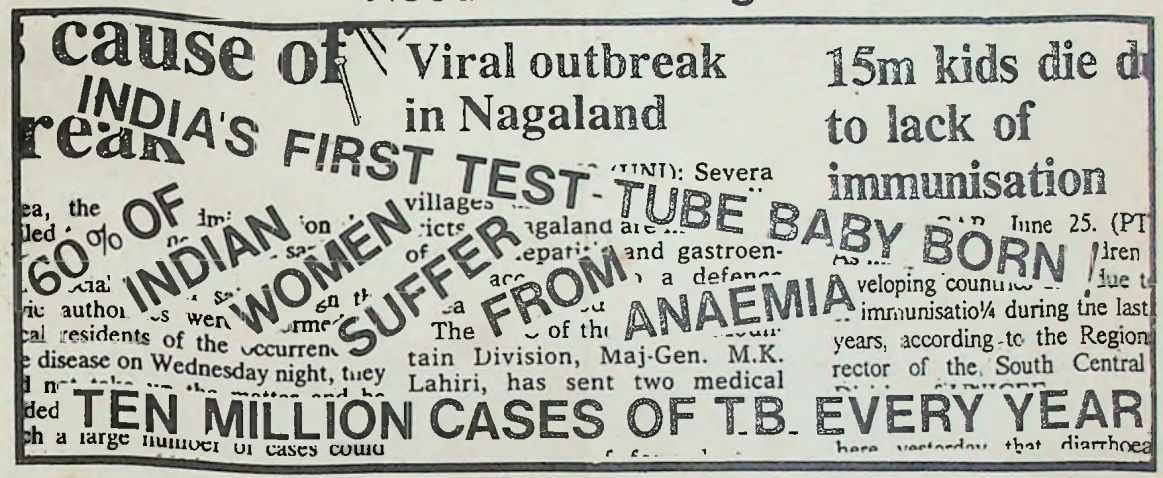
FRCH NEWSLETTER

November-December, 1986 Vol. I No. 1

Need For a Dialogue



TO work towards the goal of Health for all, we need a firm basis in research at all levels—medical and social—and also a continuous dialogue between individuals and groups with similar orientation and goals.

We in the FRCH hope to begin such a dialogue through this newsletter and to inform about our activities as well as about attempts elsewhere.

About us...

The FRCH was established in 1975 as a non-profit voluntary research organisation. We have among us doctors, social workers, economists, sociologists, anthropologists, management professionals and scientists. Some of our major contributions include:-

- A decade-long integrated community health project in Raigad district, western Maharashtra, covering a population of 35,000 in 31 villages. The 'Mandwa Project' as it was called, pioneered the successful initiation of semi-literate village women as primary health workers.
- A key role in the research and preparation of the report 'Health for All: An Alternative Strategy', the outcome of a national committee of health experts. A significant part of the Sixth five year plan for health was based on the recommendations of this report.
- Creating popular knowledge about basic medicine, increasing public awareness and demystifying medicine through extensive articles and reports in magazines and newspapers as well as through direct contacts with consumer groups, women's groups, etc.

Through our research over the last decade, we have collected valuable research material, which is today being utilised by us at the FRCH and by a few others. We have increasingly come to realise that it would be more meaningful for this collection of information to be available to a maximum number of people. Besides, this could also avoid a wasteful duplication of research, as the areas needing research are vast and unlimited. Also, any research, particularly social research, needs a continuous dialogue, a 'feedback'. That precisely is the idea behind this 'NEWSLETTER'.

Through this newsletter, we hope to discuss a wide range of issues in the field of health—health finance, health education, the role of non-government organisations in health planning, primary health care, women and health, child health, nutrition, drugs and therapeutics, environment and government policies towards these issues.

There would also be a section on our library and documentation facilities—an "additions" list, a quick survey of recent literature, abstracts of books, reprints, etc. We also hope to include important announcements and events in the various fields of health.

We visualise this attempt mainly as a form of dialogue between those of us interested in the question of health and like any other dialogue, would depend upon all of you to respond, initiate, criticise and shape this newsletter.

—FRCH collective

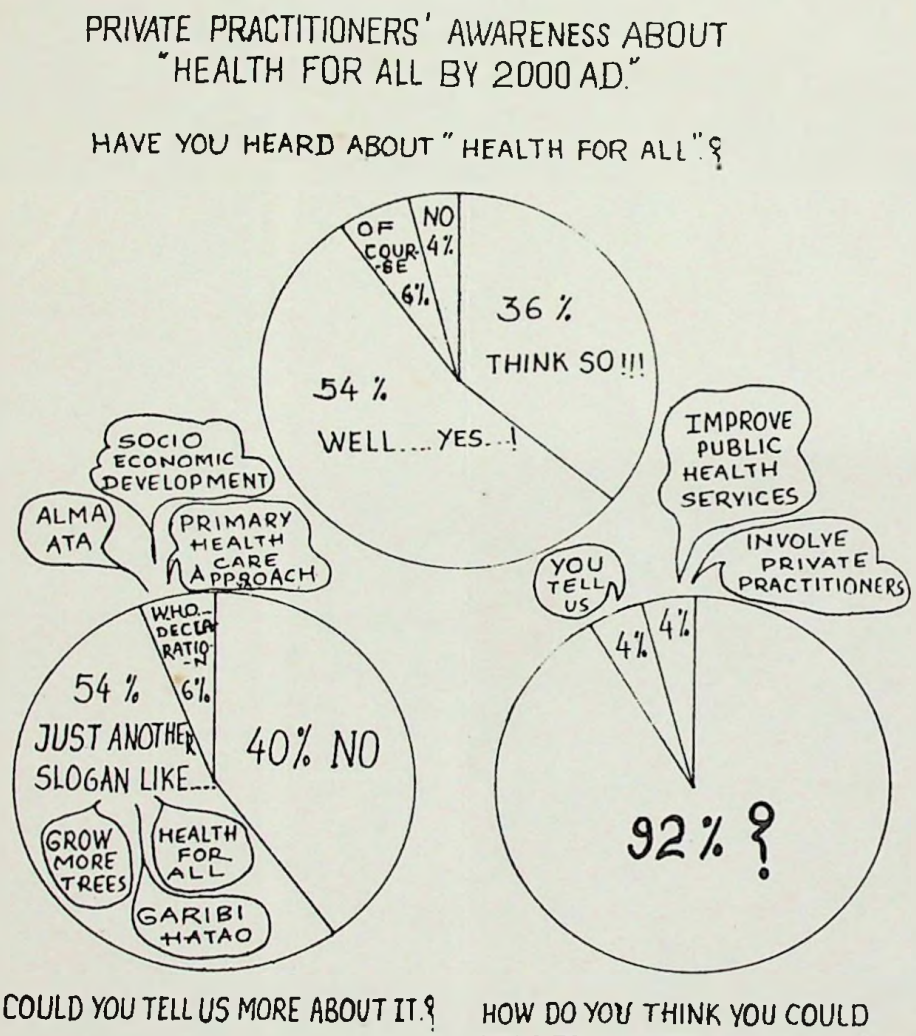
FOR PRIVATE CIRCULATION ONLY



Practice of Medicine

—Dr Mukund Uplekar

How many practising general practitioners know about 'Health for All by 2000 A.D.'? Our quick telephonic survey of 50 doctors (M.B.B.S), chosen randomly in Bombay revealed to us the following:



No Comments

—compiled by Sujata Gothoskar

"The examination of the genitals should command special attention. It must take place in good light in the lithitomy position, with the parts fully exposed. No *false modesty* should be allowed to interfere with a thorough, careful, unhurried examination, as a *man's liberty* may depend on this." (page 481).

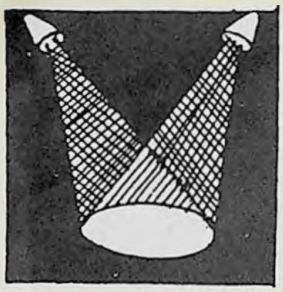
"Vulval and vaginal injuries may be maliciously produced in children by instruments or fingers and a false charge of rape brought against an individual with a view to take revenge or extorting money from him." (page 488).

"Often, the victim's story gives a strong indication of the falsity of a charge. The girl who tells of..... on recovering her senses found her clothes in disorder, and complains that she has been interfered with, is almost certain to be an hysterical one, rather than a victim of rape." (page 489).

"The statement of a woman, who presents no signs of a struggle and who appears to have offered no resistance to her assailant, that she was under the influence of a drug must be accepted with great caution." (page 489).

"In such a case, a close inquiry must be made into the history of the case.... the complainant must be pressed for details and the story may be so clear that drugging may be ruled out." (page 489).

(From Parikh's Textbook of Medical Jurisprudence and Toxicology—for classrooms and courtrooms. 1983 edition. The book is subsidised by the Government of India, through the National Book Trust, India for the benefit of the students.)



Battling Sex Determination

Manisha Gupte

SCIENCE and technology are not neutral in content. That they are determined by the prevailing social structure is clearly demonstrated by the sex determination and sex preselection techniques. Amniocentesis, a technique originally designed to detect foetal defects, but grossly misused to detect foetal sex and thereby for female foeticide has raised considerable storm in India.

Whereas in radical circles abroad, there have been lengthy debates on the ethics of eliminating the handicapped foetus and that the definition of 'normalcy' is infact eugenic in character, in India the main concern has been over the meteoric growth of sex determination clinics all over the country. A mutual vested interest develops within sex determination, on the one hand satisfying the male child preference in individual families, and on the other hand, offering a lucrative business prospect to the medical and para medical professions. Clinics therefore are manned by even untrained practitioners who merely extract the amniotic fluid and then send samples to specialised laboratories for prenatal sexing.

With a highly adverse sex ratio (937 females per 1000 males in India according to the 1981 census), there is imminent danger that atrocities on women, including rape, purdah, forced polyandry and female infanticide will increase. Doyens of population control have also squarely blamed women for reproduction and in the same spirit, the Government of India has pledged itself to the NRR-1 (Net Reproduction Rate Unity) by the year 1990, spelling out in lay person's terms, that only one daughter should replace her mother. We believe that elimination of the victim cannot solve the problem; infact it only legitimises oppression. What is required is a systematic questioning of the problems that surround women and the role of the medical profession *vis a vis* maintaining the status quo. We have to question whether technology can successfully understand and solve non-technological problems.

Vocal protest campaigns, especially in Bombay have been raising pertinent issues for the past five years, the most active campaigners being the Forum Against Sex Determination (SD) and Sex Preselection (SP) techniques and the Doctors against SD and SP techniques. With rising storm, two bills were recently presented, one in the Maharashtra legislative assembly which seeks to ban sex determination procedures and the other in the parliament that seeks to amend the existing Medical Termination of Pregnancies (MTP) Act of 1972.

Mere amendment in the MTP Act cannot strengthen legal action against amniocentesis because it is difficult to legally establish the nexus between sex determination and subsequent female foeticide. Most often the reason for MTP is registered as 'failure of contraception' or 'grave mental injury (sic) to the pregnant women! We also feel that an Act to ban sex determination and sex preselection must be passed at the Centre and not at the state level. Aware that mere banning will not erase the problem, we still feel that it is the minimum that has to be done by the government.

The FRCH is represented on a committee that has been formed by the state government to study the magnitude of the problem that sex determination tests pose and the measures necessary to curtail them. This committee, comprising further of technical, legal and public awareness subcommittees will present its report to the government by mid November 1986.

We see the two Bills and the formation of this committee as a positive step for a number of reasons. Besides stripping sex determination of its respectability and legality, it is heartening to see that a people's campaign has created pressure in government circles. The scope and the scale of debate will undoubtedly widen with these developments. As a next step we need to consolidate various campaigns that revolve around the issue of reproductive technology and to question their role within the context of a woman's right over her own body and also with reference to the ideology and role of medicine.

* "Better 500 now than 5000 later", coax the posters by the Bhandari Hospital in Amritsar. (The 500 indicates the price of the test and abortion and 5,000, the price of dowry, if the girl is allowed to be born (sic !).

* According to a study by R.P. Ravindra, in Dhule, a small district town in northern Maharashtra, with a population of 2.5 lakh, five such clinics have sprouted in just 3 years! Other small towns like Jalgaon and Amravati also have such clinics.

* Sex determination is but one method of getting rid of the female foetus, others being CVB, Ericsson and Japansese method of preselection, B.N. Purandare's method of Rudraksha and Podar Medical College's Ayurvedic nasal drop technique. And many more are threatening to come every minute!

Health Expenditure in India

Ravi Duggal

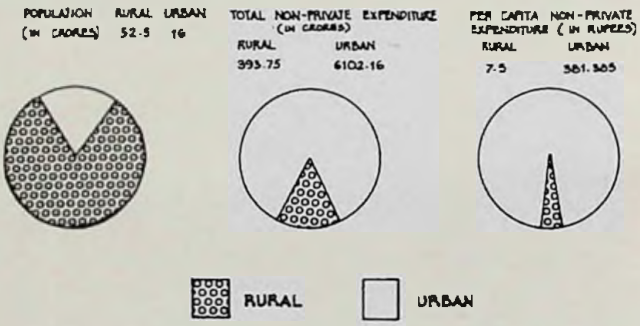
ESTIMATES of health financing in India are surrounded with a great deal of controversy. The fact is that, public financing (at least aggregate figures) is more or less well known and documented. It is also well known that public sector services are utilised by only about 20 per cent of the population; the 80 per cent that remains, is a very grey area of which very little is known. A few widely varying estimates are available.

For instance, the National Sample Survey (28th round, 1973-74) has estimated household health expenditure at Rs. 843 crore or Rs. 14.05 per capita per annum which was 300 per cent over and above a public expenditure of Rs. 280 crore in the same year. Applying this same ratio for the year 1981-82, we get, Rs. 83.58 per capita private health expenditure in addition to the Rs. 27.86 per capita of public health expenditure. This means that for 1981-82 we get a total health expenditure of Rs. 7635.87 crore (Rs. 111.44 per capita) which is 5.14 per cent of Gross Domestic Product (GDP) (Rs. 148678 crore, 1981-82 prices).

But according to the estimates of the CMIE, health expenditure was only 2.1 per cent of the GDP in 1981-82 (0.8 per cent government and 1.3 per cent private) giving us a total expenditure of Rs. 3122.24 crore or Rs 45.57 per capita (Standard of Living, 1984).

Culling data from various sources, a somewhat different picture emerges. In the year 1981-82, the state expenditure on health (excluding family planning) was Rs. 1908.97 crore (Rs. 27.86 per capita—Combined Finance and Revenue Account, quoted in CBHI, 1984). Of this expenditure, an estimated 80 per cent was spent in urban areas (Rs. 95.45 per capita) and only 20 per cent in rural areas (Rs. 7.3 per capita). Besides the state expenditure, in urban areas, municipal corporations and municipalities spent around Rs. 53 per capita (estimated from a 1976-77 based NCAER study of municipal resources, 1980) or totally Rs. 848 crore. And on the basis of Pune zilla parishad and Dhule zilla parishad expenditure accounts, we conclude that zilla parishads on an average spend Rs. 0.20 per capita per annum (rural).

Further, on the basis of data of selected public sector and private sector organisations (see 22nd estimates committee of the Lok Sabha and an ORG study on health financing in India) a weighted average estimate for a 12 crore population (employee families included) works out to Rs. 3726.96 crore or Rs. 310.58 per capita. This figure includes insurance expenditures (ESIS, CGHS, etc.).



What remains unaccounted is private household expenditure. On the basis of two urban studies and one rural study, the FRCH has been able to make a reasonable estimate of private household expenditure.

In urban areas, middle class citizens (all members of the Mumbai Grahak Panchayat), whose family annual incomes ranged between Rs. 10,000 to Rs. 25,000, incurred a health expenditure of Rs. 240 per capita per annum (Rs. 1200 per family or 6.86 per cent of their average income). This excluded reimbursements from employers or other subsidies. In another study of class IV employees (average income Rs. 7000 per annum) of a medical research institute it was found that these families spent Rs. 176 (excluding reimbursements) per capita per annum (Rs. 880 per family or 12.57 per cent of their average income). From this we estimate a figure of Rs. 208 per capita per annum as urban private household expenditure on health care. This entire amount went to the private health sector (private practitioners, private hospitals, diagnostics and drugs).

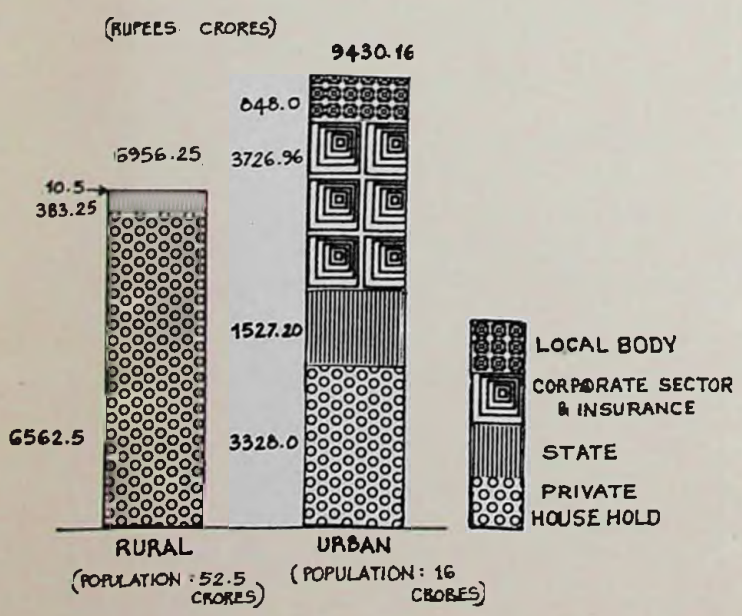
In the rural study conducted in five different districts of Maharashtra we estimated private household expenditure on health care to be Rs. 125 per capita per annum, for the year 1981-82. This is based on one month's actual expenditure in a sample population of 4537.

All this for the country works out to as follows:

Urban (16 crore population)

(a)	State expenditure (1981-82)	= Rs. 1527. 20 crore (Rs. 95.45 per capita)
(b)	Municipal expenditure (estimate for 1983)	= Rs. 848 crore (Rs. 53 per capita)
(c)	Public & private industry including insurance schemes	= Rs. 3726.96 crore (Rs. 310.58 per capita)

WHO BEARS THE BURDEN OF HEALTH FINANCING?
AN ESTIMATE BY FRCH



(for 12 crore population—estimate for 1981-82)

(d) Private household expenditure (1984) = Rs. 3328 crore (Rs. 208 per capita)

Urban Total = **Rs. 9430.16 crore** (Rs. 589.39 per capita)

Rural (52.5 crore population)

(a) State expenditure (1981-82) = Rs. 383.25 crore (Rs. 7.3 per capita)

(b) Z.P. expenditure (1983-84) = Rs. 10.5 crore (Rs. 0.2 per capita)

(c) Private household expenditure (1984) = Rs. 6562.5 crore (Rs. 125 per capita)

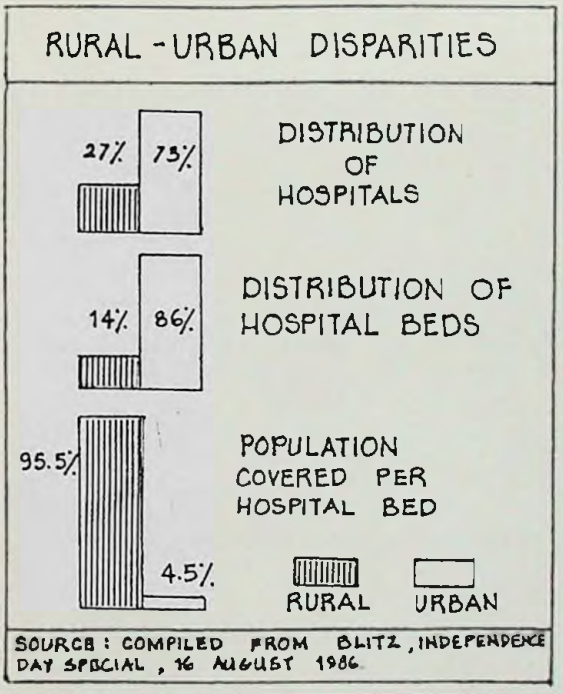
Rural total = **Rs. 6956.25 crore** (Rs. 132.50 per capita)

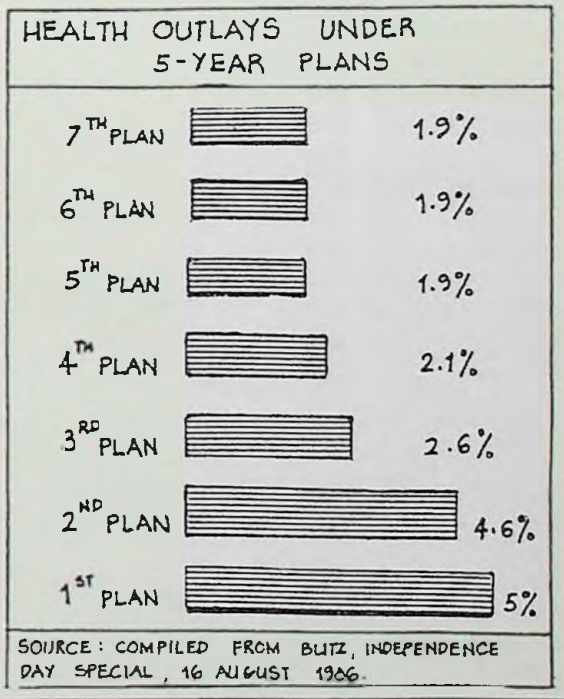
India Total = **Rs. 16386.41 crore** (Rs. 239.22 per capita)

These estimates indicate that health expenditure in India works out to 8.33 per cent of GDP (Rs. 196,745 crore at 1983-84 prices). Of the above estimated health expenditure 60.4 per cent is borne by households as a part of their consumption expenditure (an astonishing 94 per cent in the rural areas and only 35 per cent in the urban areas).

This only adds to the disparity between rural and urban areas. Not only are public facilities and expenditure are highly skewed in favour of urban areas, but the rural population also spends 2.68 times more on health care from its own household resources, as compared to the urban population.

The FRCH will soon be undertaking a large study monitoring health expenditure over a period of one year in a representative district in order to carry out a detailed analysis of private household expenditure. Any advice and help is welcome.





Dear Reader,

We hope you have enjoyed reading our Newsletter and have found it meaningful. Would you like to continue receiving it? Do fill up the following few queries and send them to us.

Do also send in your suggestions, criticisms and any contributions. The format of the newsletter is fairly flexible and will depend on all of you to change it. Eg. There would be half a page or more for letters..., that is, if you send us any.

We hope to receive answers to these queries as fast as possible.

Yours

FRCH COLLECTIVE

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* We would like/would not like to receive the FRCH Newsletter.
* We would like the newsletter to focus on _____
_____
* We would like the newsletter to cover topics like _____
_____
* If there was a contribution to be made towards the newsletter, would you still like to receive it? **Yes/No.**
* Our activities and interests are _____
_____

India and China—A Comparison

Dr. Ramesh Awasthi

INDIA and China together constitute over one-third of the total world population and therefore offer great attraction to the expanding world market. Both these countries have recently opened their flood-gates to free trade economies, the consequences of which will be watched with interest throughout the world.

Having rid themselves of the colonial clutches almost at the same time, the two giant neighbours in Asia were faced with similar challenges, with their backward economies and traditional societies. The two towering men, Gandhi and Mao, who led their peoples' struggles for independence, had an almost identical vision of a new social order—a society free from all forms of exploitation, a decentralised economy and power in the hands of the people. They however differed in the means for achieving the desired goal.

In this context, it is worth comparing the performance of the two countries in the last three decades in the fields of agriculture, health services and infrastructure, living standards and economic equality.

While India has taken the help of massive import of Western technology, huge aid, loans and investment by the multinational corporations, China's achievements have been without any dependance on imported technology, but through the mobilisation of the people in all the aspects of development. In fact, it is clear that India and China have much more to learn from each other's experience than from the West.

TABLE I: AGRICULTURE

	India (1950-51)	China (1950-51)	India (1984)	China (1984)
Cultivated land (mill. hect.)	119	141	143	144
Irrigated land (mill. hect.)	21	20	53	44.5
Total food production (mill. tonnes)	55[a]	164[a]	150	407

[a]: figures for 1952.

With nearly an equal area under cultivation and the same level of irrigation, China produces about 3 times as much of food grains as India does with all its green revolution technology, high yielding varieties and chemical fertilizers.

TABLE II: HEALTH INDICATORS

	India (1950)	China (1950)	India (1981)	China (1981)
Infant mortality rate (Per 000)	134[b]	—	121	35
Child (1-4) death rate (Per 000)	—	—	11[d]	2[d]
Crude birth rate (Per 000)	40[b]	37[b]	35	21
Crude death rate (Per 000)	27[c]	17[c]	13	6.4
Life expectancy at birth (yrs.)	32	—	52	67
Population growth rate (mill)	—	—	2.1[e]	1.5[e]
Total Population	361	542	749[d]	1029[d]

b: figures for 1950-51; c: figures for 1951; d: figures for 1984
e: figures for 1971-81

TABLE III: HEALTH INFRASTRUCTURE

	India (1950)	China (1950)	India (1983)	China (1983)
Per 10,000 population				
No. of physicians	1.65	6.7	3.9	13.4
No. of nursing persons	0.23[f]	0.6[g]	2.1	6
No. of hospital beds	3.	1.5	7	21

f: figures for 1946; g: figures for 1949.

China has far exceeded the targets that we in India have set forth for 2000 A.D. and that too without any access to the latest western technology, which was available to India.

TABLE IV: LIVING STANDARDS

	India (1952)	China (1952)	India (1982)	China (1982)
Literacy percent	16.7[h]	20[h]	36[j]	69[j]
Per capita availablity				
Foodgrains (gms/day)	384	542	450[k]	669[k]
Sugar (kgms./yr)	12.4	0.9	21.4	4.4
Edible Oils (kgms./year)	3.1[i]	2.1[i]	5.8[l]	3.5[l]
Cotton and Synthetic Textiles (meters/year)	11.0	5.7	13.5	10.0

h: figures for 1951; i: figures for 1951-52; j: figures for 1980; k: figures for 1983; l: figures for 1981-82.

Because of the wide gulf between the consumption levels of the rich and the poor, the per capita aggregate figures for India hide more than what they reveal about the true condition of the vast majority of the population. This is not the case with China due to its egalitarian distribution as evident from the data given below.

TABLE V: ECONOMIC DISPARITIES

INDIA (1984)	CHINA (1982)
Only 20.25 per cent of the households have an income between ± 50 per cent of the average household income whereas 60 per cent of the households get less than the average.	89 per cent of the population has an income between ± 50 per cent of the per capita average of 41.7 yuan per year.

In India the top 20 per cent corner 49.4 per cent of the total household income.

Sources of Data:

1. *China: A statistics survey in 1985; State statistical bureau, China, 1985.*
2. *China: A general survey, Foreign language press, Beijing, China, 1981.*
3. *Life in modern China, New world press, Beijing, China, 1984.*
4. *World development report 1986, Oxford university press, 1986.*
5. *Indian agriculture in brief, ministry of agriculture, New Delhi, 1982.*
6. *Health statistics of India, 1984, ministry of health and family welfar, New Delhi, 1984.*



Library and Documentation Cell

FOR any serious and useful research, a good library is an invaluable asset. The in-house library of the FRCH has been developed as a result of the collective efforts of our researchers over the last decade.

The library covers areas like health economics, health education, primary health care technology, environment, ecology, safety and government policies on these issues.

The Breakup of this collection is as follows:

Books	appx. no.	3000
Reprints	appx. no.	3000
Journals		65
Newspapers		8

The library also provides documentation services like classified newspaper clippings, indexing and abstracting of important articles in journals, providing an 'additions' list every month, photocopying on payment etc.

The library is open to any reader. A letter of recommendation from her/his institute/college/university will be appreciated. The library however is meant only for reference work.

The Library timings are as follows:-

9 a.m. — 5. p.m. Monday to Friday.

What is  New?

World health organisation (TRS-722), "Use of essential drugs" — Geneva: WHO, 1985.

World health organisation (TRS-622), "Promotion and development of traditional medicine". — Geneva: WHO, 1978.

Mamdani M. et.al, "Essential drugs and developing countries". — London: EPC publications, 1985.

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Chattopadhyay M., "Condition of labour in Indian agriculture: apparent and real".—Calcutta: K. P. Bagchi and Co., 1985.

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Leontief Wassily and Duchin Faye, "Future impact of automation on workers".—New York: Oxford university press, 1986.

Sahabat Alam Malayasia, "Bhopal tragedy—one year after".—Penang: Sahabat Alam Malayasia: 1986.

Morehouse Ward and Subramaniam A. "Bhopal tragedy".—New York: Council of international public affairs, 1986.

Weir David, "Bhopal syndrome".—Penang: IOCU, 1986.

Books in Brief

Manish Mankad

1. *Harrington, N.M. (Ed.), "Recent advances in occupational Health, number 2",* London: Churchill Livingstone, 1984, pp 283.

   This book, 2nd in this series, is a compendium of articles written by occupational health and safety experts on recent developments in this area. There are 20 articles, divided into 5 sections, viz, work hazards, investigative methods, environmental control, socio-economic aspects and controversy. Each article is rich in references. The book also contains good photographs and charts, as well as an exhaustive and useful index.

2. *Banerji Debabar, "Health and family planning services in India: an epidemiological, socio-cultural and political analysis and perspective",* New Delhi: Lokpaksh, 1985, pp. 464, price Rs. 300/-.

   The main theme of this book is an analytical account of the growth and development of health services in India and a discussion of the factors influencing their availability and accessibility to different sections of the population.

   The content is organised in six parts. I. The broad cultural, social and political analysis of the factors which determine the basic elements of the health services; II. Programmes for communicable diseases; III. Population growth and family planning; IV. Formation of primary health care services; V. Aspects of intersectoral action for health; VI. Perspective for alternative approaches. The epilogue deals with the postulates of the proposed theory. This book also contains 81 tables and 9 charts.

3. *Wilson, M.X. (Ed.), "Directory of foreign funding organisations",* Madras: Commercial laws data corporation, 1986: pp. 88, Price. 120/-.

   This directory is divided into 8 sections. However, there is no order—sequential or alphabetical—in either of these. Neither are there any cross references from areas of interest to the corresponding donors. For the majority of the organisations mentioned, there is neither the full postal address nor the aims or objectives. Even the codification of the entries is unexplained.

   Besides, there are a few more directories which provide information about foreign funding organizations.

PUBLIC MEETING

ON

HEALTH CARE SERVICES IN INDIA:
DO PEOPLE MATTER?

AT

VANMALI HALL, DADAR (W),
OPP. CHHABILDAS HIGH SCHOOL

ON

SUNDAY, 16 NOV. 1986

AT

4.00 P.M.

ORGANISED BY

THE FOUNDATION FOR RESEARCH IN COMMUNITY HEALTH

RESEARCHERS, ACTIVISTS AND PROMINENT PERSONS FROM THE HEALTH FIELD WILL SPEAK AND ANSWER YOUR QUESTIONS.

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* 'The State shall regard the raising of the level of nutrition and the standard of living of its people and the improvement of public health as among its primary duties'.
  —Part IV, Article 47, Constitution of India.
* In 1981, the Study Group of ICSSR and ICMR concluded that there had been little or no improvement in the nutritional status of Indians over the past 30 years.
* In October 1985, in a national seminar, experts revealed that over 200 million people in the country suffer from some degree of malnutrition.

Source: Compiled from Blitz, Independence day special, 16 August, 1986.

* According to the Indian Council of Medical Research, more than 7 million new-born babies in the country, every year, are underweight.
* 30 per cent infants who survive have a low birth weight of less than 2,500 gms.
* Diarrhoea claims the lives of 1.5 million babies each year.
* 40,000 Indian babies go blind every year owing to Vitamin A deficiency.
* Early childhood malnutrition is also the single greatest cause of mental and physical retardation.

Source: Compiled from Blitz, Independence day special, 16 August, 1986.

Edited by Sujata Gothoskar with the co-operation of Manish Mankad and secretarial assistance from Sunita Vichare and Amirbanu Sumnani. Art work by Madhu Rokle and Vineeta. Produced by The Foundation for Research in Community Health, 84-A, R. G. Thadani Marg, Worli, Bombay - 400 018. Printed by Modern Arts and Industries, A-Z Industrial Estate, Lower Parel, Bombay.