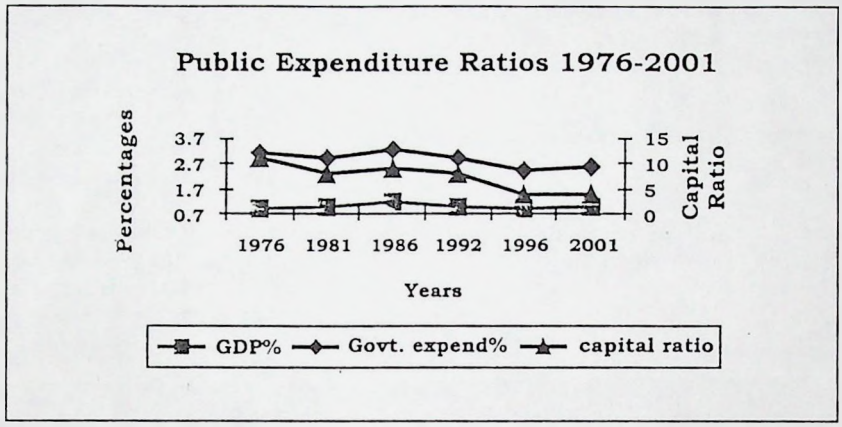
The Constitution of India guarantees the 'Right to Life' to **all** citizens. However, the disparities relating to survival and health, between the well off and the poor, the urban residents and rural people, the adivasis and dalits and others, and between men and women are extremely glaring.

- The Infant Mortality Rate in the poorest 20% of the population is **2.5 times higher** than that in the richest 20% of the population. In other words, an infant born in a poor family is two and half times more likely to die in infancy, than an infant in a better off family[3].
- A child in the 'Low standard of living' economic group is **almost four times** more likely to die in childhood than a child in the better off 'High standard of living' group. An Adivasi child is one and half times more likely to die before the fifth birthday than children of other groups[3].
- A girl is 1.5 times more likely to die before reaching her fifth birthday, compared to a boy! The **female to male ratios** for children are rapidly declining, from 945 girls per 1000 boys in 1991, to just 927 girls per 1000 boys in 2001[16]. This decline highlights an alarming trend of discrimination against girl children, which starts well before birth (in the form of sex selective abortions), and continues into childhood and adolescence (in the form of worse treatment to girls)[3].
- Dalit Women are one and a half times more likely to suffer the consequences of chronic malnutrition (stunted height) as compared to women from other castes. Children below 3 years of age in scheduled tribes and scheduled castes are twice as likely to be malnourished than children in other groups.
- A person from the poorest quintile of the population, despite more health problems, is **six times less** likely to access hospitalization than a person from the richest quintile. This means that the poor are unable to afford and access hospitalization in a very large proportion of illness episodes, even when it is required.
- The delivery of a mother, from the poorest quintile of the population is **over six times** less likely to be attended by a medically trained person than the delivery of a well off mother, from the richest quintile of the population. An adivasi mother is half as likely to be delivered by a medically trained person[3].
- The ratio of hospital beds to population in rural areas is **fifteen times** lower than that for urban areas[14].
- The ratio of doctors to population in rural areas is **almost six times lower** than the availability of doctors for the urban population[14].
- Per person, Government spending on public health is **seven times lower in rural areas**, compared to Government health spending for urban areas.

These **health and health care inequities are increasing**, and are deeply unjust -- a just health system would ensure that all citizens, irrespective of social background or gender, would get basic quality health care in times of need.

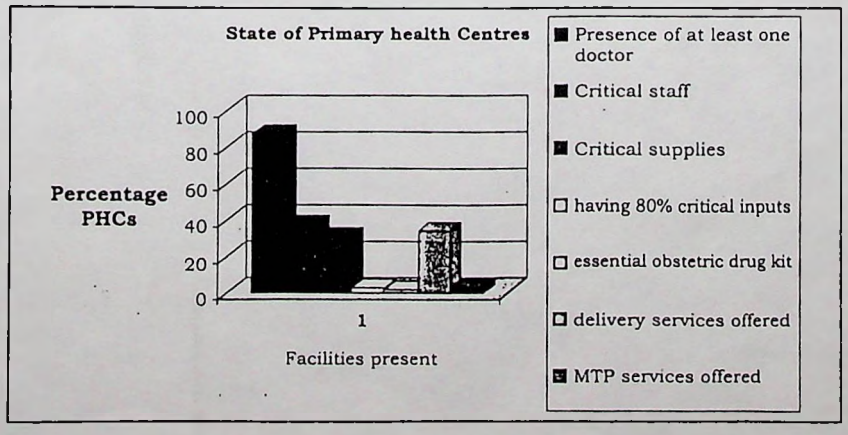
Public health being weakened, people's health being undermined

The NDA Government has recently claimed that one of its signal achievements has been the allocation of 6% of GDP to Health care. In reality, the government spends just 0.9 % of the GDP on Health care and the rest is spent by people from their own resources. Thus only 17% of all health expenditure in this country is borne by the government — this makes the Indian public health system grossly inadequate to meet healthcare demands of its people, and makes the health sector the **most privatised in the world.** Only five other countries in the world are worse off than India regarding public health spending (Burundi, Myanmar, Pakistan, Sudan, Cambodia[6]). The W.H.O. standard for expenditure on public health is 5% of the GDP. The average spending today by Less Developed Countries is 2.8 % of GDP, but India presently spends only 0.9% of its GDP on public health, which is merely one-third of the less developed countries' average[6] !



The consequence of this dismally low allocation, which stands at the lowest levels in the last two decades, (in contrast to 1.3% of GDP achieved in 1985), is deteriorating quality of public health services. For example, Primary health centers (PHCs), meant to serve the needs of the poorest and most marginalized people have the following shocking statistics:

- Only 38% of all PHCs have all the critical staff
- Only 31% have all the critical supplies (defined as 60% of critical inputs), with only 3% of PHCs having 80% of all critical inputs.
- In spite of the high maternal mortality ratio, 8 out of every 10 PHCs have no Essential Obstetric Care drug kit!
- Only 34% PHCs offer delivery services, while only 3% offer Medical Termination of Pregnancy!
- A person accessing a community health center would find no obstetrician in 7 out of 10 centers, and no pediatrician in 8 out of 10!



Source: 7

Private health care and essential drugs are increasingly unaffordable !

The dominance of the private sector not only denies access to poorer sections of society, but also skews the balance towards urban biased, tertiary level health services with profitability overriding equity, and rationality of care often taking a back seat.

- A growing proportion of Indians cannot afford health care when they fall ill. National surveys show that the number of people who could not seek medical care because of lack of money increased significantly between 1986 and 1995[15]. The proportion of such persons **unable to afford health care almost doubled**, increasing from 10 to 21 % in urban areas, and growing from 15 to 24% in rural areas in this decade[15].
- **Forty percent** of hospitalised people are forced to borrow money or sell assets to cover expenses[15].
- **Over 2 crores of Indians are pushed below the poverty line** every year because of the catastrophic effect of out of pocket spending on health care[10].
- Irrational medical procedures are on the rise. According to just one study in a community in Chennai, **45% of all deliveries were performed by Cesarean operations,** whereas the WHO has recommended that not more than 10-15% of deliveries would require Cesarean operations[17].
- Due to **irrational prescribing**, an average of 63 per cent of the money spent on prescriptions is a waste. This means that nearly two-thirds of the money that we spend on drugs may be for unnecessary or irrational drugs[11].
- The pharmaceutical industry is rapidly growing...yet only 20% of the population can access all essential drugs that they require. There is a proliferation of brand names with over 70,000 brands marketed in India, but the 2002 Drug policy recommends that only 25 drugs be kept under price control[13]. As a result, many drugs are being sold at 200 to 500 percent profit margin, and essential drugs have become unaffordable for the majority of the Indian population.

Health policy developments since the 1990s have critically weakened the health system

The effectiveness of the public health system and access to quality health care, especially for the poor has worsened since the decade of the 1990s, due to a variety of policy developments, at both national and state levels:

- Stagnant public health budgets and decreasing Government expenditure on capital investment for public health facilities.
- Introduction of user fees at various levels of public health facilities.
- Freezing of new recruitments and inadequate budgets for supplies and maintenance in the public health system.
- Contracting out health services or privatisation of health facilities.
- Encouragement of growth of private secondary and tertiary hospitals through tax waivers, reduced import duties, subsidized land etc. which have led to a further expansion of the unregulated private medical sector.
- Promotion of 'Health tourism' for foreign visitors, while basic health services remain inaccessible for a large proportion of the Indian population.
- Conducting occasional, expensive and largely ineffective 'Health melas' instead of upgrading the public health system as a sustainable solution.
- Deregulation of the pharmaceutical industry, lax price controls on drugs — the list of drugs under price control being proposed to be reduced to 25 drugs (compared to 343 drugs under price control in 1979.)
- Many bulk drug manufacturing units have closed down due to liberalized import and dumping as a result of the implementation of the WTO agreement and autonomous economic liberalization policies. Due to reduction of customs duty and increase of excise duty, imported drugs will become cheaper while local drugs will become more expensive.

Is this inevitable ? Can only developed countries manage good health care for their people ?

Indians need not accept poor health as their inevitable fate! Many other developing countries, which have given a high priority to people's health, have achieved much better health outcomes compared to India. As a country, we spend a higher proportion of the GDP on health care compared to these countries – but an overwhelming percentage of this (83%) is private expenditure. As a result we have a weak public health system with poor health outcomes forcing families to spend a lot on private medical care, which is expensive, and not always appropriate, leaving us with **'poor health at high cost'**! Here is how some other Asian countries are doing in comparison with India...

Health Outcomes in Relation to Health Expenditures in some Asian countries[10]

	Total Health Expenditure as % of GDP	Public Health Expenditure as % of total	Under 5 Mortality	Life Expectancy	
				Male	Female
India	**5.2**	**17**	**95**	**59.6**	**61.2**
Sri Lanka	3.0	45.4	19	65.8	73.4
Malaysia	2.4	57.6	14	67.6	69.9

Does India have the resources to provide health care for all ?

As a country, Indians spend more on health care than most other developing countries, but this is mostly out-of-pocket spending. Health care facilities have grown substantially, but these are mostly in the private sector. The system is producing more and more healthcare professionals, but we lose them to the private sector, or to western countries. To give some idea of the available health care resources in India –

- Compared to 11,174 hospitals in 1991 (57% private), the number grew to 18,218 (75% private) in 2000[11]. In 2000, the country had 12.5 lakh doctors and 8 lakh nurses! At the national level, there is one allopathic doctor for every 1800 people, or one doctor from systems including ISM and homeopathy for 800 people. This means there are more doctors than the required estimate of one doctor for 1500 population[12].
- Approximately 15,000 new graduate doctors and 5,000 postgraduate doctors are produced every year and one-fifth of them leave the country for greener pastures[13].
- We have an annual pharmaceutical production of about 260 billion rupees[14], and we export a large proportion of these drugs - Sadly, while our exports grow, 80% of our people do not have access to all the drugs they require.

In short, we have substantial health care resources, but because of the privatised, unregulated and inequitable nature of the health care system, it is unable to ensure good quality health care for a majority of citizens. Rather than producing more doctors or setting up more private hospitals, what we need is a reorganisation of the health system, with substantial strengthening of public health, greatly enhanced public expenditure, regulation of the private medical sector and an overall planned approach to make health care resources available to all.

What can be done as immediate steps ?

The objective should be to **make Health care a Fundamental right and an operational entitlement**. This would require a National Public Health Act, which mandates right to basic healthcare services to all citizens through a system of universal access to healthcare. The Indian Constitution through its directive principles provides the basis for the Right to health care, and the Indian state has ratified the International Covenant of Economic, Social and Cultural Rights which makes it obligatory on its part to comply with Article 12 that mandates right to healthcare. Universal access to healthcare is well established in a number of countries including not only developed countries like Canada and United Kingdom, but also developing countries such as Cuba, Brazil, Costa Rica and Thailand. There is no reason why this cannot be made a reality in India. Hence we need to set in motion processes, which will take us towards the goal of universal access to health care, in a Rights-based framework and with equity.

Some immediate steps related to the health care system that need to be taken include:

- Making healthcare a fundamental right by suitable constitutional amendment. The formulation of a National legislation mandating the Right to Health care, with a clearly defined comprehensive package of health care, along with authorization of the requisite budget, being made available universally within one year.
- Significant strengthening of the existing public health system, especially in rural areas, by assuring that all the required infrastructure, staff, equipment, medicines and other critical inputs are available, and result in delivery of all required services. These would be ensured based on clearly defined, publicly displayed and monitored norms.
- The declining trend of budgetary allocations for public health needs to be reversed, and budgets appropriately up-scaled to make optimal provision of health care in the public domain possible. At one level adopting a fiscal policy of block funding or a system of per capita allocation of resources to different levels of health care, with an emphasis on Primary Health Care will have an immediate impact in reducing rural-urban inequities by making larger resources available to rural health facilities like Primary health centers and Rural hospitals. Simultaneously, the budgetary allocation to the health sector must be increased substantially, targeting the 5% of GDP as public expenditure on health care as recommended by the WHO.
- If the public health system fails to deliver it should be treated as a legal offence, remedy for which can be sought in the courts of law. The public system must ensure all elements of care like drug prescriptions, diagnostic tests, child birth services, hospitalization care etc. One way to ensure this could be that in exceptional situations, where patients who do not receive these services from the public facility they may be referred to seek them from alternate facilities, which are registered with the state agency. Such registered and regulated facilities would honour such referrals, for which the state would reimburse them at a mutually agreed rate. This would maintain pressure on the public health system to provide all elements of care, and would ensure that the patient is not deprived of essential care at time of need.
- Various vulnerable and marginalised sections of the population have special health needs. There is a need for a range of policy measures to eliminate discrimination, and to provide special quality and sensitive services for women, children, elderly persons, unorganised sector workers, HIV-AIDS affected persons, disabled persons, persons with mental health problems and other vulnerable groups. Similarly, situations of conflict, displacement and migration need to be addressed with a comprehensive approach to ensure that the health rights of affected people are protected. The **People's Health Charter** deals with issues related to such special sections of the population, and can provide a basis for formulation of appropriate policy initiatives, in consultation with organisations representing these social segments.
- Putting in place a National legislation to regulate the private health sector, to adopt minimum standards, accreditation, standard treatment protocols, standardised pricing of services etc.
- Adopting a rational and essential medications-based drug policy. All States must have an essential drugs and consumables list and all the drugs and consumables on this list must be under price control. Further all state governments must adopt procurement and distribution

policies similar to what has been done by the Tamilnadu State Medical Services Corporation and hence ensure that essential drugs in the list are actually available in every facility.

- The state should introduce a new community-anchored health worker scheme, and implement it in a phased manner with involvement of people's organizations and panchayati raj institutions, in both rural and urban areas, through which first contact primary care and health education can be ensured.
- Integration of medical education of all systems to create a basic doctor ensuring a wider outreach and improvement of access to health care services in all areas.
- All state level coercive population control policies, disincentives and orders should be revoked. Disproportionate financial allocation for population control activity should not be allowed to skew funding from other important public health priorities.
- Integration of medical education of all systems to create a basic doctor ensuring a wider outreach and improvement of access to health care services in all areas. Effective regulation of the growth of capitation based medical colleges.

Conclusion

The persistence of unacceptably large numbers of avoidable deaths, resurgence of communicable diseases, declining quality of public health services and unaffordable, often inappropriate private medical care need not remain the lot of over a billion ordinary Indians. Recent policy changes of privatisation, declining public health budgets and pro-drug industry measures need to be replaced by strong public health initiatives, with the active involvement of communities and civil society organisations.

By and large, India today possesses the humanpower, infrastructure, national financial resources and appropriate health care know-how to ensure quality health care for all its citizens. What is needed is a major restructuring and strengthening of the health system. This involves two major ingredients: popular mobilisation for operationalising the Right to Health Care, and the political will to implement policy changes necessary to transform the health system. Jan Swasthya Abhiyan is today involved in the former task, by reaching out to people across the country, enabling them to mobilise for their just health rights. It calls upon political parties, which recognise people's right to healthy lives, to address the latter task, and to perform their historic duty by establishing and operationalising the Right to Health care as a Fundamental right.

This document focuses on the need for strengthening of the health care system, and certain immediate steps required for this. However, improvement of people's health requires equally importantly, provision of other necessary **facilities and conditions required for a healthy life**, such as safe drinking water, sanitation, food security, healthy housing, basic education and a safe environment. The **People's Health Charter** has dealt with these issues, and may be taken as a guideline to develop effective policies and improve people's living standard in order to achieve better health.

Published by CEHAT for JAN SWASTHYA ABHIYAN

Indian People's Health Charter

We the people of India, stand united in our condemnation of an iniquitous global system that, under the garb of 'Globalisation' seeks to heap unprecedented misery and destitution on the overwhelming majority of the people on this globe. This system has systematically ravaged the economies of poor nations in order to extract profits that nurture a handful of powerful nations and corporations. The poor, across the globe, as well as the sections of poor in the rich nations, are being further marginalised as they are displaced from home and hearth and alienated from their sources of livelihood as a result of the forces unleashed by this system. Standing in firm opposition to such a system we reaffirm our inalienable right to and demand for comprehensive health care that includes food security; sustainable livelihood options including secure employment opportunities; access to housing, drinking water and sanitation; and appropriate medical care for all; in sum - the right to **Health For All, Now!**

The promises made to us by the international community in the Alma Ata declaration have been systematically repudiated by the World Bank, the IMF, the WTO and its predecessors, the World Health Organization, and by a government that functions under the dictates of International Finance Capital. The forces 'Globalisation' through measures such as the structural adjustment programme are targeting our resources - built up with our labour, sweat and lives over the last fifty years - and placing them in the service of the global "market" for extraction of super-profits. The benefits of the public sector health care institutions, the public distribution system and other infrastructure - such as they were - have been taken away from us. It is the ultimate irony that we are now blamed for our plight, with the argument that it is our numbers and our propensity to multiply that is responsible for our poverty and deprivation. We declare health as a justiciable right and demand the provision of comprehensive health care as a fundamental constitutional right of every one of us. We assert our right to take control of our health in our own hands and for this the right to:

- A truly decentralized system of local governance vested with adequate power and responsibilities, provided with adequate finances and responsibility for local level planning.
- A sustainable system of agriculture based on the principle of land to the tiller – both men and women – equitable distribution of land and water, linked to a decentralized public distribution system that ensures that no one goes hungry
- Universal access to education, adequate and safe drinking water, and housing and sanitation facilities
- A dignified and sustainable livelihood
- A clean and sustainable environment
- A drug industry geared to producing epidemiological essential drugs at affordable cost
- A health care system which is gender sensitive and responsive to the people's needs and whose control is vested in people's hands and not based on market defined concept of health care.

Further, we declare our firm opposition to:

- Agricultural policies attuned to the needs of the 'market' that ignore disaggregated and equitable access to food
- Destruction of our means to livelihood and appropriation, for private profit, of our natural resource bases and appropriation of bio-diversity.
- The conversion of Health to the mere provision of medical facilities and care that are technology intensive, expensive, and accessible to a select few
- The retreat, by the government, from the principle of providing free medical care, through reduction of public sector expenditure on medical care and introduction of user fees in public sector medical institutions, that place an unacceptable burden on the poor
- The corporatization and commercialization of medical care, state subsidies to the corporate sector in medical care, and corporate sector health insurance
- Coercive population control and promotion of hazardous contraceptive technology which are directed primarily at the poor and women
- The use of patent regimes to steal our traditional knowledge and to put medical technology and drugs beyond our reach
- Institutionalization of divisive and oppressive forces in society, such as communalism, caste, patriarchy, and the attendant violence, which have destroyed our peace and fragmented our solidarity.

In the light of the above we demand that:

1. The concept of comprehensive primary health care, as envisioned in the Alma Ata Declaration should form the fundamental basis for formulation of all policies related to health care. The trend towards fragmentation of health delivery programmes through conduct of a number of vertical programmes should be reversed. National health programmes be integrated within the Primary Health Care system with decentralized planning, decision-making and implementation with the active participation of the community. Focus be shifted from bio-medical and individual based measures to social, ecological and community based measures.

2. The primary health care institutions including trained village health workers, sub-centers, and the PHCs staffed by doctors and the entire range of community health functionaries including the ICDS workers, be placed under the direct administrative and financial control of the relevant level Panchayati Raj institutions. The overall infrastructure of the primary health care institutions be under the control of Panchayats and Gram Sabhas and provision of free and accessible secondary and tertiary level care be under the control of Zilla Parishads, to be accessed primarily through referrals from PHCs.

   The essential components of primary care should be:
   - Village level health care based on Village Health Workers selected by the community and supported by the Gram Sabha / Panchayat and the Government health services which are given regulatory powers and adequate resource support

- Primary Health Centers and sub-centers with adequate staff and supplies which provides quality curative services at the primary health center level itself with good support from referral linkages
- A comprehensive structure for Primary Health Care in urban areas based on urban PHCs, health posts and Community Health Workers under the control of local self government such as ward committees and municipalities.
- Enhanced content of Primary Health Care to include all measures which can be provided at the PHC level even for less common or non-communicable diseases (e.g. epilepsy, hypertension, arthritis, pre-eclampsia, skin diseases) and integrated relevant epidemiological and preventive measures
- Surveillance centers at block level to monitor the local epidemiological situation and tertiary care with all speciality services, available in every district.

3. A comprehensive medical care programme financed by the government to the extent of at least 5% of our GNP, of which at least half be disbursed to panchayati raj institutions to finance primary level care. This be accompanied by transfer of responsibilities to PRIs to run major parts of such a programme, along with measures to enhance capacities of PRIs to undertake the tasks involved.

4. The policy of gradual privatisation of government medical institutions, through mechanisms such as introduction of user fees even for the poor, allowing private practice by Government Doctors, giving out PHCs on contract, etc. be abandoned forthwith. Failure to provide appropriate medical care to a citizen by public health care institutions be made punishable by law.

5. A comprehensive need-based human-power plan for the health sector be formulated that addresses the requirement for creation of a much larger pool of paramedical functionaries and basic doctors, in place of the present trend towards over-production of personnel trained in super-specialities. Major portions of undergraduate medical education, nursing as well as other paramedical training be imparted in district level medical care institutions, as a necessary complement to training provided in medical/nursing colleges and other training institutions. No more new medical colleges to be opened in the private sector. No commodification of medical education. Steps to eliminate illegal private tuition by teachers in medical colleges. At least a year of compulsory rural posting for undergraduate (medical, nursing and paramedical) education be made mandatory, without which license to practice not be issued. Similarly, three years of rural posting after post graduation be made compulsory.

6. The unbridled and unchecked growth of the commercial private sector be brought to a halt. Strict observance of standard guidelines for medical and surgical intervention and use of diagnostics, standard fee structure, and periodic prescription audit to be made obligatory. Legal and social mechanisms be set up to ensure observance of minimum standards by all private hospitals, nursing/maternity homes and medical laboratories. Prevalent practice of offering commissions for referral to be made punishable by law. For this purpose a body with statutory powers be constituted, which has due representation from peoples organisations and professional organisations.

7. A rational drug policy be formulated that ensures development and growth of a self-reliant industry for production of all essential drugs at affordable prices and of proper quality. The policy should, on a priority basis:

- Ban all irrational and hazardous drugs. Set up effective mechanisms to control the introduction of new drugs and formulations as well as periodic review of currently approved drugs.
- Introduce production quotas & price ceiling for essential drugs
- Promote compulsory use of generic names
- Regulate advertisements, promotion and marketing of all medications based on ethical criteria
- Formulate guidelines for use of old and new vaccines
- Control the activities of the multinational sector and restrict their presence only to areas where they are willing to bring in new technology
- Recommend repeal of the new patent act and bring back mechanisms that prevent creation of monopolies and promote introduction of new drugs at affordable prices
- Promotion of the public sector in production of drugs and medical supplies, moving towards complete self-reliance in these areas.

8. Medical Research priorities be based on morbidity and mortality profile of the country, and details regarding the direction, intent and focus of all research programmes be made entirely transparent. Adequate government funding be provided for such programmes. Ethical guidelines for research involving human subjects be drawn up and implemented after an open public debate. No further experimentation, involving human subjects, be allowed without a proper and legally tenable informed consent and appropriate legal protection. Failure to do so to be punishable by law. All unethical research, especially in the area of contraceptive research, be stopped forthwith. Women (and men) who, without their consent and knowledge, have been subjected to experimentation, especially with hazardous contraceptive technologies to be traced forthwith and appropriately compensated. Exemplary damages to be awarded against the institutions (public and private sector) involved in such anti-people, unethical and illegal practices in the past.

9. All coercive measures including incentives and disincentives for limiting family size be abolished. The right of families and women within families in determining the number of children they want should be recognized. Concurrently, access to safe and affordable contraceptive measures be ensured which provides people, especially women, the ability to make an informed choice. All long-term, invasive, systemic hazardous contraceptive technologies such as the injectables (NET-EN, Depo-Provera, etc.), sub-dermal implants (Norplant) and anti fertility vaccines should be banned from both the public and private sector. Urgent measure be initiated to shift the onus of contraception away from women and ensure at least equal emphasis on men's responsibility for contraception. Facilities for safe abortions be provided right from the primary health center level.

10. Support be provided to traditional healing systems, including local and home-based healing traditions, for systematic research and community based evaluation with a view to developing the knowledge base and use of these systems along with modern medicine as part of a holistic healing perspective.

11. Promotion of transparency and decentralization in the decision making process, related to health care, at all levels as well as adherence to the principle of right to information. Changes in health policies to be made only after mandatory wider scientific public debate.

12. Introduction of ecological and social measures to check resurgence of communicable diseases. Such measures should include:

- Integration of health impact assessment into all development projects
- Decentralized and effective surveillance and compulsory notification of prevalent diseases like malaria, TB by all health care providers, including private practitioners
- Reorientation of measures to check STDs/AIDS through universal sex education, promoting responsible safe sex practices, questioning forced disruption and displacement and the culture of commodification of sex, generating public awareness to remove stigma and universal availability of preventive and curative services, and special attention to empowering women and availability of gender sensitive services in this regard.

13. Facilities for early detection and treatment of non-communicable diseases like diabetes, cancers, heart diseases, etc. to be available to all at appropriate levels of medical care.

14. Women-centered health initiatives that include:

- Awareness generation for social change on issues of gender and health, triple work burden, gender discrimination in upbringing and life conditions within and outside the family; preventive and curative measures to deal with health consequences of women's work and violence against women
- Complete maternity benefits and child care facilities to be provided in all occupations employing women, be they in the organized or unorganized sector
- Special support structures that focus on single, deserted, widowed women and minority women which will include religious, ethnic and women with a different sexual orientation and commercial sex workers; gender sensitive services to deal with all the health problems of women including reproductive health, maternal health, abortion, and infertility
- Vigorous public campaign accompanied by legal and administrative action against sex selective abortions including female feticide, infanticide and sex pre-selection.

15. Child centered health initiatives that include:

- A comprehensive child rights code, adequate budgetary allocation for universalisation of child care services
- An expanded & revitalized ICDS programme. Ensuring adequate support to working women to facilitate child care, especially breast feeding
- Comprehensive measures to prevent child abuse, sexual abuse and child prostitution
- Educational, economic and legal measures to eradicate child labour, accompanied by measures to ensure free and compulsory quality elementary education for all children.

16. Special measures relating to occupational and environmental health which focus on:

- Banning of hazardous technologies in industry and agriculture
- Worker centered monitoring of working conditions with the onus of ensuring a safe and secure workplace on the management
- Reorienting medical services for early detection of occupational disease
- Special measures to reduce the likelihood of accidents and injuries in different settings, such as traffic accidents, industrial accidents, agricultural injuries, etc.

17. The approach to mental health problems should take into account the social structure in India which makes certain sections like women more vulnerable to mental health problems. Mental Health Measures that promote a shift away from a bio-medical model towards a holistic model of mental health. Community support & community based management of mental health problems be promoted. Services for early detection & integrated management of mental health problems be integrated with Primary Health Care and the rights of the mentally ill and the mentally challenged persons to be safe guarded.

18. Measures to promote the health of the elderly by ensuring economic security, opportunities for appropriate employment, sensitive health care facilities and, when necessary, shelter for the elderly. Services that cater to the special needs of people in transit, the homeless, migratory workers and temporary settlement dwellers.

19. Measures to promote the health of physically and mentally disadvantaged by focussing on the abilities rather than deficiencies. Promotion of measures to integrate them in the community with special support rather than segregating them; ensuring equitable opportunities for education, employment and special health care including rehabilitative measures.

20. Effective restriction on industries that promote addictions and an unhealthy lifestyle, like tobacco, alcohol, pan masala etc., starting with an immediate ban on advertising, sponsorship and sale of their products to the young, and provision of services for de-addiction

Constituents of the JAN SWASTHYA ABHIYAN

The Jan Swasthya Abhiyan at the national level is the coalition of the networks of voluntary organizations and peoples movements involved in healthcare delivery and health policy, who made themselves a part of the Peoples Health Assembly campaign in India in the year 2000, and have continued to participate in this process. These national networks have numerous constituent organisations, which implies that a few hundred organizations are involved directly in the national process. Beyond these networks, several hundred other organizations have been involved at state, district and block level activities across the country. The networks that constitute the National Coordination Committee of Jan Swasthya Abhiyan are:

1. All India Peoples Science Network
2. All India Democratic Women's Association
3. All India Drug Action Network
4. Asian Community Health Action Network
5. Bharat Gyan Vigyan Samiti
6. Catholic Health Association of India (CHAI)
7. Christian Medical Association of India (CMAI)
8. Federation of Medical Representatives and Sales Associations of India (FMRAI)
9. Forum for Creche and Child Care Services (FORCES)
10. Joint Women's Programme
11. Medico Friends Circle (MFC)
12. National Alliance of People's Movements (NAPM)
13. National Alliance of Women's Organisations (NAWO)
14. National Federation of Indian Women (NFIW)
15. Ramakrishna Mission
16. Voluntary Health Association of India (VHAI)
17. Association for Indian Development, India (AID-India)
18. Breastfeeding Promotion Network of India (BFPNI) National Resource Groups:
19. Centre for Enquiry into Health and Allied Themes (CEHAT)
20. Centre for Social Medicine and Community Health, Jawaharlal Nehru University
21. Community Health Cell (CHC)

The representatives of all the above organisations constitute the National Coordination Committee of JSA, which is the national decision making body of the coalition. N.H. Antia is the Chairperson and D. Banerjee is the Vice-Chairperson of JSA. National organisers of JSA include B. Ekbal as Convenor, Abhay Shukla, Amit Sengupta, Amitava Guha, Thelma Narayan and T. Sundararaman as Joint convenors, with Vandana Prasad and N.B.Sarojini as National secretariat members.

Jan Swasthya Abhiyan presently has state units or contacts in the following states:
Andhra Pradesh, Assam, Bihar, Chhattisgarh, Delhi, Gujarat, Haryana, Himachal Pradesh, Jharkhand, Karnataka, Kerala, Madhya Pradesh, Maharashtra, Orissa, Rajasthan, Tamil Nadu, Tripura, Uttar Pradesh, West Bengal.

Jan Swasthya Abhiyan contact addresses

B. Ekbal,
National Convenor, JSA
Ph: 0471-2306634(O)
e-mail: ekbal@vsnl.com

Abhay Shukla
National Secretariat, JSA
Ph: 020-25451413 / 25452325
e-mail : cehatpun@vsnl.com

Amit Sen Gupta
Jt. Convenor, JSA
Ph: 011-26862716/ 26524324
e-mail: ctddsf@vsnl.com

Amitava Guha
Jt. Convenor, JSA
Ph: 033-24242862(O)
e-mail:
guhaamitava @hotmail.com

Thelma Narayan
Jt. Convenor, JSA
Ph: 080-5505924 / 5525372
e-mail: sochara@vsnl.com

T. Sundararaman
Jt. Convenor, JSA
Phone: 0771-2236104, 2236175
e-mail:
sundar2@123india.com

Sarojini
Member, National Secretariat
Ph: 011-26968972 / 26850074
e-mail: samasaro@vsnl.com

Vandana Prasad
Member, National Secretariat
Phone: 0120- 2536578
e-mail: chaukhat@yahoo.com

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