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Health for All: For Women's Empowerment or Further Subjugation?

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In our health programmes, women and children are considered to be special target groups. This recognition in our health services came long back—even the Bhore Committee Report (1946), whose recommendations laid initial basis for the development of health care infrastructure in India, identified women and children as vulnerable groups and recommended that they need special care. Since the mid-1960s, they are brought under closer surveillance of the health care services. The minimum needs programme, the family welfare programme and the implementation of 'child survival strategies' have, in last one decade, oriented our health care services strongly towards the care of women and children. From my own experience in the field I have found that the staff at the Primary Health Centres, the chief nerve centres of our public health infrastructure, spend over two third of their total working time in implementing three programmes, viz. Family Welfare, Immunization and Maternal and Child Health (MCH).

Our country is signatory to the Alma Ata Declaration (1978), which set the goal of achieving Health for All (HFA) by 2000 AD. The HFA also heralded inauguration of the Community Health Volunteer Scheme (now called Village Health Guides) for the delivery of Primary Health Care. By March 1987, almost four hundred thousand of VHGs were trained and placed in their respective villages. Between 1974 and 1987, over 5.5 hundred thousand *dais* were given training for conducting safe deliveries in the village. In addition, over 100 thousand Auxiliary Nurse Midwives are already appointed at sub-centres to take care of the health of women and children.

The government funding for the women and children related programmes have also not lagged behind. In the Seventh Five Year Plan, the outlay for the Family Welfare programmes was Rs. 3256.26 crores, while that for the health programmes was Rs. 3392.89 crores. That is, the Family Welfare Programmes were provided with as much funds as those given for all other health programmes combined.

In short, the public health services of our country is heavily oriented to the family welfare programmes which are for all practical purposes directed to women and children. Thus, in the field of health, unlike, say, in the field of education, it is difficult to talk about reorienting health care towards women and children, especially in terms of financial allocation, amount of time spent by the health workers for those programmes, the programme priority in the health management and so on.

This does not mean that orientation to women and children have radically improved the health status, their bargaining power and their capacity to control their own body, in any radical way. In the "Country Rankings of the Status of Women" prepared by the Population Crisis Committee (Population Briefing Paper, No. 20, June 1988), after analysing data on 20 indicators related to health, marriage & children, education, employment and social equality, drawn from 99 countries of the world; India scores only 43.5 points out of total 100 points scale and occupies shameful position in the category of countries having *very poor* status of women (see table).

Sector	Highest Possible Score	India's Score
1. Health	20	10.5
2. Marriage & children	20	12.0
3. Education	20	6.0
4. Employment	20	4.5
5. Social Equality	20	10.5
Total	100	43.5

Needless to say by merely bringing women at the centre of health care programmes they can not be 'empowered' to improve their health status. One has to go beyond numbers and look into the quality of health care programmes, their patriarchal assumptions and the status of women health care workers in our health care services. But before we do it, let us discuss briefly the concept of empowerment.

Need for Conceptual Clarity

Now, it seems, the 'in thing' is the term empowerment. Other day the discussion used to centre around the term called 'participation'. Before that the talk used to be on

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'upliftment', 'integrated development', *'shramdan', 'Sarvodaya'* and so on. Unfortunately our planners and policy makers have a special liking for new terminologies and concepts, which are used more for confusing the issue rather than clarifying it. Inherent to this is the tendency to discover new terminology from the experience of the failure of old ones.

For instance, we started with *'Sarvodaya'* i.e. upliftment of all, and the integrated development. In no time we realised that our economic policies and development programmes have lifted only few but created armies of the poor. Thus from 'uplifting all' we shifted to the 'target group approach'. The target group approach informs us that by helping such specific group of people—for example people below poverty line, women, children etc—more equitable development could be achieved. However, we soon realised that there are programmes, the programme targets are more or less achieved, but their fruits have not reached target groups. Thus came the orientation to what is called community participation, people's participation and so on. Particularly in the field of health, the concept of participation made big impact. Thus, village Panchayats were asked to donate land for having sub-centre or PHC—a way to participate. The ANMs were served with administrative orders to form *Mahila Mandals* and *Mandals* were paid for organising meetings—a way for women to participate in the MCH, the Family Planning and the Immunisation Programmes. This was taken to a ridiculous extent by arguing that if people are made to pay for the health care they would better participate—indeed a backdoor entry to the concept of privatisation.

And yet, the people did not seem to participate so wholeheartedly as expected. Now it is said that education and communication, and perhaps empowerment would motivate people to participate.

This long history of conceptual innovations make me very skeptical to the term 'empowerment'—not because I have anything against women empowering themselves, but because of my genuine fears regarding the fate it very likely would meet in the hands of our policy makers. Further, I have real aversion to the terms which sound very high but convey very little. Perhaps such terms are choosen with the intention of using 'value-free' or "neutral" expression. The terms 'participation' and "empowerment", in absence of any added ideological value, become empty shells. For they sound very elitist—the powerful empowering the powerless. For they sound dependency creating—there is a need for the consent of the powerful in order to empower the powerless. For they do not give autonomy to the masses—our programmes, you participate or you are being empowered to participate in our programmes.

Therefore, unless pro-women and pro-working people or anti-patriarchal and anti-capitalist value base of the process and goal of empowerment is made clear; and a programme for action is devised accordingly, the empowerment would only confuse and help apoliticise women's issues.

As the concept of community participation turned out to be a hollow exercise in absence of independent people's power, the concept of empowerment could turn out to be a pipe dream in the absence of radical change in power relationships. That is, women's empowerment should seriously challenge and change the existing patriarchal gender relations, the capitalist economic relations and other social relations in the society.

In any discussion of social change, normally the focus is on two interrelated but separate fields, viz. the state and the society. In our country, two central assumptions (apart from others) underlying the state power, are patriarchy and capitalism. The patriarchal assumptions become clear when we analyse the constitution, the personal laws and broad state policies. If such state wants to initiate processes in the society which could empower women and challenge societal value system, it has to radically change itself. A process of women's empowerment started by a state which has not transformed itself in such a manner, would not be able to change any power relationship in the society; and at worst, such attempts could become tools to further enslave women.

Therefore, the genuine process of empowering women would be much more independent of the state—in fact the more independent the process, the more empowering it would be and the more pressure it would create on the state to change its policy.

Are Our Health Programmes Pro-Women?

In the field of health we must have a look at the existing so called pro-women programmes. As I narrated earlier, there is an unmistakable orientation towards women and children in the health programmes. But does such orientation make those programmes pro-women and therefore empowering?

It is an undisputed fact that all stratas of society having low health and socio-economic status need special attention in the health care. But, are women given special attention to improve their health status and to enable them to make independent decisions in the field of health?

My contention here is that in the field of health women are targetted to achieve targets and not to improve their health status. First of all, the women oriented programmes are clubbed under the family welfare programmes. Thus, these programmes recognise woman only as a reproductive machine and mother. It is not her care, it is the care of the reproductive machine that is emphasized throughout these programmes. Secondly, the care of this reproductive machine is at two extreme levels-either to control it from reproducing or to make it reproduce the way the dominant patriarchal ideology would like it to reproduce. This statement may sound very provocative, but I urge you to face facts. Under family planning programme, the brunt of all measures is borne by women. The way the methods—from sterilisation to injectables and implants—are sought to be 'promoted' for women have made them real helpless target of the target practitioners. The unethical ways in which new contraceptive technology is tested, for example injectable contraceptive & implants, have made them human guinea pigs. I wonder whether the morbidity load created by such contraceptives far outweigh the benefits of preventing a pregnancy. The other end of this spectrum is the choice of child's sex. All kinds of technologies are allowed to flourish (and attempted laws to check, it have remained on paper) which can lead to foetal sex determination and the abortion of female foetuses.

Thirdly, there is a deliberate neglect to promote male contraceptive practice, sterilisation and the research in that field. It is deliberate because the health care is dominated

(Contd on page 7)

Training of Local Health Educators at Arogya Shikshan Kendra

In January 1989, Arogya Shikshan Kendra (ASK) entered into the second phase of its work selecting educators from the local community and training them to impart health education to the people at large.

Accordingly, through personal contacts in each village as well as by circulating information about the intention to hold a training camp for potential educators, young men and women from all the eighteen village around Malshiras were invited to be trained over a period of fifteen days.

On an average 45 people attended the training camp each day. Of these, 15 were women. The villagers of Malshiras requested the ASK to conduct the sessions using a microphone system. Thus interested villagers would gather at the entrance of the village. which was very close to the venue of the camp and would listen to the training sessions.

The ASK decided to involve as many government doctors in the educators' training as possible. The reasons for this were multifold. Firstly, the decision to call outsiders for the technical training was taken because among the staff at ASK there is no medically trained person. Since Malshiras has low access, doctors from nearby areas would have to be called. Secondly, ASK closely works with the public health service and therefore the co-operation of the latter is very important in the day to day functioning of Arogya Shikshan Kendra. Thirdly, we at ASK also had a good opportunity to listen to health education training by government health professionals. Fourthly, we wanted doctors from the public services because they would not have much of a vested interest in increasing private clientele through these lectures. The only private practitioner whom we invited (he has the reputation of being very sensitive medical practitioner and he has always offered to co-operate in our activities) refused, saying that he felt diffident about teaching and training others.

We were however, quite aware that often the training sessions by government health functionaries may end up being too technical and devoid of social content. Therefore, we also invited some socially conscious and motivated doctors/professionals to deliver some key sessions. Dr Anant Phadke of Medico Friends Circle was called to speak about the concept of Primary Health Care and its importance, Mr Soni from Aurangabad was invited to speak upon indicators of health status and demography. Dr. Arvind Patwardhan of Arogya Dakshata Mandal, Pune was asked to speak on Methods of Health Education (unfortunately he could not come) and Dr. Anil Pilgaonkar from Bombay was requested to teach very basic pharmacology to our educators. Some sessions such as the need and scope of health education, health rights of people and the theory of infection, resistance of disease, menstruation and conception were handled by the staff of ASK.

The technical inputs normally were given in the earlier part of the day. In the afternoons, the trainees would be encouraged to discuss what they had learnt in the morning. This session was normally conducted in the absence of the guest speaker and during this session the social, economic as well as political aspects of various diseases were explained and a debate was generated. The issues like caste and gender discrimination, or the relation of poverty to disease and to subsequent utilisation of proper medical care were brought up in the afternoon sessions.

The technical topics that were covered during the fortnight included illnesses of children, preventive medicine, the structure and functioning of public health services, infections of the lower respiratory tract, identification of high risks during pregnancy, stomach ailments, diarrhoea and diarrhoea management. Tuberculosis, was unfortunately not covered due to the unavailability of the desired guest speaker-however during the continuing education sessions, this topic will be dealt with.

We are aware that the above package does not cover all the aspects that a health education programme should deal with. Therefore, we have decided to hold training/evaluation sessions, once a week for the next two years. In these sessions, not only will new topics be discussed, but also various methods of health education (through workshops on communication methods) would be designed and evaluated.

At ASK we have defined health education in a very wide context, encompassing areas that are not strictly related to medicine or to health care such as maternity benefits on Employment Guarantee Scheme sites or IRDP loan distribution. Our educators thus would have to be very versatile, motivated and astute to be able to impart this kind of knowledge or to generate the demand for such knowledge among the community without actually pushing people into accepting what they have to say. Also, training of education to use culturally acceptable forms of education will be necessary.

At the end of the training camp, personal discussions with the trainees as well as group discussions with them, enabled us to select our educators for health education. We have thus selected seven men (all in their twenties) and four women. We have encouraged only married women to become our educators because they are sure to reside in these villages even after our five year health education programme ends.

Though our first training camp is now over, we have to find out whether people accept our health education and what changes are required in form and content. It is possible that people may reject certain packages entirely or partially and that would certainly be worthwhile training for all of us at ASK.

Contributed by Arogya Shikshan Kendra Team.

With this 12th issue we are entering into IIIrd year. We request our readers to contribute minimum Rs 30/- to cover the printing cost.

Health Professional as an Abuser or Victim

Amar Jesani*

After the November Trial of the doctors who participated in the torture, killing and unethical experiments on human beings in the fascist concentration camps, a need to create an ethical code to regulate doctors' behaviour in relation to torture, prisoners, prison conditions, death penalty etc, was increasingly felt. The momentum gained by the human rights movement within the health professionals ultimately created certain milestones and with them the relevant codes of ethics. In 1975, in Singapore, the International Council of Nurses adopted a resolution on "Role of the Nurse in the care of Detainees and Prisoners", in the same year the World Medical Association adopted its famous Tokyo Declaration, "Guidelines for Medical Doctors concerning torture and other cruel, inhuman or degrading treatment or punishment in relation to detention and imprisonment". The organisations of other health professionals, such as psychiatrists, psychologists etc. also formulated their own codes of ethics in this field. As a consequence, on 18th Dec 1982, the United Nations General Assembly adopted, "Principles of Medical Ethics relevant to the Role of Health Personnel, particularly Physicians, in the Protection of Prisoners and Detainees against torture and other cruel, inhuman or degrading treatment or punishment".

Such international advances in the ethical principles brought into focus two problems - (1) how to implement these codes and to identify the health personnel violating these codes and to punish them (2) how to protect those who uphold these principles from the repression/victimisation by the authorities. Thus, the health professionals must be addressed to as an abuser as well as a victim.

The seminar started on the 19th Jan with the plenary session of all participants. Later on, participants were French Section of the Amnesty International organised an International Seminar, at UNESCO headquarters in Paris from 19th to 21st January 1989. I had an opportunity to participate in this seminar as delegate from India. Over hundred individuals and organisations participated in the seminar.

The seminar started on the 19th Jan with the plenary session of all participants. Lateron, participants were divided into four groups. Each group was given a specific subject for discussion. The group one discussed on, "A Universal and Unequivocal Definition of the Principles of Medical Ethics". This included-i) the breadth and limits of the principles of ethics as defined today, ii) finding a cure for the ambiguities and deficiencies. The Group two discussed on, "Finding an international cure for medicine at risk". It included-i) Developing trans-national interventions, ii) developing and improving existing international mechanisms. The Group three discussed on, "Finding cure for medicine at risk at the national level". It included-i) introduction of the principles of ethics in national codes of law and legislation, ii) independence of Health Professionals, iii) constraining structures. The Group four discussed on, "Ethics, Education and Information". The participants were requested in the plenary session to be specific and concrete in their discussion in the groups so that some recommendations could emerge from the deliberations of the seminar. Accordingly, the discussions in most of the groups were properly channelised. In the group one, controversy came up on the Kuwait declaration of the "Islamic code of Medical Ethics". The protagonists of the Islamic code argued that it concerned with all aspects of Islamic society and the code in itself was a major step forward. However, the critiques felt that the Islamic code was trying to justify certain barbaric punishments like flogging, amputation etc, which are in themselves not Islamic as they go long back in history. The Group one made three recommendations on, 1) doctors should never participate in corporal as well as capital punishment, 2) No authority must compel doctors o force feed hunger strikers, 3) Independence of doctors from public authorities, penal institutions (eg. prison). This applies to both the medical and para-medical personnel and their associations.

The Group Two noted with distress, the participation of doctors in the torture of prisoners in South Africa and the South African Medical Association's (MASA) reluctance to take action against them. This generated heated debate as the secretary general of the World Medical Association opposed a resolution moved by some participants on South Africa. Ultimately, the deadlock was resolved and the participants were asked to sign on the resolution on their own. Majority of them signed it on the last day.

This group also recommended that international inspection visits to detention centers should become universal and such visits should occur any time at all detention centers. The sanction against the torture should be not only legal but also professional should also be looked into. The possibility of setting up a mechanism to make complaints etc,

The Group Three recommended that 1) we need strong local and national representative health workers' organisations to implement codes, 2) a general agreement on codes among all types of health workers should be found so that internal conflict among professionals be minimised, 3) mutual support amongst the organisations, 4) the health professional should not examine the victim of execution, some hours after the execution, 5) autopsy of every death in prison must be carried out. No autopsy of such deaths should be regarded as an indicator of human rights abuse. In addition, this group also evolved seven objective criteria to suspect human rights violation in prisons.

The Group four, to which I belonged, felt that we should identify and resist not only the extreme cases but also the ordinary day to day cases found in the society. The ethics was discussed as a part of human condition and not that of only professional like doctor. Thus it was suggested that everybody should be involved in the fight and not only doctors. The human body should be considered inviolable and nobody should be given the right whether the health personnel, police, a maker of execution chair etc; to violate it. We should not medicalise torture. The group discussed about various ways to inform people, to educated professionals, the training to examine and treat victims and so on. This group also suggested that a committee may be formed to follow up the discus-

Medicine, Science and Humanism

Dr. P. K. Sethi*

Introduction

As our country gears up for its entry into the 21st century, targets have been set. This has set the pace for some hectic activity because targets have to be achieved. WHO, hit upon the reassuring slogan of "Health for All by 2000 A.D."

This has led to more targeted research, more mission-oriented science and less basic research. There is little time to waste and so it is considered prudent to buy technology package from the west. This is the speediest path to modernisation and modernisation for our planners, has become synonymous with westernisation.

Dr Sethi fears about repercussions of such paths to modernisation, on our field of medicine. He recalled Gandhi's considerations on health being a multi-dimensional phenomenon, involving interdependent physical, psychological, social and political aspects.

Health care today is treated like a market commodity to be measured in vital statistics. It lacks a moral and ethical dimension, where Primary Health Centres spreading out across the country like post offices, are believed to distribute in neat package, as though from a huge, newly stocked inventory, "health".

It is a good thing that the rather conservative people who make up the medical profession are becoming dissatisfied with this mechanistic-reductionist approach and have started looking for alternative paradigms. Many exciting ideas are suddenly emerging. All these have strong implications in the field of health and disease, and are enough to suggest a major revolution in biological thinking is in the offing. These new lines falling into place will provide us with a wiser framework to work on.

It is unfortunate though that while modern biologists are realising the inter-dependence of all living things in our biosphere, market forces continue to make use of some of our discarded ideas about microbes. They continue to frighten us merely to be able to push their products for sale. We are bulldozed by the strong advertisement media into believing that without antibiotics in our systems, disinfectants everywhere, deodrants into our noses, mouth, underarms, and even into the telephone, our lives would be in total jeopardy, surrounded on all sides by human seeking germs. We live in a world where microbes seem always trying to get at us but in fact, there is marvellous symbiosis between us and them, examples of which can be found in the animal and plant kingdom. We pay too little attention and respect, to the built-in durability and sheer power of the human organism. Its surest tendency is towards stability and balance. Science has, at long last, been providing legitimacy to this ecological view of health, of the bio-universe as a huge symbiotic organism.

I think, as medical persons, we have not been passing on such information to the public which could augment confidence in their illnesses. It is interesting to note that most of the criticism of modern medicine has emerged from the affluent societies of the west. Probably the most strident criticism has been voiced by Ivan Illich who considers the medical establishment intolerable for three reasons: (a) It produces clinical damage which outweighs its potential benefits, (b) It obscures the political conditions of an over-industrialised society which renders it unhealthy, (c) It takes away the power of the individual to heal himself. Medical audit does also reveal that achievement of modern medicine really be attributed to food, housing, working conditions, neighbourhood cohesions as well as cultural mechanisms which make it possible to keep the population stable. The other fact of modern medicinal habits is to methodologically decompose the patient as a person and convert him into a set of laboratory findings. It is with this shadow of a person reconstructed from the results of laboratory tests the modern hospital is concerned. The practice of medicine, as opposed to its scientific base, is not, and perhaps can never be an exact science.

In the management of disease, there are three different levels of technology in medicine. The first is what is meant by 'supportive therapy i.e, "caring for" and "standing by". The second is the kind of technology best termed 'Halfway technology'. This represents the kinds of things which are done to compensate the effects of certain disease which one is unable to do much about. It is the technology designed to make up for disease, or postpone death. The third kind of technology is so effective that it attracts very little attention, it comes as a result of a genuine understanding of human mechanisms, and when it becomes available, it is relatively inexpensive and easy to deliver. The best examples of immunisation, the treatment of tuberculosis, vitamin deficiency disease, endocrinal disorders with appropriate hormones and therapist, must understand the technique of the scientist and the vision of the humanist. Unbalanced development in either direction continued too long, imperils the enterprise of healing.

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sion and agreements arrived at the seminar.

The group discussion was followed by a plenary on the second day. On the third day, an open plenary session with the participation of concerned individuals from the people, including media wo/men was organised. The final report of each group was presented. In this open meeting the participants from Pakistan, South Africa and Algeria etc. gave testimonials on the human rights violations in their country. The resolution on South Africa and Algeria were kept for the participants for putting their signature. The movers of those resolution were not disappointed as participants queued up to express their solidarity.

On the whole, despite certain limitations in the organisation of the seminar, problems in understanding each others specific problems etc, the seminar was a good experience to meet number of people who are risking their lives and careers to uphold medical ethics.

Report on the International Seminar "Medicines at Risk: the health professional as an abuser or victim", organised by the French section of Amnesty International, at the UNESCO headquarters in Paris -19th - 21st January 1989.

* Excerpts from Dr P K SETHI'S speech at Gandhi Memorial lecture delivered at Raman Research Institute, Bangalore on 2nd Oct 1988. He is Emeritus Professor at SMS Medical College, Jaipur, India.

Privatisation and New Medical Technology—II

Ravi Duggal*

(In 1946 Bhore Committee had recommended a 75 bedded primary unit with 6 doctors, 6 Public Health Nurses, 6 Midwives and 66 other paramedics and non-health supportive staff for a 10,000 to 20,000 population, supported by a 650 bedded secondary unit serving 50,000 population with 140 medical officers of a wide variety of specialities; and the secondary unit will in turn be supported by a 2,500 bedded hospital with 269 doctors serving a 3 million population). (GOI, 1946).

The above description clearly shows that the proliferation of modern medicine through the public sector has been a slow process. It's access is very dispersed. On one hand the private sector, even though of questionable quality, piggy backing on the public sector, has sunk deeper roots and is more easily accessible (physically) to the population-only the access is related to purchasing power. A strong curative medical care system, as had been suggested by the Bhore Committee, has never been considered by the state for the mass of unorganised population in the periphery. However, in major industrial centres and cities the public health care facilities are relatively far better developed and also better utilised. This unequal development clearly substantiates the enclave sector patterns of development of the health sector.

The same holds good for the NMT. The difference between NMT and introduction and development of modern medical services is only academic. In the case of the latter, the public sector did the groundwork of introduction of modern medicine (of course, missionaries had already done it in a few areas much earlier) on a wide scale in the periphery and the private sector followed and established themselves-it is very clearly established that the public health services in the periphery are only an appeasement and not a well grounded and proper health care service that meet the needs of the population. In the case of NMT it is the private sector that is introducing the technology but again with the assistance (tax subsidies, duty exemptions etc.) of the State. The NMT is very expensive to use and thus has restricted access to an insignificantly small proportion of the population. But given the nature of private medical practices in India with its system of kickbacks an overuse/misuse of NMT is taking place and its use proliferating to groups of population who even find preceding medical technologies an extreme financial burden to use. And NMT is the forerunner of corporatisation.

Another important development that has diverted the development of a proper medical care system is the *community health or medicine model* exported to underdeveloped countries by ideologues of imperialism. Talking of community medicine in a class society is absurd because a community in such a society does not exist-'it appears only as a mystifying label placed on poor peasants, urban subproletarians and the families of workers, and the ultimate intention of such community services is not to provide the people with the best possible care but to install a cheap and invisible structure of "concession" and "repression" through medicine' (Breilh, 1981).

Community medicine as a concept has existed for a long time but it was demonstrated in India by the John Hopkins' project at Narangwal, Punjab, in the late sixties under the leadership of Carl Taylor who had earlier been associated with community development projects in India. For capitalism the community medicine type of low cost technology serves as an instrument of redistribution and helps provide health services (albeit of an inferior kind) with a negligible investment (of course by the state) that appears as a special concession and demonstrates the humanitarian concerns of the state (ibid).

It may also be noted that this model of health care has been promoted very actively in India with the collaboration of a host of NGOs. This again shows strong public-private linkage and indicates a unique trend in privatisation because resources used by NGOs are invariably of government, if they are not imperialist.

Thus, the lack of properly organised basic health care/medical care services for the masses, the emergence of NMT that contributes to further inequality and the model of community medicine that reeks of double standards and of course institutionalises an unequal health/medical care service, all are indicative of the vested interests that are served in the process of providing of health care and the development (rather underdevelopment) of the health sector in India.

Conclusions

The NMT has provided a firm footing for the growth of monopoly capital in the health sector. Since historically the health sector has had large scale public investments, monopoly capital can only survive and grow further through the process of privatisation.

In India privatisation has always existed; only presently the forms are changing in keeping with trends the world over.

Privatisation, if furthered in India is going to have drastic consequences. The health sector in India, unlike those in developed countries, is inadequate and underdeveloped and it is highly unequally distributed. If steps are not taken to arrest its growth it will generate further inequality. The developed countries already have well developed health care systems which are either national systems or insurance based or a combination of the two. Privatisation in those countries will not have as serious a consequence as in underdeveloped countries because the former have a well organised workforce which demands health as a right-whether the government provides it or it pays the private sector to provide it. One thing must be made clear that state health expenditures will not decline either in developed or underdeveloped countries because of privatisation-the difference will be that the state will contribute more to the private sector!

Thus a demand for a national health service in India and other underdeveloped countries becomes even more urgent because of privatisation.

Arguments in favour of privatisation stress the importance of cost containment and cost-efficiency in health care delivery. The privatisation lobby promises more efficient services that would not cost the state much; fees payable by the patient are supposed to act as disincentives for 'overutilising' health services. Their arguments are based on the following principles.

— The individual is responsible for his/her own health.
— Access to unlimited free health care is a privilege, and not a right.
— There must be a unitary health care delivery system.
— The individual, rather than the institution should be subsidised.

— User charges should be levied.
— Medical aid schemes should be restructured, over-usage of health services should be curbed, and a more market-oriented health care delivery system should be developed (Critical Health, 1987).

If one looks closely at these arguments and principles it becomes clear that the privatisation lobby is not interested in meeting health care needs but in serving vested interests such as private hospitals and practitioners and the pharmaceutical and the medical equipment industry. Also privatisation will make access to health care dependent on paying capacity of the individual. This would mean if you don't pay, you won't get good health care, but if lucky you may have access to third rate indigent health aid packages or community health care.

For the capitalist state privatisation is a welcome step because health has become highly political and privatisation could help depoliticise it and liberate the state from this responsibility. Thus privatisation will help the state to break it's umbilical connection with the private sector (if not that of its protector) and leave the masses at the mercy of the whims of the market.

All these manoeuvres of capitalism have thus to be arrested and the demand for health as a right and a national health service has to be pushed vigorously as an answer to privatisation for the sake of "health for all"

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This is an extract from the paper "Medical Services, Medical Technology and Privatisation" presented at the Annual Meet of the Medico Friend Circle held from 26-28 January 1989 at Alwaye.

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by men and the patriarchal value system. Also because any strong 'promotion' on men is considered to be politically counter-productive. Fourthly, health education, care of children including immunization, safe deliveries etc. are considered necessary not on their own merits but to control women's fertility. Fifthly, now even female education is being promoted, not because it should be a fundamental right of every human being to get adequate education, but to change the fertility behaviour of women. Same is true for all other kind of intersectoral development in health care—they are all linked to the fertility of women. Sixthly, children are always bracketed with women. There is no mention of father and his responsibilities towards children anywhere.

Further, very little is talked about the gender inequality in the provision of medical and health care. For family welfare related programmes women are targeted, but no special health care is envisaged, say to combat anaemia amongst non-pregnant women or say TB.

In short, targeting women is assumed to be beneficial to women to improve their status. The thrust of the programmes is such that even if they improve few indicators, the women's status as reproductive machine dominated by patriarchal values and as mother will never change. Therefore there is very little indication that current orientation of health care will ever empower women to change their social position.

Oppressed Women within the Health Care

The health care system can empower women only to the extent that it allows the women within it to get empowered. From this angle too the situation appears to be very depressing.

The key health worker to take care of women and children is the Auxiliary Nurse Midwife. She works at the sub-centre and the PHC. Our experience in the field suggest that amongst all paramedies, the ANM is the better functioning and more efficient cadre. Yet their status within the PHC structure is the lowest and their social condition appaling.

As compared to other staff, the ANMs are found to be more meek, vulnerable and pushed around. Their harassment in work as well as sex object is not so uncommon. And they being the chief vehicle for target fulfilment in the family welfare programmes, they are trained to view women and children as potential targets, and thus distorting their relationship with the rest of women.

Conclusion

For initiating any process of empowerment, a radical revision in the orientation of current health care is a must. Fundamental to such revision is:

(1) Reestablishing the concept that health services is for the care of individual and community. It can not be reduced to indicators showing health status. The improvement in indicators should be by-product of the total health care of individual and community.
(2) Family planning (FP) should be delinked from population control. The FP should mean the woman's and man's right to get (and provision of) scientific contraceptive education, contraceptive facility and safe sterilisation facilities. The target practice in the EP should be completely abolished.
(3) Abolition of sex determination practices.
(4) Guarantee of getting free and quality medical care. Enacting health care as the fundamental right of all citizen's.
(5) Child survival is basic to any human society. The child survival is not mere anti-mortality programme but for survival with quality of life. Adequate child care is a right in itself. Linking it to the FP is degrading to children.
(6) Radical improvement in the condition of work and the status of women health workers. They must get adequate power to counter the demands made by the male superiors and colleagues. Needless to say, scanty representation of women in the category of doctors and bureaucrats is not so conducive to such change.

Empowerment is multi-dimensional process. In the ultimate analysis, no social strata can empower itself without consciously recognising its collective strength. Only the power of women emerging independently and in position to patriarchal domination can ensure the real empowerment.

* Amar Jesani is the Senior Research Officer working with FRCH.

(Paper prepared for the Working Group Committee for the Seminar: Empowerment of Women: Multidisciplinary Perspectives)

Book Review

Manish Mankad

1. *Kannapiran Chandra et. al., "Basics of documentation".* - New Delhi: Voluntary Health Association of India, 1988. p.90. Rs 150/-

Library management, especially documentation has remained a neglected area in India. It is true even at academic and research levels where flow of information is substantial. This neglect has led to a cascading effect of duplication of research efforts, development of social models, both by grassroot workers and policymakers without getting the feedback about already existing models which may or may not be useful.

The reason is, the task of managing information is difficult. It is a scientific process requiring basic knowledge of techniques of documentation. The above mentioned book has taken a right step by providing the same in an easy-to-read-understand and apply manner.

Though not comprehensive in nature, it does give a start to a fresher who would like to set up a documentation unit. It can act as a ready reference tool and also as a course material for those who conduct training workshops in the documentation techniques.

The book has been well written and produced. Though its high price could be one of the deterrents for the buyers. Also, a hard bound edition would have been appreciated. I hope in future, VHAI would come up with more detailed document with updated information of appendices, especially see chapters V, VI, VII, barring a few editing errors it deserves a special mention.

2 *Moulik T.K. "Biogas energy in India"* - Ahmedabad : Academic book centre, 1982, p 150, Rs 55/-. In 1975 the Centre for Management of Agriculture, Indian Institute of Management, Ahmedabad conducted a detailed status evaluation survey of biogas programme in Gujarat. This study was followed by a smaller socio economic evaluation of biogas programme on all-India basis.

One of the major recommendations of this study was the promotion of large size community biogas plants in order to reach the poorer sections of the population.

The book is intended for the government and other agencies involved in the department of various biogas programmes in India.

Are many pacemakers implanted unnecessarily?

In 1983 more than 120,000 pacemakers were implanted in the U.S. at a cost of some $ 12,000 each. Designed to maintain steady contractions of the heart muscle in patients whose heartbeat is arrhythmic or exceedingly slow, these small electrical devices are thought to be lifesavers for the millions who have them.

Not necessarily, say investigators at the Albert Einstein Medical Centre in Philadelphia. In the New England Journal of Medicine, Allan M. Greenspan write that less than half (44 per cent) of the pacemakers implanted in Philadelphia in 1983 were clearly justified on medical grounds. 36 per cent were of questionable medical value and 20 per cent had no medical justification whatsoever.

The study was based on an indepth review of the medical charts of 382 Medicare patients who received pacemakers from January to June of 1983 at 30 hospitals in Philadelphia. An eight-member panel of experts, which included four board-certified cardiologists, reviewed the patient data and concluded that one in five pacemarker insertions was unnecessary. That held true for every hospital included in the study, regardless of its size or academic affiliation.

Physicians and hospitals stand to gain sizeable financial rewards from the procedure when in doubt, moreover, physicians are likely to recommend it for fear of malpractice suits.

One of the major concerns is that pacemakers can be psychologically debilitating, especially when they are not really needed. For many older patients they signal the end of a productive life.

Source: Scientific American, March 1988.

New additions at Aaroyga Shikshan Kendra's library at Malshiras

1. Pattullo Polly, "Women at work", - London: Tavistock, 1981, P 191, Rs 110/-.
2. Fishlock Trevor, "India file", - London: John Murray, 1983, p 189.
3. Guha Ranjit, "Selected Subaltern Studies", - New York: Oxford University Press, 1985, p 434.
4. Kakar Sudhir & Ross John, "Tales of love, sex and danger", - Delhi: Oxford University Press, 1986, p 249, Rs 140/- .
5. Kakar Sudhir, "The Inner World: apsycho -analytic study of childhood and society in India", - Delhi: Oxford University Press, 1987, p 241, Rs 65/-.

Reprints

1 Deodhar, N A, 'Health education in the context of traditions, 1975, p 14.
2 Banerjee, D, 'Ten years after the alma ata declaration: Cholera outbreak in Delhi', 1988, p 28.
3 Lancet, 'Evaluating homeopathy', 1988, p 95.
4 Swift, Cameron G, 'Prescribing in old age', Vol 296, 1988, BMJ, p 913-915.
5 Anita N. H, 'Leprosy Control by a People's Program, a new concept in technology transfer, IJHS, 1987.
6 Paul, Charlotle, 'The New Zealand cervical cancer study: could it happen again?, BMJ, Vol 297, 1988, p 533.
7 BMJ, 'Detecting Bacteriuria in primary maternal and child health care programme', Vol 296, 1988.
8 Mooney Gavin, 'What does equity in health mean', 1987, p 1-3.
9 Johnson, Anne M, 'Heterosexual, transmission of human immunodeficiency virus', BMJ, Vol 296, 1988.
10 Whitfield H & Bucks R, 'General practitioners' responsibilities to their patients', BMJ, Vol 29?, 1988.

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Health Expenditure in an Indian District

* Ravi Duggal

(In 1987 a study team from the FRCH, carried out a research assignment for the Indian Council of Medical Research, Government of India. This is a summary of the study which is to be reported back to the respondents. The study aimed at finding out what the common people spent from their own pocket on treatment when they fell ill. The research study was conducted in six villages of Jalgaon district and six wards (including two slums) of Jalgaon city. Jalgaon was selected for this study because in terms of socio economic development it is an average district in the country, so to say a representative mini India. Five hundred and forty three households with a population of 3,459 were included in the study to find out their socio-economic and health status. Information about the economic status, illness in the family, consumption expenditure, utilisation of various health services and expenditure for treatment of illnesses was collected from these households in three different months (one each in Summer, Monsoon and Winter). The reference period of the information for this study is the year 1987.)

How Much Do the Poor and Rich Earn ?

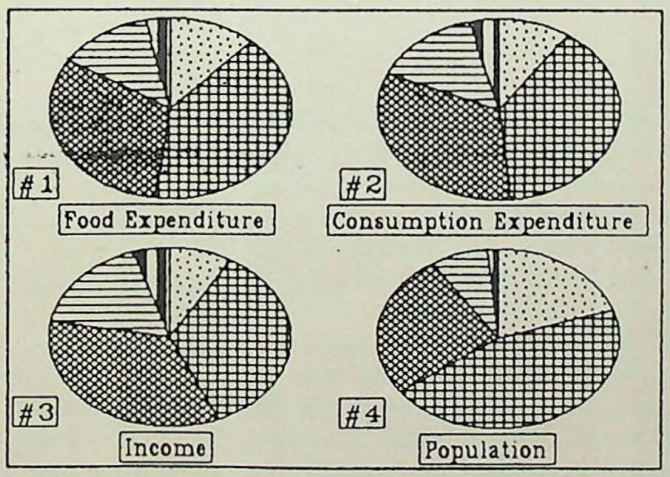
From the 3459 people covered by the research study 2,248 (or 65% combined population of the Poorest and Lower Middle Class) belong to the poor class who live below or at a subsistence level. The average monthly income of this class is Rs. 650 per family. In comparison the richest class which constitutes approximately 1% of the population (45 persons out of 3,459) has an average monthly income of Rs.3,500 per family which is over five times that of the poor class. Further, the top 9% owned 22% of the wealth and the poorest 20% had a share of only 8% of the wealth.

Food and Other Expenditure

With regard to consumption expenditure, similar disparities are seen. The poorest class spends Rs. 68 per person per month on food whereas the richest class spends Rs. 273 per person per month which is four times that of the poorest. The food expenditure of the rich is almost three times the total consumption expenditure of the poor. After spending on food the poorest class has on an average only Rs. 29 per person per month left for other expenditure like clothes, home rent, etc. In contrast the richest class has Rs.309 per person per month i.e. ten times more than the poorest class.

Socio - Economic Profile of Sample Population

#	1	2	3	4	
	12	10	8	20	%
	40	38	35	45	%
	32	33	35	26	%
	13	15	17	8	%
	3	4	5	1	%



Poor Lower Middle Middle Upper Middle Richest

(Distribution of selected socio-economic variables show that their share amongst various classes is disproportionate to the respective class population size. Thus the poorer classes have a very small share of income , food expenditure and consumption expenditure in comparison to their numbers.)

FOR PRIVATE CIRCULATION ONLY

Falling Ill

The study team did not clinically examine the population to find out if they were ill. We interviewed the head of the family or other responsible persons and asked them to report on the illness of their family members.

From the information given to us it is revealed that the rich have reported sickness more often than the poor. This is something unexpected. Given the inadequate living conditions of the poor we expect them to fall ill more often than the rich. The information given to us shows that out of every 100 persons in the rich class 28 are ill in any given month. In contrast among the poorest class for every 100 persons only 13 reported as falling ill in a given month. Why this unexpected difference ?

We live in a market economy. Almost everything that we need has to be bought from the market. Thus we need adequate money to buy what we need. The rich have the money but the poor do not. If we fall ill and we do not have the money to go to a doctor then we try and avoid perceiving illness (but if we must we will borrow), and if we have the money then for even a minor cough and cold we will run to the doctor. Thus if we have the money we can afford to "fall ill"!

This is exactly what has emerged through the findings of our study. The poor, as we have indicated earlier, have very little money left after they have met their requirements for food. Their purchasing power is very limited. Therefore they tend to ignore minor illnesses. On the other hand the rich have lots of money and so on the slightest pretext they can run to the doctor. The poor can only afford to go to the doctor when their capacity to earn a livelihood is affected by the illness. This, then, we feel is the reason why the poor have reported fewer illnesses than the rich.

Going to the Doctor

In our country, for treatment of illnesses we have three types of facilities available. One is the private doctor or hospital, second are public health services such as the government or municipal hospital, dispensary and primary health centre and the third is the traditional practitioner like the vaidya, hakim, mantrik, bhagat and so on.

Government and Municipal hospitals or dispensaries and primary health centres are supposed to provide health services free of charge (except for the small charge for case-paper). In India today there are 33,775 government owned (includes municipal) hospitals, dispensaries and Primary Health Centres. This means that on an average there is one government health unit for every 22,000 population today or one unit in every 97 sq.km. area. This makes us believe that within a distance of between 5 and 10 km. there is a government health facility.

However, this is not true because, most of the government's health care institutions are concentrated in cities and towns. For example out of the 4,215 government hospitals in the country only 822 are in the villages and the remaining 3,393 in large cities and towns. This means that out of every 100 hospitals 81 are in cities and only 19 in villages inspite of the fact that out of every 100 persons in our country 75 live in villages and 25 in cities.

If we now rearrange the distribution of government health facilities we discover that on an average in cities there is one government health facility for every 17,000 population or one in every 5 sq.km. area and in the villages there is one government health facility for every 25,000 population or one in every 140 sq. kms. This means that in cities on an average a government facility is located within walking distance but in villages where most Indians live the average distance of a health facility would be between 10 km. and 15 km. (and in villages we know that transport facilities and roads are very poor). This same dismal situation exists in Jalgaon district.

Our study reveals that city dwellers use government facilities more often than village people. Out of every 100 patients seeking treatment in the city 16 used a government facility whereas in the village it was 10 out of 100. Out of every 100 patients using government facilities 54 are city dwellers.

Further, the experience of people is that even if you are near a government health facility or manage to reach it somehow, there is no guarantee that you will get proper care, unless of course you happen to know an official, businessman, politician or dada. This then clearly shows whose interest the government, that has been elected, serves.

The private doctor and hospital is the biggest provider of health services in India. Today there are about 7 lakh doctors (Allopathic, RMPs, Ayurvedic, Unani etc.) in India out of which about 5.5 lakhs (or 78%) work in the private sector. So it is obvious that taking treatment in the present condition is most often going to cost money and lots of money.

In our study, the people we interviewed in Jalgaon district reported that they go most often to the private doctor even if they have to borrow money. Thus out of every 100 persons falling ill 77 went to the private doctor or hospital, 13 went to the government hospital or health centre, only 2 took treatment from a traditional practitioner, another 2 treated themselves through some home remedy and the remaining 6 did not do anything about the illness. Worse still in the villages, where government health services are most inadequate, 80 out of every 100 persons falling ill go to a private doctor.

Does this mean that the private doctor is good ? Not necessarily. Since the private doctors in our country function in a market economy and have nobody to answer to about what they do, many of them would take advantage of this situation. They will practice very often irrational and dangerous medicine by prescribing unnecessary drugs which are sometimes harmful.

The unnecessary use of injections in Jalgaon district is rampant. Out of every 100 patients treated by private doctors as many as 84 patients received some injections. In the case of public health insitutions the rate of giving injections was lower - for every 100 patients treated 60 received injections. In rational general practice very few injections are given. Many well known doctors say that, leaving aside immunisations, not more than 10 patients out of every 100 should receive injections. To prove that in our study doctors have misused injections we looked at a few common diseases that don't need injections for their treatment and found use of injection to be extremely high. For example out of every 100 patients with diarrhoea 73 patients were given injections (this excludes intravenous drips that are necessary in case of dehydration). Similarly for malaria 88 out of 100 patients given an injection, for influenza 82 out of 100 received an injection and even for simple cough and cold 67 out of 100 patients were given injections.

There are many reasons responsible for such malpractice by doctors at the expense of poor patients. An important reason is the nexus between the drug industry and the doctor -- it has become a partnership in profiteering through the exploitation of poor patients. It is unfortunate that the government allows this inspite of the fact that 85 out of every 100 doctors are trained in government medical colleges with people's money, and from this about three quarters of doctors will set up private practice. We must not forget the fact that today the government spends over Rs. 2 lakhs for the education of each doctor, and this money which is spent by the government is peoples' money. Thus in 1987-88 out of the Rs. 553 lakhs that the Maharashtra Government spent on doctors' education, Rs. 415 lakhs was spent on doctors who end up doing private practice. This Rs. 415 lakhs could have been used to provide good medical services to the people through 7 new 200 bedded district hospitals in Maharashtra that would serve a population of 100 to 150 lakhs !

Cost of Health Care

As pointed out earlier, in our country, in order to treat one's illness most often we go to the private doctor and thus have to pay for the treatment. We have also seen earlier that the poor classes have just enough money to buy a bare minimum of necessities for their simple livelihood.

This is a vicious cycle. The poor don't have money to buy enough food. As a result they lack proper nourishment. Therefore they are more prone to illnesses. But if they fall ill they cannot seek proper care because they don't have enough money. So they avoid reporting their illness. On the other hand the rich have more than adequate nourishment and are at a lesser risk of falling ill but they seek medical care for even minor ailments because they have the resources to purchase health care.

On the one hand, there is an argument that the government spends enough money in providing health care free of charge, especially for the poor. In our study we found that the poor form the largest number of those using government health services. Also, when the utilisation rate among various facilities is compared within the rich and poor classes the poor utilise government facilities more often.

But we have also seen that access to government health care, though supposedly free, is both difficult and often expensive. Firstly, government health facilities are on an average more dispersed (or at a greater distance) than private facilties. Secondly, if one manages to reach the government health institution then the waiting period is very long. This does not suit the poor because if they spend too much time seeking health care they are likely to lose their daily earnings or wages. Thirdly, it is not only the loss of wages that keeps the poor or even the middle classes in Jalgaon from using government facilties but also other important reasons such as :

* impersonal and inefficient services,
* non-availability of adequate and proper drugs and other facilities,
* unsuitable timings,
* private fee charging by government doctors,
* obsession with family planning, especially at Primary Health Centres.

Government Expenditure

At present the government spends about Rs.40 per person per year on health care and family welfare in the country. In terms of today's prices this is definitely not an adequate sum, but even this does not reach the poor. For instance out of this Rs.40 only 30% is given to rural health services (Rs 16 per village person) and the remaining 70% for urban health services (Rs. 111 per city person) when 75% of the popultion resides in rural areas. In addition to this in the cities municipal bodies spend about Rs. 50 per city person per year. This means that total government expenditure is Rs 161 per city person per year and only Rs 16 per village person per year. Thus the government spends 10 times more for health care services for the city dweller as compared to the villager. Even this large amount spent in the cities seems inadequate because even in a city like Jalgaon 73 out of every 100 persons use private health care services. This means what the government spends on health services is a miniscule proportion of the existing demand, which is availed of by the people from the private sector.

Personal Expenditure by the People

We have already seen that the utilisation of government facilities is very small in comparison

(Contd. on page 6)

STATE EXPENDITURE (in million rupees)

YEAR	HEALTH									EDUCATION			DEFENCE	TOTAL GOVT EXPENDITURE			YEAR
	REVENUE ACCOUNT				CAPTIAL ACCOUNT			(Cap+Revl		Rev A/C	Cap A/C	(Cap+Revl		REV A/C	CAP A/C	REV+CAP Total	
	Medical	PHS	Fam.Wel	Total	Medical	PHS	Fam. Wel	Total	Grand Total	Eductn	Eductn	Grand Total	Gross Exp				
1951	148.98	69.36	0.29	218.55	@	2.86	@	2.86	221.41	468.39	@	468.39	1860.16	8136.09	1452.23	9588.32	1951
1956	306.65	198.71	4.31	509.67	@	20.69	@	20.69	530.36	1183.90	@	1183.90	2059.66	11703.74	3255.84	14959.65	1956
1961	559.41	335.93	49.72	945.06	@	87.76	@	87.76	1032.82	2391.95	@	2391.95	3040.88	211001.18	6608.13	27609.31	1961
1966	927.42	623.38	134.26	1685.06	@	108.20	@	108.20	1793.26	4326.13	@	4326.13	9153.37	51385.76	12838.25	64224.01	1966
1971	1316.45	1410.73	617.55	3344.73	@	201.67	@	201.67	3546.40	7791.14	@	7791.14	12753.62	87369.73	15317.98	102687.71	1971
1976	4170.75	2182.09	787.70	7140.54	274.56	502.70	34.70	811.96	7952.50	17990.08	188.42	18178.50	26043.09	174933.02	36627.30	211560.32	1976
1981	8143.38	5657.26	1419.48	15220.12	625.80	1693.69	44.54	2364.03	17584.15	33927.37	470.00	34397.37	40421.48	361277.68	72481.04	433758.72	1981
1988	NA	NA	NA	43466.00	NA	NA	NA	NA	NA	100663.00	NA	NA	88930.00	816690.00	NA	NA	1988

NOTES :

: STATE = Central, State and Union territory Govts.
: Health = Medical + PHS + Famwel
: PHS = Public Health, Sanitation & Water supply ; Famwel = Family Welfare
: REV = Revenue account ; CAP = Capital account
: @ = Capital expenditure on Medical/Family welfare included in PHS capital and in some cases under PWD.
: In the case of education, capital expenditure is presuably under PWD, etc.
: For the year 1988, the figures relate to only revenue expenditure.
: All figures relate to the year specified.
: NA = Not available.

SOURCE :

Combined Finance & Revenue Accounts (CFRA), CAG, 1951-83, GOI.
1951-71 : The data for F.W. - REV A/C have been taken from Family Welfare Yearbook, 1979-80, GOI.
FW expenditure has been deducted from Medical expenditure-REV-A/c.
For 1988 = Report on Currency & Finance, 1987-88, Vol.II, Statistical Statement, RBI.

NOTES :

In the first few years after Independence expenditure by the government on health (2.3%) and education (5%) was very low, whereas the defence expenditure (19.4%) was very high. In the case of health services the Bhore Committee had recommended 15 to 20% of government's expenditure as provision for health care. However this did not happen.

By the end of the First Five Year Plan Education saw a sharp rise in investment by the state and this remained more or less stable at around 8% of government's expenditure until the new Education Policy which provided a boost to raise expenditure considerably reaching a proportion of over 12% of total government expenditure in 1988.

Health expenditure has remained quite static over the years, fluctuating between 3 and 4%. It crossed 5% in 1988 but this itself is quite misleading because health includes Family Planning and Water Supply which together constitute almost half of this expenditure. This recent rise in health expenditure is largely due to substantial increase in investment in family planning and water supply.

Defence expenditure has averaged over 10% of States expenditure. It's declining ratio, especially after 1966 is quite misleading because this expenditure is only expenditure incurred through the defence ministry. Defence production, Science & Technology, espcially space and unclear research and application etc. have seen a phenomenal increase in the late seventies and eighties but are not reflected in this defence expenditure.

RATIO OF STATE HEALTH, EDUCATION AND DEFENCE EXPENDITURES (REVENUE & CAPITAL) .

(Percentage to Total Government Expenditure)

YEAR	HEALTH	EDUCATION	DEFENCE
1951	2.31	4.89	19.40
1956	3.55	7.91	13.77
1961	3.74	8.66	11.01
1966	2.79	6.74	14.25
1971	3.45	7.59	12.42
1976	3.76	8.59	12.31
1981	4.05	7.93	9.32
1988*	5.32	12.33	10.89

* Only Revenue Expenditure.

(This data was Compiled by Sunil Nandraj and Saraswathy Ananthram both researchers at FRCH as a part of the research project "Health Expenditure in India " sponsored by the ICMR)



(Contd. from page 3).
with the private facilties. For the use of private health facilities people have to pay directly from their own pocket. (It is not that government facilties are free. The public, and even the poor, pay for government facilties through taxes such as income tax, sales tax and so on .In fact the tax collected in India is 18% of the income of the people and inspite of this people have to spend vast amounts on social expenditures like health and education).

Before providing information as to how much burden people have to bear to seek health care it is important to note that the expenditure to treat an illness is not only what is paid to the doctor and hospital, purchase of drugs and diagnostic tests. It also includes transport charges to reach a health facility, rituals performed for warding off the illness, the cost of special diet, case-paper charges in government hospitals, or tips paid to the hospital personnel for special treatment or attention and any other expenses because of the illness. Also many poor people lose wages because of their illness and have to borrow money.

In our study in Jalgaon district we found that to treat their illnesses the public spends on an average as much as Rs.183 per person per year. Thus for a family of five persons a household would spend as much as Rs. 915 in a year. Out of this Rs. 183 spent per person in a year, Rs. 154 went towards doctor's fees, medicines, hospital costs and diagnostic tests. That is out of every Rs. 100 spent on health care by a household, Rs. 84 went towards health services. Of the remaining Rs. 7 was spent on transport, Rs. 2 on rituals and another Rs. 7 on bribes, case paper charges and special diet. Besides this Rs. 183 per person per year, for every child born in the family Rs. 209 was spent per birth.

Further, if we look separately at private and government health services utilisation in Jalgaon we find that on an average to use private health services people spend Rs. 208 per person per year and to use government health services they spend Rs. 137 per person per year. The poorest class spends Rs. 69 per person per year if they use private health services and Rs. 20 if they use government health services.

We have already seen that the poor classes have reported fewer illnesses than the rich classes, therefore it is obvious that they spend less than the rich. From the Jalgaon study data we find that the poorest class spend on an average Rs. 51 per person per year on health care compared to Rs. 257 per person of the middle class and Rs. 367 per person per year of the richest class. This means that the richest class spends on an average 7 times more than the poorest class when their rate of falling ill is 2.25 times more than that of the poorest. The lower expenditure of the poorer class is also due to the fact that they use government services more often than the rich as well as because of their higher non-use of services than the rich due to their lack of purchasing power.

The next question is, to whom does the money paid by the people go to ? For every illness in the household the family on an average spends Rs. 102. Most of this goes to the private doctors. Thus out of every Rs. 100 paid by the people to the health services Rs. 88 went for the private health sector and Rs. 9 for the government health serivces. From among those spending on private health care for every Rs.100 spent by them Rs 87 went to the healthcare services, Rs. 6 was spent on transport charges to reach the health facility and the remaining Rs. 7 on other items. From among those who used government health services for every Rs. 100 spent by the people Rs. 81 went to the government health services, Rs. 13 on transport and the remaining Rs. 6 on other items.

This clearly shows that --

* The private health care services divert a major share of the expendable resources of the people.
* The government health services also cost a considerable amount.
* The people using government health services spend twice as much on transport as compared to those using private services,
* and the amount spent by people on treating their illnesses is three and a half times more than and in addition to what the government (including municipal bodies) spends.

Is This Justified?

We believe that health care is the right of the people and as suggested in the directive principles of our constitution it should be provided free of charge to all the people. Yet the majority of the people, including the poor who can ill-afford, have to bear considerable expenses to meet their health care needs.

The services provided by the government are inadequate both in quality and quantity, of difficult access to the majority, and hence forces the poor to incur substantial expenditure on private health care. Given their locational disadvantage villagers use public health services less often than city dwellers and as a consequence the village people have to use private doctors more often, and hence have to spend much more on treatment of their illnesses compared to city people.

The poor report lower rates of falling ill, have greater nonutilisation rates when they fall ill, and use public health facilities more often than the rich. As a consequence they spend far less on health care than the rich but even that amount is a burden for the poor because they have barely enough resources to meet their essentials of livelihood.

Thus what has emerged from these findings is that as long as health care remains a commodity within the context of our present economic conditions, the existing human misery will only be compounded. When people pay so much money as taxes to the government then is the appalling lack of basic health care services, as recommended by the government's own health committee (the Bhore Committee) on the eve of our nation' s independence from colonial rule, justified?

* (Ravi Duggal , is a Researcher at FRCH)

Degraded Breadwinner and Harassed Health Worker

(Socio - economic Background and Problems of the Auxiliary Nurse Midwife)

*Amar Jesani

(The FRCH conducted a study of primary health centres (PHC) in Maharashtra for the state government in 1987-88. The main objectives of the study were to understand the functioning of the PHC and the problems faced by the health workers; using a qualitative/ anthropological method of data collection. In the first phase of the study, three PHCs were selected in consultation with the government. These PHCs were selected in such a way that three regions of Maharashtra were represented, one of them was from the tribal areas, one was upgraded PHC and all of them fully functional with the majority of the staff appointed. Three researchers of the FRCH spent two to three months at each PHC for the data collection. In this phase all ANMs working at the PHC and its sub-centres were interviewed at length using a structured schedule as well as an interview guide. The researchers accompanied many of them in their daily field work. The Staff Nurses (SNs) at the upgraded PHC(or the Rural Hospital) were also similarly interviewed. In the second phase of the study additional 10 PHCs and 2 RHs were selected. The researchers spent 2 to 4 days at each place and interviewed one ANM from these PHCs using the same interview schedule and the guide. This way in two phases of the study, 30 ANMs and 10 SNs (totally 40 of them) were interviewed. Following is a short summary of our findings on the ANMs'/SNs' socio-economic background and problems.)

Unlike the Village Health Guides (VHGs) who are recruited by the Panchayat, the ANMs are recruited at the district level by the Zilla Parishad. Our study revealed that 41% of the ANMs/SNs came from an urban background which is a significantly high percentage and this was due to the factors relating to low education amongst rural women and the social stigma attatched to the work particularly in rural areas. 20% were working away from their home district. This could be due to transfer of the husband or due to personal choice as many prefer to work away from their native village to minimize problems relating to the low status accorded to their work.

Our survey revealed a number of marriage related problems of the ANM/SN. This is partly due to the nature of work, her constant travelling and irregular hours of duty. Many have to stay overnight with their colleagues after the monthly PHC meetings as getting transport back home becomes virtually impossible.

Although ANMs are considered part of the Nursing Council, their status is much lower than the nurses in urban hospitals. This affects their marriage prospects and they are not considered the right choice for males of the so called respectable families. Even male workers in the health services who may be "friendly" with ANMs do not consider the ANM as the right marriage partner. They feel "ANMs do not come from good families" or "Good girls do not take up this work".

Thus the irregular hours and the low status accorded to their work forces them to marry a man who is unemployed, an alcoholic or one who is earning much less. If the husband is politically or economically powerful, very often the ANM is the second wife.

Family Structure :

The ANM is an outsider in the sub-centre village. Thus to take up the job, she has to leave her house. The unmarried woman has to either stay alone or persuade some family members to stay with her. In the case of the married woman, the husband finds it virtually impossible to get a suitable job in the sub-centre village or nearby. Besides, the ANM is regularly transferred. Therefore in a majority of cases there is disruption in their family lives. In 48% of sub-centres ANMs do not stay with any family member, in fact they are actually separated from the family in order to work as an ANM.

It is important that rules, regulations and criteria regarding transfers applicable to male employees should not be applied as rigidly to women employees.

Caste and religion are important indicators of social status. This was observed during our survey of ANMs. The 62% belonged to the upper castes i.e. Maratha, Kunbi or Brahmin. They did not face the problems that ANMs from lower castes faced. The latter included the Scheduled Castes(SC), Neo-buddhists and Christians. Says Christian ANM " I am a Christian but an original SC. The doctors harass me and insult me. I am neither allowed to go inside the house, nor to touch the expectant mother". Other complaints by the SC ANM included, "We are harassed in many ways; the electricity in our quarters is cut of." "The doctors do not like our presence and do not allow us to stay in the quarters even when they are empty". "The upper castes do not take medicine from us". "Nobody rents me a house so I have to live in another village". "I have not done any delivery although I have worked for a year". "Leave aside the illiterate villagers, even my colleagues never ate food with me and ignored me".

It was observed during our stay that casteism is not restricted to villagers and lower level health workers but is prevalent even amongst doctors, DHOs (District Health Officers) and the higher bureaucracy.

The majority of ANMs/SNs came from landless and poor peasants households. 15% of ANMs/SNs had education less than 10th standard. The rest were educated upto the Xth or were college dropouts. However it was observed that graduates do not consider ANMs job worth doing.

It appeared that many of the ANMs had parents who were illiterate while a few had parents who had educational levels less than those of the ANMs. Of the currently married ANMs the majority marry men who have either equivalent or higher education and certainly most marry men who are educated more than

their fathers and mothers.

40% of ANMs had fathers who are cultivators, artisans or landless labourers. 25% of ANMs' fathers had fixed salaried income or were professionals. In the case of husband 50% had occupation equivalent or better than the ANMs/ SNs. However nearly 50% ANMs either did not respond or had husbands who were unemployed. This high percentage could be again attributed to the low status accorded to an ANMs job which leads her to marry such a person who in the events of transfer can give up his occupation because her job is better paying.

While it is difficult to collect data regarding income our survey revealed monthly income of Rs.1244.50 (±270.30) per month. The study took into account only cash incomes. The average income of the ANM/SN appeared to be higher than that of their parents and husbands.

It is often said that economic independence does improve the women's status within her family, but ANM's/SN's position is contradictory. Although she is either the only breadwinner or a very essential earner, her work is not given any respect. In fact it is considered a necessary evil. Family members showed embarrassment in admitting their relatives working as ANM/SN. "We know she does not do good work, goes around with men and people gossip but she earns well and we need her income". The ANM is often scolded by the MO/ADHO (Assistant District Health Officer) and DHO in front of the family members which again does not enhance her status.

Social Image of the ANM .

How does the society view the ANM? This is an important social issue which needs to be understood. Three interrelated aspects contribute to the construction of the social image (or stereotype) of the ANM, these are (1) The ANM as a woman (2) The ANM as a working woman (3) Her providing certain kind of services as a health worker. She has to do family planning work, speak regarding contraceptive methods, motivate villagers to use them. Any woman talking about sex is suspected to be of loose character. Further the fact that she has to go on house visits is not respected. Most people have a stereotype image of the ANM. "We know the kind of women who become ANMs. Do not make us say it openly".

The Male Health Worker's View :

Whilst 28% of male health workers who were also interviewed said that ANMs were respected by the village people since they perform deliveries and look after the health of children, 31% evaded answering the question. This could be due to the fact that they were either indifferent or that they had a negative image of the ANMs which they did not want to discuss with the female interviewer. The remaining 41% , who said the ANM was not respected gave one of the reasons that she deserved it. "How people behaved with you depends on what kind of person you are". If the ANM is not working well and afraid of people complaining about her, she is likely to be exploited by some persons in the village. Such persons included politically powerful people in the Panchayat Samiti and the ZP; they also named the Medical Officer, the ADHO and the DHO. Some stated that "initially people look down on the ANM. But if she works well they protect her". Such health workers felt that ANMs need protection and can get it provided they work well. Some stated that we know that people ill treat them but at the same time "the conduct of women in the health department is not good".

The ANM's View

The ANMs themselves were eager to speak about their image in society. 22% of ANMs said that some respected and some did not. They felt that the tribals "do not behave badly" and "take care" but the "outsiders" were not safe and trustworthy. They also felt that "educated people-treat us well, but the uneducated look down upon us. They think we are bad women. Some felt that, "in some areas people are good and treat us well, but in some parts they are not and we face problems".

12% felt that there had been some improvement compared to the past. "Earlier people thought badly of nurses, now they understand our work and have developed respect for us". 45% said that people had an unfavourable opinion about them "people think we are vagabonds and roam with men". "They consider the ANM to be of bad character". "She teaches the Family Planning Methods so she must be using it.". "Men come to us to learn and make suggestive gestures". "When we talk to men, people gossip that we are having affairs - multiple affairs". Some ANMs who felt that they were not respected stated that it was due to the "character of the individual ANM". They felt "if we behave well we can earn respect. We have to prove that we are not misusing our independence".

Inspite of this background of social image what could be the reasons for a woman to join as ANM? Is it idealism, the zeal to serve or other considerations?

67.5% of the ANMs/SNs started their career with this job. They were informed and encouraged by relatives since the family is dependant on the ANMs income in most cases. It must be pointed out that on the one hand they are unwilling to respect her work, on the other they encourage her to take up the ANM's job.

22.5% admitted that they had used influence either of a friend in the health department or a politician to obtain the job. 90% of the ANMs/SNs took up the job due to economic compulsions.

Whilst 75% said their economic expectations were fulfilled those who said they were not, gave reasons such as "bad living conditions and less pay".

Non-economic reasons for non-fulfillment of expectations included response such as, "we had thought we would become nurses", "We are working in far off areas and people are ignorant. There is tremen-

dous pressure to achieve Family Planning targets".

Transfers:

It was observed that 23.3% of ANMs and 20% of SNs are first posted outside their home district by the government. This could be due to expansion in infrastructure. 10% of the ANMs stated that they wanted to be posted outside due to the bad social image of the ANMs and the desire to be independent and escape from family problems.

56% of ANMs had completed only 3 years or less of their service, 23% had worked for more than 3 years (Upto 10) whereas 20% had worked for more than 10 years. The average length of service was 6.7 years. In the case of SNs the average length of service is 16.4 years and 60% of them had worked for more than 10 years. This was due to the fact that many of them were earlier ANMs and had been promoted at the time of expansion.

In a transferable job those who were not happy tried to use all means to get transferred. Several days spent by the researchers at the DHO's office revealed that there was not a single day when he was not approached for a transfer by at least one health worker either directly or through a politician.

43% and 33% of ANMs working at the sub-centre and PHC respectively were not satisfied with their current postings.

Our study revealed that all the ANMs appointed at the PHC headquarter stay in the PHC. Most do get a quarter to stay at the PHC and that compared to the SNs, the ANMs show a better tendency to stay at the place of appointment.

Work Priorities:

The ANMs were asked to list the three important "duties" they perceived as being most emphasized by the government. It was found that Family Planning (30%) and Immunisation (24%) and Maternal and Child Health (MCH) (20%) topped the list. Of these the first priority is given to FP.

Other duties listed were house to house visits, record keeping and taking slides. Tasks such as TB, leprosy control and health education are given least priority.

Time Allocation:

Again FP tops the list of duties in which the ANM spends the maximum working hours. House to house visits occupied second place. This is not surprising considering the fact that they have to travel around without a vehicle. MCH in terms of time spent overtook immunization. The immunization programme is implemented by the camp method which are organised on fixed days. For the MCH a regular clinic day is kept. Besides the ANM has to make extra visits to the houses of some women. The curative tasks of the ANM are neither given enough time nor are they emphasized. Malaria control, leprosy, TB,curative work and blindness control were listed as the most neglected duties of the ANM in terms of time spent by her.

It emerges from this exercise that the government does not use or orient the ANM as a multipurpose worker. They are essentially oriented as FP or MCH workers or what is called family welfare workers.

Number of Deliveries

One of the functions of ANM is to conduct deliveries. This could be at the homes of the pregnant woman, the sub-centre or at the PHC. Asked on how many deliveries were conducted in a specified calendar year by the sub-centre ANMs, 14.3% did not respond making us suspect that these women had not conducted any delivery in the reference year. Another 14.3 % admitted they had not, 23.8% conducted upto 5 deliveries and 19% upto 10. In the case of PHC ANMs two thirds had conducted more than 20 deliveries.

Family Planning :

Whilst 30% of the ANMs stated they did not have to make any extra efforts to motivate people to accept FP, 70% described various methods used to "get cases". These include extra care of the family, providing transport or food for the case and her relative, paying extra money or providing alcohol. This shows that winning a FP case is of central importance to the ANM as she is terribly scared of not fulfilling her target. The health system does not only approve but encourages and sanctions such personal effort by the ANM to get FP case.

Only 5 out of 30 ANMs felt that the FP work is not an obstacle in doing other duties. 7 of them felt that though it was important to do FP its method of implementation through target orientation should be changed. 14 of them said they were fed up of FP work and believed that its removal would improve their performance in health care programmes. They stated that the FP had distorted their relationship with the community.

Harassment:

Some personal observation by the ANM regarding harassment has been discussed earlier but here we present a few other cases.

One ANM was facing problems with the doctor, and this was affecting her work. "It started because I refused to take money for injections from the Out Patients' Department (OPD) patients. He does not allow me to be in the OPD or in the operation theatre. How can I work like this?""What is new in harassment? All women face things like eve-teasing. Once a young man made passes. I told him I am not the kind who flirts After that he stopped"."The doctor used to invite all the bad people in the village. They used to come and harass us".

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"In some places my younger colleagues were molested. Sometimes doctors help, sometimes they are not bothered. Female workers really need protection".
"The relatives of the FP cases come drunk at night and create all sorts of problems for us"."The incidents of sexual harassment are so high that it is an issue which can not be taken lightly".

Suggestions by the ANM:

The ANMs felt that general measures such as women's education and special health education to school children would automatically improve things.

Regarding the job the ANMs felt that -- 1. The sub-centre should have a building with instruments and drugs. It should have electricity and water. 2. Fixed duties should be laid down by the government. 3. The FP cases should be provided with good food and transport facilities. 4. The ANMs at headquarters should be allowed to visit her family on weekends and also to go to the field . 5. The female attendant and the VHG should be paid regularly. 6. The MO should stay at the PHC full time. 7. A female attendant or a trained dai should be provided to help in deliveries.

In these types of working conditions ANMs felt that they should be given full protection and a watchman should be provided at the PHC. Again the quarters should be separated from the sub-centre and a wall provided in order to keep certain bad elements out.

*(Roopashri Sinha, Rupande Panalal, Prabha Tirmare and Madhu Rokle participated in the data collection. Roopashri Sinha also helped in the preparation and analysis of data. We also thank Malini Sheth for summarising the 124 pages long section in the present form . While thanking them we add the usual disclaimer that only the author is responsible for the views expressed in the above summary.)

Some facts...

If we keep in mind the fact that the greatest need in the country is for basic health services, it would follow that appropriately trained medical staff would consist of ANMs, nurses and Lady Health Visitors. Since fewer people need specialized care such as is given by doctors and specialists it is natural to assume that we need fewer of them.

The number of health personnel available at present in each of these categories is however, directly contradictory to the need. In 1983, we had :

ANM's	80,012
Nurses	1,62,875
Doctors	2,68,712

1981	1 doctor for 2550 people	1 nurse for 4442 pople	1 ANM for 9333 people

The above figures become all the more significant when we consider the well known fact that 70-80% of doctors and 90% of the nurses are in urban areas while 80% of the ANM s work in rural areas.

In 1946, a Committee set up to plan the development of health services in India (Bhore Committee) had recommended that by 1971, the country should aim to have one nurse for every-500 people. According to the recommendations of this Committee, in the next 30-40 years (i.e. by the 1980's) our country should have trained :

Doctors	2,33,650
Nurses	6,.80,000
Midwives	1,12,500

According to the above recommendations and recent WHO (World Health Organisation) estimates, we clearly have a surplus of doctors while there is tremendous shortfall in the number of nurses. Inspite of this, our country continues to train more doctors than nurses

ANM s trained per year	5,572
Nurses trained per year	8,144
Doctors trained per year	12,170

(The above figures are for 1981-82.)

According to a recent estimate it has been pointed out that even if the government wants to achieve its short term targets of providing health coverage for the whole country, it would need to train on an average 15,321 ANM s per year between 1981 and 1985. Considering that the number of ANM s being trained at present is a mere 5,572, it seems impossible to bring about an increase of 275% in such a short period of time.

To sum up, if people in rural areas are to be provided with basic health services, there needs to be a sufficient number of ANM s and doctors working in these areas. From what we have seen, there is a clear shortage of ANM s in the country. On the other hand, there are enough doctors but a majority of them are not working in rural areas.

(Extracts from, 'Taking Sides' - The Choices Before the Health Workers, 1986.-by Dr.C.Sathyamala, Nirmala Sundharam and Nalini Bhanot.)

Public Information ? No - 'Selective Dissemination'

* Ramesh Awasthi and Sarita Pungaliya

Information is power. After armaments and capital, information is fast emerging as a new source of power which may completely reshuffle the traditional power balance in the world. India missed the industrial revolution by atleast a hundred years and we are yet to catch up. On the contrary, conditions in the village indicate that even if urban India somehow manages to gear up itself, the rural India (or 'Bharat' as Sharad Joshi would call it) is not likely to make anywhere near it. However the present political as well as technological leadership in the country seems determined that it should not miss the information revolution. We never bothered ourselves about reaching industrial development to rural India, yet why do we want communication to reach every village?

Since information is power, dissemination of selective information can be used selectively to the advantage of those who are in power and who wield control over the means of communication. Control over media therefore, has become the focus of power struggle in our country today. A widest possible communication network with control over dissemination of information is likely to give the ruling elite greater power over the people. The foundation of communication development in the country was laid by the inauguration of one TV station per day during 1976 just before the '77 elections. It is now being followed up with modernising telephone exchanges and building national computer networks. Indian brains from America have been put on these technology missions for trouble-shooting. Developing a communication industry or solving bottlenecks in indigenous production of communication hardware systems may require technology storm troopers' but using communication for rural development or for eradicating poverty is certainly not a problem that can be solved through technology. Technology can not find shortcuts to socio-economic, cultural and political barriers to communication.

Poverty in rural India is a multi-faceted package. The deprivation is in every facet of life, whether it is in terms of purchasing power, entitlement to resources, social status, access to health care, education or share in political power and information. As a part of our national plan strategy to eradicate poverty, the government intervention in the last 15 years has been in terms of target-group oriented anti-poverty programmes. We, tried to find out how much information people have in villages about these programmes, how they get the information and through which media would they like to receive information.

A quick survey of two villages (Tondal and Dhankawadi) of Purandar taluka in Pune district of Maharashtra was done in August 1989. Both the villages are located about 60 kms south-west of Pune city, have a population of less than 1000 each. While Tondal has four TV Sets, Dhankawadi has only one. Being small gram-panchayats, none of them could raise enough contribution to be entitled to a free TV set (for the panchayat) from the taluka panchayat samiti. 100 adults were interviewed, 50 from each village (covering all castes) and 50 percent of the respondents were women.

By no means can this study of two villages and 100 respondents be called representative of rural Maharashtra or even rural Pune. It is only an indicative study. The main findings are -

a. **Information about Government Schemes** (**IRDP, NREP, EGS, TRYSEM & JRY)

Out of the 100 respondents 48 have no information about any of these programmes. Of the 24, IRDP beneficiaries barely 5 persons knew that IRDP was only for BPL cardholders and that they got loan-subsidy for buying goats, sheep etc. Most respondents knew about EGS and that they get wage labour on EGS works, but none of them had even a vague idea of the most important 'Guarantee' aspect of the EGS. In many other villages too, we found through group discussion that EGS workers were uninformed about their right to demand work under the very concept of EGS. NREP, inspite of being a village level scheme, except one panchayat member none of the respondents knew about it. About the TRYSEM programme, 2 of the 4 beneficiaries and 2 non-beneficiaries had any information.

The much publicised Jawahar Rojgar Yojana drew a blank as to what it was all about. Only 14 of the respondents had heard about it but knew nothing beyond the name.

b. **How People Get the Information:**

Whatever information the people had; where did they get it from? Friends and relatives (24%) and the Gram Sevak (21%) were the main sources of information for only 6-8% of the respondents. It means that word of mouth through personal contact still rules as the most common means of communication.

TV was not considered as a medium for getting useful information. It was seen as a provider of entertainment. 63% of those who watched TV did so for popular serials such as the Ramayan and Mahabharat. Tuning to a transistor-radio for news was still a popular habit. 77% of the radio listeners put it on mainly for the news while 24% often enjoyed film songs. Only 21% of the radio listeners and 13% of the TV viewers stayed on for programmes related to agriculture.

When the people were asked through which media they would like to receive information it became clear that people somehow do not perceive radio and TV as sources of information. None of them opted for radio

Book Review

1. Morgan Myfanwy et.al. '*Sociological approaches to health and medicine*'. - London: Routledge, 1985, p.297.

The sociology of health and medicine is now an established part of the curriculum in a wide range of academic and professional courses.

This book draws attention to the influence of both empirical epidemiology and theoretical sociology on the development of sociology of health and medicine. Although empirical research continues to illuminate many social aspects of medical care, recent work has expanded the whole basis of discipline into new fields beyond pure medical concerns. Similarly within sociological theory the application of Marxist and feminist analysis have provided powerful critique of the dominant approach to health and the organisation of medical practice.

2)Lewis Jane, '*What price Community medicine; the philosphy, practice and politics of public health since 1919*', ,- Sussex: wheatsheaf, 1986 p.172.

This book brings out the recent development in public health since the first world war in Great Britain, and argues that during this century public health has lacked a firm philosophy to guide its practice.

The author considers the problems faced by public health and community medicine in relation to the political difficulties raised by public health's claim to a broad mandate for diagnosis and tackling health problems, and the medical politics involved in determining both the status of public health doctor and the community physician.

New Arrivals : Books

1. Government of India, 'Handbook of industrial statistics: 1987'. - New Delhi, 1987, p.255
2. Government of India, 'Report of the committee on child labour'. - New Delhi, 1987, p.112.
3. Government of India, 'Economic Survey 1987-88'. - New Delhi: Ministry of Finance, 1988, p.55.
4. Sharma P, 'Caraka Samhita'.-Varanasi. Chankambha Orientalia, 1981, 3 Vols., p.544, 879, 414.
5. Kochler G. 'The handbook of homeopathy: the principles and practice'. - Welingborrah : Thorsons publishing group, 1987, p. 240.
6. Glantz S.A., 'Primer of biostatistics'. - New York, McGraw Hill book, 1981, p.379.
7. Sharp Sue, 'Just like a girl": how girls learn to be women.- London : Pengiun books 1976, p.328
8. Greig David N.H., 'Team work in general practice'. London: Castle house, 1988, p.175.

New Additions : REPRINTS

1. Sethi, P.K., 'Medicine, Science and humanism', Current Science, 1988, p. 1-9.
2. Angell, M., 'Euthanasia', NEJM, 1989, p.1348-50.
3. Nichter M., 'Drink boiled water : a cultural analysis', SSM, 1985, p.667-69.
4. Stacey M., 'A Sociologist looks at the GMC', Lancet, 1989, p. 713-14.
5. Berwick D.M., 'Continuous improvement as an ideal in Health Care', NEJM, 1989 p.53-56.
6. Metson D, 'Lessons from an audit of unplanned pregnancies', BMJ, 1988, p.904-906.
7. Ramprasad, 'Immunisation mission boon or curse', Illustrated Weekly of India, 1988, p.50-51.
8. Maguire P. 'Communicate with cancer patients: Handling uncertainity, collusion', BMJ, 1988, p.972-73.

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and only three persons felt that it would be allright if information is given on TV. Obviously, they cannot be sure as to when the desired information will be transmitted and if they can watch TV at that precise moment. Secondly they cannot refer back to radio or TV, if they miss some information or need some clarification. Therefore the most popular choice of medium was one where the animator will be present i.e. through camps (34%) public meetings (30%), and through personal contact (25%). Many of them (25%) wanted public meetings or camps to be supplemented with handbills or pamplets to which they could refer to (later on), whenever required. In one of the villages, the Gram-Sevak belonged to the same village, stayed there and had good rapport with the people, for 34% of the respondents the Gram Sevak was the first choice as a reliable source of information.

Women Respondents

As far as women are concerned, their access to mass media is further curtailed due to socio-cultural reasons. Women also do not attend public meetings or camps unless organised exclusively for them. Moreover women in general did not visualise themselves in the role of decision makers. When they were asked about issues, problems or schemes about which they would like to receive information, they were surprised. Some of them expressed it explicitly saying "ask this question to the menfolk, what are we women to do with all this information?".

Whether it is the women or any other deprived section of society lack of information is a part and parcel of the total deprivation condition that they live in, where there is a cultural conditioning as well, for accepting such a situation. Public information is an important and essential input for any change. But even mass media is incapable of breaking through the social, economic, cultural as well as political barriers or bypassing the strong vested interests that maintain these barriers.

Abbreviations.

IRDP	Integrated Rural Development Programme.
NREP	National Rural Employment Programme.
EGS	Employment Gaurantee Scheme.
TRYSEM	Training Rural Youth for Self-employment.
BPL	Below Poverty Line.

(The study was carried out on behalf of FRCH by Ramesh Awasthi, and Sarita Pungaliya, both researchers at FRCH. The interviews were conducted by - Chandrakant Dudhane and Chhaya Sable .)

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