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Panchayat Raj and Health Care: The Karnataka Experience

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Panchayati Raj was ushered in in Karnataka three years ago with a view to 'take power to the people'. The preamble to the Karnataka Zilla Parishads, Taluk Panchayat Samithis, Mandal Panchayats and Nyaya Panchayats Act 1983 states,

"Whereas it is expedient to provide for the establishment in rural areas of Zilla Parishads, Taluk Panchayat Samitis, Mandal Panchayats and Nyaya Panchayats to assign to them local government and judicial functions and to entrust the execution of certain works and development schemes of the State Five Year Plans to the Zilla Parishads, Taluk Panchayat Samithis, Mandal Panchayats and to provide for the decentralisation of powers and functions under certain enactments to those local bodies for the purpose of promoting the development of democratic institutions and securing a greater measure of participation by the people in the said plans and in local and Governmental affairs and for purposes connected with and incidental thereto..."

1. The expressions in the preamble are significant. The legislation aims at promoting democratic institutions which are expected to function as units of Government in their areas. These institutions are to be entrusted with development schemes under the Five Year Plans; wider opportunities should thereby become available for people's participation in the execution of the Plans, as also in the affairs of local government. There is to be a decentralisation of powers and functions to enable the Panchayat Raj institutions to discharge the responsibilities cast on them.

2. It must be recognised right at the outset that the Karnataka model of Panchayat Raj is not just an administrative innovation aimed at improving the efficiency of programme implementation through administrative decentralisation. Its goal lies much deeper, namely transfer of the function of governance from the state level to the district and lower levels. The Panchayat Raj institutions are visualised as units of government enjoying a great deal of autonomy; at the same time, proximity of the elected representatives in these bodies to the electorate would ensure greater accountability. The process of planning is expected to become more effective as these institutions have intimate knowledge of local resources. While it is the larger political and economic goals which underlie the concept of Panchayat Raj, secondary benefits would also flow in terms of more efficient administration as a consequence of closer supervision and answerability of the local bureaucracy to the elected bodies.

3. In the Panchayat Raj structure in Karnataka, executive power is vested at two levels, the Zilla Parishad at the district level and the Mandal Panchayat which covers a cluster of villages with a population of 8000 to 12000. There are two other levels-at the bottom, there is the Gramsabha which comprises of all the adults in the village and is required to meet twice a year to review the activities of the Mandal Panchayat. In between the Mandal Panchayat and the Zilla Parishad, there is the Taluk Panchayat Samithi, which includes the local MLA and the chairman of all the Mandal Panchayats in the taluk. This body is essentially a coordinating body without any executive power. The Zilla Parishad is designed to be the main agency for planning and development of the district. The personnel of all the development departments (including health and family welfare) at the district level and below are placed under the administrative control of the Zilla Parishad, the official machinery in the district being headed by a senior officer designated as Chief Secretary. In order to enable them to discharge the planning responsibility, each Zilla Parishad is provided with a planning team which includes a statistician, agricultural expert etc. Conceptually, the Mandal Panchayat is a plenary body in its area as, like the Zilla Parishad, it is also directly constituted. In reality, its area of operation is mainly as an implementing agency. It however wields considerable power in regard to the selection of beneficiaries in beneficiary-oriented programmes; it also has a decisive voice in the choice of works to be taken up in the local area and their location. As regards finance, the Panchayat Raj institutions in Karnataka depend almost wholly on grants transferred by the State Government through the annual budget voted by the Legislature. The scale of transfer however is considerable and presently amounts to a little less than a third of the state budget. Thus, there is a genuine attempt to transfer both powers and functions on the one hand, and commensurate resources on the other, to these institutions, to enable them to truly function as units of government in their areas.

4. As stated earlier, the prime responsibility of the developmental activities in the district has now been placed on the Zilla Parishad. This includes public health.

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Section 182 of the Karnataka Panchayat Raj Act lists the various functions of the Zilla Parishad; among these is the management of hospitals and dispensaries, excluding hospitals at the district headquarters and institutions managed by Municipal Corporations or Councils. One of the Standing Committees of the Zilla Parishad is the Health Committee which shall "perform the functions relating to health services, hospitals, water supply, family welfare and other allied matters". The Mandal Panchayat has also some responsibilities in areas of sanitation and health, but these are mostly what one may describes as the traditional municipal functions of maintaining sanitary conditions in the local area. Every Mandal Panchayat is required to constitute an Amenities Committee to "perform functions in respect of education, public health, public works and other functions of the Mandal Panchyayat". It will be seen from the foregoing account that it is the Zilla Parishad which has a crucial role in the health administration of the district. The role of the Mandal is somewhat undefined and indirect. The following figures from Karnataka's annual budget for 1990-91 give an indication in financial terms of the extent of decentralisation in rural health administration.

	Plan	Non-Plan	Total
Total Revenue budget for Medical and Public Health	40.69	174.93	215.62
Deduct provision for Urban Health Services and Medical Education	10.86	95.45	106.31
Total Provision for Rural Health Services	29.83	79.48	109.31
Of which, transfer to ZPs	20.71 (69.4%)	65.63 (82.6%)	86.34 (79.0%)

As the above figures show, almost-four-fifths of the health budget meant for the rural areas are now controlled by the Zilla Parishads.

5. What has been the experience of the working of the Panchayati Raj institution in Karnataka, during the last three years administration? When radical changes are introduced in the politico-administrative system, it is only natural that there is a period of transition during which teething problems are bound to be encountered. This was compounded by the fact that in the initial period when these institutions required to be nurtured, some unforseen adverse factors cropped up. Among these, the most important were the fluid political situation in the State during 1988-89 and the State's acute financial stringency which imposed severe restrictions on the flow of resources to the Panchayat Raj institutions. Besides, the Seventh Five Year Plan had been frozen before the establishment of the new bodies, leaving hardly any free resources to them to launch new initiatives. Given these limitations, the performance of these institutions must, on the whole, be considered encouraging,though three years is too short a period to pronounce final judgment.

6. The working of Zilla Parishads and Mandal Panchayats was reviewed by an Evaluation Committee which submitted its report in 1989. Referring to health administration in the districts, the Committee reported "Likewise, there has been significant progress in the area of medical and public health facilities. Besides a big improvement in the attendance of doctors and other medical personnel, steps have been taken to secure the supply of drugs and medicines more regularly and in accordance with local requirements. Pressure from local governments has also led the State Government to make substantial modifications in its medical stores purchase policy, and ZPs have been able to secure more of their supplies locally more cheaply and promptly". Thus, there is evidence to indicate improvement in two directions-first in mobilising local resources for strengthening the infrastructure for health services and secondly in greater accountability of the doctors and paramedical workers. Also, there appears to have been some improvement in the supply of drugs.

7. One cannot however say with confidence that improvement in the performance of the health service is visible all over the state as a result of Panchayat Raj. As yet, there has been no comprehensive study and one has to rely on case studies or impressions gathered from a cross-section of people. The general picture is that as in other sectors, there have been transitional difficulties in rural health administration. Personnel management has been a problem area; recruitment, transfers and disciplinary control have been a source of friction between the State Government and Zilla Parishads. Inevitably, the initial complement of Panchayat Raj personnel comprises Government officials on deputation. It is only over a period of time that ZPs can build up their own cadres. There are legal limitations to the extent to which administrative control over deputed personnel can be passed on to the borrowing authorities. This is by no means an unsolved problem and it should be possible to evolve working arrangements which demarcate the roles of Government and Panchayat Raj institutions. But, on account of lack of coherence and consistency in thinking in the different segments of Government at the highest level, there has been considerable misunderstanding and confusion which could have been aovided. An ambivalence in governmental attitude towards PR persists even now. Yet another, but anticipated, factor has been the evolution of new relationships between the officials and the elected representatives at different levels. It was only to be expected that it would take sometime for the vast body of officials, specially those operating close to the

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In Karnataka, there has been massive transfer of resources to Panchayati Raj institutions. Last year, Zilla Parishads and Mandal Panchayats spent Rs. 1,500 crore between themselves. Besides, a finance commission to decide devolution of funds, there is in the State high-power committee of experts to examine various circulars issued by the Government to eliminate the possibility of any bureaucratic attempts to fiddle with the Panchayati Raj institutions. Panchayats enjoy the power to levy tax and the entire staff of all development departments of Government has been transferred to Zilla Parishads for all practical purposes barring disciplinary powers which have been kept with respective heads of department. The lists of beneficiaries of anti-poverty programmes are approved by panchayats. the president of Zilla Parishad enjoys the status of a Minister of State and the vice-president that of a deputy Minister.

Source: Indian Express, 11/6/89.

Convergence of Social Development Services Related to Women and Children

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We nave yet to solve the problems of poverty, inequality and improve the quality of life for the majority of our people despite remarkable technological advancement, economic progress, and increased food production in the country. It is not that human resource development and meeting basic needs of the population have not been recognised as important objectives and priority areas for action. On the contrary, there is wide-ranging consensus on meeting these needs, cutting across political affiliations and ideological differences. To tackle the major problems of poor health, malnutrition, high population growth and mass illiteracy, we have national programmes run by the respective ministries with functionaries at different levels, upto the village level. The Integrated Child Development Scheme (ICDS) is one of the more successful programmes in the mother and childcare services. In ICDS areas, malnutrition has been found to be 60 per cent lower than in the non-ICDS areas. Infant Mortality Rate (IMR) is also approximately 20 per cent below the national average in the ICDS areas.

However, we must admit that we have yet to achieve the desired results with regard to universal immunisation, reduction in birth rate, reduction in mortality of infant and children under 5 and maternal mortality. We have yet to eliminate widespread malnutrition, or promote universal literacy, and community self-reliance.

It is now being increasingly recognised that health, nutrition, environmental sanitation and education are such closely interrelated factors that isolated delivery of any single input will not show the desired impact at best, or very often, could even negate the gains made by one intervention due to the absence of other essential inputs. The present structure of social welfare is bureaucratic, and has a top-bottom approach. For instance, for improving the curative health services like the hospital referrals, availability of personnel and drugs is very essential. However, it will not improve the health status of the community if the water and sanitation facilities are very poor, or, if the people do not have economic access to nutrition due to poverty. The nutritional status of children is affected by poverty, the family's physical and economic access to food, intra- household distribution of food, mother's awareness to nutrition, and health, availability of health care services and safe drinking water. When so many interrelated factors affect the nutritional status, no wonder a lone supplementary nutrition programme fails to show positive impact.

Similarly the success of family welfare programmes at the national level, or acceptance of family welfare measures at the individual level, is determined by a number of factors which affect the knowledge, attitude and behaviour of the women. Firstly, the woman's status in the family and society affects her level of autonomy or choice in such matters. Her decision for a terminal method of contraception will be affected by the incidence of infant mortality and morbidity. The health status of the woman and the quality of health care services are also important factors. Added to this is the near absence of social security and public assistance available to the families, in old age. No wonder the couples wish and wait for the birth of a male child to the detriment of the FP programme.

Another major and very serious limitation of the present delivery of social services is the lack of community participation at different levels. There is straight jacket approach, i.e. programmes are designed at the centre/state and are expected to be implemented uniformly in every village irrespective of the local condition. Thus the community needs and priorities at the local are hardly reflected in the programmes. The community members are rarely consulted in the design, implementation and monitoring of the programme meant for them. The functionaries involved in providing these services do not feel accountable to the community. Their concept of accountability is restricted to reporting to the immediate supervisor of the line department and that too mainly related to giving account of the materials used (e.g. medicine or food) or 'targets' fulfilled.

To make these services more responsive to people's needs, a thorough restructuring of the existing service delivery system is needed. But here in this Working Paper we have dwelt on only one crucial aspect, to get the maximum result out of the resources now being spent on these services in a fragmented manner.

In tune with the Plan priorities, for better and more effective delivery of the services related to women and children, the basic approach will be towards:

i) convergence of social sector services related to women and children, and

ii) active community participation in formulating and implementing these programmes.

Needless to say that the effectiveness of the convergence will itself depend on the active community participation involving particularly the local women.

When once the need for convergence has been recognised, it is necessary to spell out some of the specific aspects for *operationalising* the concept. The issues meriting consideration in this context are:

i) Type of services/sectors: The approach has to be a phased one. The minimum package of services that need to be converged are the services of healthcare, nutrition, childcare and creche, pre school and non-formal education, immunization, family welfare, water and sanitation as these are related to the quality of life of women, girls and children. As economic programmes need a totally different, separate experience, attitude and approach it may be undesirable to converge social and economic programmes at this point. However, in future, the economic and social programmes should have active, direct interaction with each other. Income security and social security are interdependent for every household.

ii) Level of services: For the quickest and most direct

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impact, the focal point where the services are needed to be brought together is the village level. The village anganwadi can be the central place, where the women, come together, otherwise the village school could provide a base. And, for facilitating technical assistance and inter-departmental coordination, convergence should take place at the block level. Here, the functionaries involved must work as a team and share their concerns as a group. Above that level, i e, district, state, central-the line departments will have independent funtioning for the specialised skills and services required for administrative efficiency. But they will still need better coordination and interaction.

iii) Resources: The funds for all the programmes of health, nutrition, education, childcare and other services mentioned above, will need to be converged at the Block level and transferred to the implementing agency, in most cases Panchayats, in an untied manner, with broad earmarking. This will enable the community to allocate the resources in the specific areas that the people perceive as priority. Thus pooling together of monetary, human and material resources will provide greater flexibility which can lead to evolving more appropriate programmes for the target groups.

iv) Team of Functionaries: The core team of functionaries will consist of Auxillary Nurse Midwife (ANM). Anganwadi worker, Community Health Worker, Dai and preferably non-formal education workers. These functionaries would have separate and specific functions, but will share common goals and work as a team. For this, intensive training and orientation will be necessary. In addition to the specific training in upgrading the technical tasks they perform, a common training will have to be given to understand the basic aspects of other functionaries' work and in areas of communication, managerial and group work. Here, we need to clarify that we are aiming at convergence through team work and not 'integration', in the sense that we expect one single scheme or functionary to deliver a number of inter-sectoral services. This would overburden the worker, and due to allocation of multiple tasks she will try to fulfil some seemingly important tasks-for which there is greater pressure from the top (e.g. family planning)-at the cost of some other tasks, which may be equally important, (e.g. health education).

v) Administrative Mechanism: The major departure, under the proposed system, will be shifting of authority and power from the bureaucratic system to the local village Panchayat. In operational terms this would mean that the untied funds for these developmental programmes will be transferred to the Panchayats. Budget at the State level should reflect this commitment. The village level functionaries will be recruited by, report to and draw their salaries from the panchayats. This will make the service delivery system much more accountable to the people they are meant to serve. The Panchayats may form a standing committee or a separate women's committee/organisation to work closely with and monitor the delivery of these services including ensuring availability of supplies. Thus major part of monitoring will be taken over by the local people's agency.

vi) Technical Assistance: The professionals and the government departments will need to reorient their skills from supervision and control to providing technical assistance, training and support. The local level functionaries, Panchayats, Village Women's Groups will require simplified, intensive, regular training in technical managerial and communication aspects, to provide the necessary information and knowledge to the community and functionaries.

Support of voluntary agencies in these areas will be crucial. Their experience of working with people and innovative experiences will provide a new momentum and direction and act as facilitators to the community.

vii) Women's Participation: Lack of women's involvement in the programmes meant for them has been a major shortcoming of most of our development programmes. As mentioned earlier, here, the convergence of services will be coupled with the decentralisation of the design and implementation of these programmes through Panchayats. As the bulk of the health problems at the village level are related to women and children, and the functionaries are also women, village women's participation from the beginning is most crucial. Therefore, women's participation has to be built into the local, political and administrative machinery. The proposed body, say, mahila mandal, or women's committee or women's standing committee in the Panchayat, should also be able to function as a "receiving mechanism" for hitherto atomised client groups or individuals, who has no common reference point in reaching out for demanding the services. This will be the surest way of ensuring women's access to these services.

Women will actively associate themselves with the programmes at various levels. As the main users of these services, they will set priorities amongst the different programmes, be involved in information dissemination about these programmes, leading to effective demand generation and utilisation of these services. They will also play a constructive and legitimate role in monitoring and evaluation of their programmes. They will also take care of the needs and problems of the women functionaries.

What is most desirable is that Panchayats entrust the responsibility of implementing the programmes of health care, child care, family welfare, nutrition, literacy, fair price shop, safe drinking water to the committee of the village women with the necessary powers and resources. Community participation will also serve the long-term goal of empowering the community for self reliance.

viii) Monitoring and Evaluation at the National/State Level: A high level autonomous, non-government expert group for on going monitoring and evaluation will have to be formed at the national and state level. The groups will have a two-way information flow with organisations at other levels. The National/State group will not thrust centrally set 'targets' on the block level bodies, but based on realistic and locally set goals, it can provide an aggregate picture and assist in the mobilisation of needed technical, financial and managerial inputs. This expert group will act more as a facilitator, rather than as a controlling body.

Finally, a word of caution is added, that no *one* "model" or "scheme" can be prescribed for the entire country. In fact we need to develop various models. The convergence concept has to be operationalised in the first instance by way of pilot experiments in regions with different background, to start with, say, selecting blocks in

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Convergence of Services and Schemes Relating to Health, Nutrition and Education and Linkages with the Panchayat Raj

A Report

Kavita Bhatia*

Introduction

The Planning Commisssion of India sponsored a two-day meeting on "Convergence of services and schemes relating to Health, Nutrition and Education and Linkages with the Panchayati Raj." This meeting was arranged by FRCH, Pune. There were 24 participants including representatives from the voluntary health sector, researchers, academicians and government officials. The objective of the meeting was to discuss the feasibility and desirability of convergence of government services in the areas of health, nutrition and education, at the village level. The meeting was chaired by Ms. Ela Bhatt.

The discussion is of general interest as it also throws light on many relevant issues in the present health system. The following report summarises the main issues which emerged; the areas of broad agreement; and the areas thrown up requiring further consideration, while contemplating convergence, or any modification in the health system.

1. The Concept of Convergence

1.1 *Why is convergence necessary?*

Convergence of services and schemes relating to health, nutrition and education is necessary because:

(a) the trickle down benefits of the numerous vertical schemes floated by the government are minimal, compared to the huge investments in these schemes.
(b) there is lack of accountability of the schemes and the functionaries, towards the people.
(c) the various functions required at village level have been fragmented into numerous programmes, and then inter-sectoral and intra-sectoral links have been recommended between these different sectors and programmes. This approach has limited benefits for the people at the village level.
(d) there has been a dangerous trend towards over-mystification and overprofessionalisation of those functions which can be handled much more effectively locally by people equipped with some knowledge and having high cultural and social affinity, if they are equipped with appropriate training and support.
(e) One major reason is because health, nutrition, and education are closely related and seeing them as isolated programmes has proved to be a major hindrance to the effectivity of these programmes.
(f) today there are 10 departments and 16 functionaries meant for these functions at various levels. Convergence will ensure that there is no duplication or counter-productive efforts. Large investments in administration and salaries will also be avoided.

One reaction of the group was that convergence of functions at village level would have long term sustenance not only through government employees, but by drawing from indigenous knowledge bases and the traditional functionaries at the villages, who are not government employees. Such functionaries (like dais) should be upgraded and better trained, but without converting them to government employees.

1.2 *Which are the services at the village level where convergence is proposed?*

The functions sought to be converged were in the areas of Health, Integrated Child Development Scheme (ICDS), Nutrition and Education.

1.3 *Convergence defined:*

Convergence was defined as a meaningful combination of activities and functions, to foster coordination and better effectivity, and to avoid duplication. Convergence did not mean that a single functionary would take up all the activities in health, nutrition and education at the village level.

Most of the group felt that the ICDS workers and the health workers should function as a team along with the dai. However, a unilinear design does not take into consideration the informal, indigenous, traditional functionaries in a village. This issue needs to be examined deeply.

Many group members felt that whatever the changes at the village level, impact would be limited if there was no change in the entire system.

2. Convergence of health and nutrition services:

An alternative model for the country's health system, which already exists (ICMR/ICSSR report entitled Health For All: An Alternative Strategy).

This model does propose a convergence of health services. The ICMR/ICSSR model has influenced the health policies of the country, but needless to say, serious limitations in the access and effectivity of the nation's health services, still remain. Some group members felt that convergence, or indeed, any modification of health services, would be effective only if the health services were (i) decentralised and (ii) accountable to the people.

Group members listed out the curative and non-curative health functions which could be handled at village level. A new classification of diseases was proposed, which would enable a clear definition of the work loads of paramedical and medical workers at the village level and above. The Community Health Care System was one of the alternatives proposed at the discussion. (Details in the article "The Community Health Care System" in this issue).

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3. How far can health functions be decentralised?

A village can be largely self supporting for its health functions. This is possible. Field experiences have also shown that village health workers could be very effective provided:

(a) they are backed up by adequate referral and curative services. The credibility of this system would rely on the existence of an effective referral hospital whose doctors would also give technical guidance and support at the village level.

(b) this curative centre should not be a second or third grade service, and a minimum level of quality should be ensured.

(c) there needs to be a liberalization of present controls on the para-medical functionaries. An ANM today can insert a loop but cannot give an intravenous injection.

(e) transportation and communication facilities are essential.

(f) adequate resources should be available at the village level.

(g) adequate payment of village health workers.

(h) none of the health functionaries should be transferred.

One comment was that while there is no doubt about the effectivity of village workers, no categorical statement on their potential promise can be made, since this would be dependent on educational, social and cultural factors also.

4. Can the system be made accountable?

The Panchayat and the health system.

While it is undisputed that there should be accountability of the health system to the people, there was concern about the body which would be the representative of the people.

A member summed up the various suggestions of representative bodies at the village level to which the health system could be accountable:

(a) the Gram Panchayat (b) the Gram Panchayat with outside support (NGO/expert/doctors); (c) the Gram Sabha; (d) the Gram Panchayat with representation of the health worker plus NGOs (e) the Gram Panchayat with a village health committee (having area representative); (f) village Mahila Mandals.

Representation of woman at this level was a major concern, since most of the health and nutrition functions are to do with women and children. It was felt that having representative Panchayat members or women functionaries or even 30% reservation, was not enough. Two suggestions were:

(a) A statutory all women Panchayat; (b) A village committee which will be jointly responsible with the Panchayat, for the health system, to consist only of women.

Can the Panchayat adequately handle the planning and supervision of the system? It was felt that they could, with adequate training and support. They could also seek guidance from outsiders (NGO/experts/doctors).

Much debate was generated on who would control the proposed system: would there be a dual control, where financial and administrative control would be vested with Panchayat, and technical guidance with the system?

5. Training and Supervision/Support For Convergence

Training of workers at the village level, to take on their changed functions was an important aspect. There was broad agreement on the following aspects:

(a) Initially NGOs should take over the training because these are culturally and socially more affiliated to the people, hence their training package would be more relevant to the needs of the people. (b) The ANM, CHV, Dai and Anganwadi workers should be trained at one common centre, under one system, with some common training sessions. Separate sessions would also be required because these are functionaries working at different levels. (c) This training centre should be at the PHC or nearer, not at district level. (d) Training should be given to both new recruits as well as existing functionaries. (e) Continuing education and common refresher courses should be part of training for all levels. (f) All health education and information inputs at all levels, should be common so that uniform message reach the people.

If modifications in the health services, are aimed towards better accessibility and effectivity, convergence is just one of the aspects to be considered. Some other important aspects to be considered in any alternative system were also discussed. These were:

6. Funding and devolution of funds for an alterative system.

The group felt that (a) Cost is not a relevant factor in any modifications for the rural health services, because today much of the resources are going only to urban public health expenditure. (b) Rational use of drugs, no use of high technology and a lower proportion of expenditure on salaries, should be an integral part of the alternative system, and would lead to conservation of funds. (c) Optimum usage of existing funds, while creating a pressure lobby for more funds was proposed. (d) Resource collection and dissemination should both be at block/district level to ensure equatable distribution to rural areas. This may mean a change in the tax structure.

7. How much flexibility should be with the village to decide health expenditure?

(a) If firm guidelines are handed along with funds to the village, then the village's self-reliance will be non-existent. (b) Perhaps some portion of funds should be earmarked from the top, and the rest handed over to the village's discretio. All developmental funds not only health should be handed over with only a fixed portion earmarked for specific expenditure. (c) One suggestion was that the per capita expenditure should be given to each Panchayat, to spend as per its own discretion. (d) It was felt that the district level devaluation from ZP, is not the correct body for dissemination of funds, nor can the system be considered decentralised at ZP level, because the block level

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The Concept of Panchayat Raj in Health Services
Reactions from the Field

Rani Bang and Abhay Bang *

Pandit Jawaharlal Nehru in late fifties once expressed his regret to Acharya Vinoba Bhave that even though various development and welfare schemes were planned by his Government and the Planning Commission, people did not utilize these schemes. Vinoba's reply was very typical of his way of thinking. He said that he had become optimistic about the future of India after listening to that problem. It proved that people did not want to be treated like cattle. People wanted to decide their own needs and plan for it. What is the relevance of this interpretation today? In this paper we shall discuss **the need, potential and problems of decentralisation in health services.**

Public health services in India have experienced serious problems in delivering goods. Programmes like malaria control, implemented vertically through military style operations, initially produced good results. But other health programmes which ultimately depend upon human interaction between the health provider—who may be a doctor, nurse or community health volunteer—and the recipient need a different approach. Unfortunately the truth that service to people cannot be governed by the priorities of the health department is usually lost sight in the large scale functioning of the public health services. The results are not difficult to predict. The experience of two programmes should suffice. When the onus of planning ones own family was taken over from people by the health department, a massive programme of family planning was built up. In the words of Dr. Harcharan Singh, Health Advisor to the Planning Commission. "Between 1977 to 1987, the expenditure on family planning programme more than doubled, the claims of couple protection rate went up from 22% to 37% but birth rate remained static at 33 per cent per 1000 population." People are giving signals that they have their independent thinking and choices which can not be bulldozed.

Taking inspiration from the 'Barefoot Doctor' of China and successful demonstration of this concept in many small scale voluntary projects in India, a centrally sponsored Community Health Volunteer (CHV) scheme was launched twelve years ago. Several evaluations of the scheme have been pessimistic and cancellation of this scheme has been on the cards. States like Gujarat have already discarded the scheme. A question can be asked as to 'who has failed?' Has the very concept of village health worker failed or the health department has failed in properly implementing a very good and proven idea? If the later is true then who should be changed?

The lesson to be learnt from these two experiences is that public health services are unable to be sensitive to people's priorities and feelings and hence have failed in successfully implementing many public health programmes. The health services tend to turn every health programme in to a vertical campaign like activity. The Health department probably has its own compulsions. However, in this style of operation, people have no say or role except to subject themselves to the programmes. And people have refused to accept this. There is no alternative but to change the decision making style of the health programmes and to give people a more assertive role as well as responsibility.

Even within the public health services, there are serious problems due to this centralised style of decision making and top down approach. The District hospital at Gadchiroli once received 10,000 bottles of Lomodex, from Directorate of Health Service at Bombay when its annual requirement was only 50 bottles. The entire annual drug budget of the hospital was exhausted by this one irrelevant item though the hospital did not have medicines against malaria-a disease of high incidence in the district. Yet the Civil Surgeon did not dare to send back excess Lomodex or inform about it to Directorate lest he should be reprimanded for such arrogance. Gadchiroli district had not a single reported case of Guineaworm. Yet ali the health workers in the district were asked to conduct house to house survey of Guineworm because such were the orders from higher up. The District Health Officer, a doctor usually with an additional degree in public health and ten years experience had no autonomy or say in deciding what were the priority health problems in his district.

We are observing the public health services closely for the last 5 years at different levels from state capital to a remote village. The working culture of this system can be described as pushing down targets and orders and only expecting the reports of completed targets. At one time, a PHC health worker had to provide information in 120 indicators each month. Bombay, the workers perceived, only wanted figures. No other form of interaction or feedback is welcome within the line of command. The inability to listen to subordinates or treat them with respect was typically exemplified when one assistant District Health Officer (DHO) boasted to us after a monthly review meeting of a PHC, that he had never conducted a review meeting in a which minimum four nurses did not cry!

A system with such a relationship with it's own workers and colleagues can not be expected to be sensitive to the needs and feelings of poor illiterate masses, who in turn can not be expected to respond to the messages and progammes of such a health care system. This counter productive relationship needs to be changed. And any change away from this centralised style will be in the true spirit of Primary Health Care as envisaged at Alma Ata to which the world is committed. Primary Health Care was described as appropriate for local needs, planned and implemented with community participation.

The approach paper of the Eight Five Year Plan speaks strongly of people's participation in planning and implementation through Panchayat Raj. There is some interest at the level of Planning Commission in democratic **decentralization of the health care by delegating village level health care to Gram Panchayat. Is it desirable? Is it feasible? What are the possible gains and problems? We conducted discussions with sarpanchs, village health**

workers, nurses, district health officer, chief executive officer of Zilla Parishad and the collector of a district.

The first reaction of some nurses was that if they were to work under Gram Panchayat, they would seek retirement. Why?

Reactions of Nurses:-

"Villagers will consider us their servants. How can we work as subordinates under illiterate villagers? We are government servants; not the servants of the villagers". Or

"What does a Sarpanch understand about the technical matters of health?"

The most crucial resistance is going to be this outlook about villagers and the notion that being a government servant means being humiliated. Nurses were truely reflecting the values and attitude of the health services in general.

Nurses had some legitimate concerns,

"How can we work simultaneously under the sarpanch and the medical officer?" "Who will decide our targets"?

"Each village has rival groups and we will be torn apart between their pulls. The ruling group would want us to work as its private servant while the opponent group would frequently complain against us to higher officers."

"We may be sexually abused if villagers have power over us".

"A nurse has 3000 to 5000 population to be covered. This will be spread in two to three Gram Panchayats. How will the control be distributed? Where will we be based?"

After lot of dicussion on what arrangement was possible, a voting was taken in the group of 15 nurses, 14 voted against and only one in favour of working under Panchayat.

Reactions of Village Leaders and Village Health Workers

The reaction of village leaders and village health workers was diametrically opposite.

"This will ensure that nurses, medical officers stay at head quarters and work properly. Problems of absentiesm will be solved in one stroke".

"People will be able to decide what they want and get it from the health services".

"Cooperation of villagers to health programmes will improve because now the village leaders will be behind the programme."

"We will ensure that medicines for the diseases we suffer from will be available in necessary quantity."

"We will support the nurses. Villagers are not goons to rape nurses. How many such incidents have occurred in the whole state in an year? Definitely less than rapes in police custody."

On our asking as to how will villagers be able to decide about technical matters? What will happen if a superstitious sarpanch does not believe in immunisation or modern medicine? How will they ensure that health needs of women, children, lower castes or people living on the periphery will be taken care of? The suggested remedies were as follows.

Instead of giving sarpanch or elected members of Gram Panchayat total control over health activities, a separate health committee should be formed with representation of different castes, groups, genders and peripheral hamlets. Medical officer of PHC should be an advisor to this committee. The health workers in the area should work under the control of this committee. The committee shall decide health problems of priority, allocate budget including that for medicines and evaluate the work of health workers. Each member of the committee shall be responsible to see that the people in his/her mohalla or group understand the scope as well as limitations of health programmes.

But what will happen if village leaders do not believe in vaccine or treatment of TB or family planning?

"If village leaders are at such level in their understand of diseases and health measures, no health programme can be directly implemented successfully even under the present system of control. Probably that is the reason why health services are falling to achieve results. In such situation, the health programme must any way begin with the orientation of the committee or leadership."

One thinking within the health services has been that CHVs and Dais may be put under control of villagers but not the nurses, male multipurpose workers or PHC doctors. Dais are not paid by government and they are anyway working under effective social control of the village in which they function privately. CHV scheme has already been made defunct due to its handling by the health department. It will be an eyewash to hand over these workers to villagers. The mainstay of the rural health services is multipurpose workers (nurses and male workers one per 3000 to 5000 population) and Primary Health Centres. If Planning Commission is serious about any change, then these should be linked to Panchayat Raj institutions and not the defunct, malinged CHV and independent dai alone.

One concern which village leaders expressed was about targets. If targets of completing fixed number of family planning operations, collection of malaria slides and so on will continue and if the government shall expect Panchayats to be responsible for fulfilling the targets, then, in effect, Panchayats shall be forced to obey and become the tools of health department rather than the otherway. A solution must be thought of for this problem.

Predictably the health department will be extremely resistant to lose power and control over it's vast empire of PHCs and nurses in the villages. Unless complete administrative control of these workers is handed over to Panchayat Raj institutions especially power of appointment, transfer, writing of confidential records, promotion and disbursement of salaries, the workers will always continue to treat village leaders as insignificant. The Gramsevak who is secretary to Grampanchayat is not under the control of sarpanch though the secretary of a department of State or Central government is under control of the concerned minister. Hence gramsevak usually controls and makes the sarpanch run according to his wishes. A similar situation in the proposed plan of decentralisation of health services will ruin the purpose.

Then what shall be the role of medical officer of PHC?

He shall provide curative services at the PHC, shall respond to emergency call by health workers, shall advise village Health Committee and shall supervise the technical quality of the work of health workers but shall exercise control over health workers through the village committee or

appropriate Panchayat institution."

But will there not be lot of corruption?

Probably there will be some. But since it will not be hidden in the files and behind the walls of office buildings under the cover of technicality or confidentiality as it happens today, it will be noticed by other villagers and will be brought out. Moreover, there is not going to be huge amount available for swindling. If villagers do not get services, they will immediately shout; so the one who siphons money will be soon exposed.

Reactions of the Sarpanchs

"What about the experiences of Jawahar Rojgar Yojana?" Sarpanchs felt that Government officers forced them to take up schemes of their choice by framing rules and controlling funds but the villagers blamed Sarpanchs for not doing what people wanted. "We do not want to become instruments in the hands of Government officers and be accused by our own people. Hence if health activities are to be given in the hands of Panchayat Institutions, it should be given with much more autonomy"

Reactions of IAS Officers and District Health Officers

IAS officers and District Health Officer had some constructive suggestions.

"Instead of the current pattern of one Anganwadi worker for 1000 population, one CHV for 1000 population and 2 MPWs for 5000 population, only one female worker per 1000 population based in the village should be trained for health and child development activities. All the present nurses in villages and anganwadi workers should be first absorbed in this rule, retrained and made accountable to Gram Panchayat." "One such female health worker, and a budget for medicines, vaccines and water purification should be provided to each Gram Panchayat by Zilla Parishad."

"Village health committee should be made accountable to Gram Sabha. People do not attend Gram Sabha meetings today because it has no power or influence. If it is given teeth people would like to attend and assert."

"Targets and performance on National Programmes will suffer initially. Except for minimum grant, additional money as reward should be linked to the performance of previous year".

"Information and reports will suffer because village committees will not be much interested or be particular about it". But with planning and monitoring becoming decentralized, there may not be much need for volumes of data flowing up most of which is the superflous and is never used."

"If health workers shall be accountable to health committee and village leaders, there must be some mechanism of making village leaders accountable, otherwise they may use workers and funds arbitrary for personal gains."

"If even a village Panchayat is to be given autonomy in planning and implementing it's health activities, then similar autonomy must be given at district level."

Some Reflections on Panchayat Raj in Health Services:

The health activities were made the responsibility of Mandal Panchayat in Karnataka since 1987. Recently the Karnataka experience was discussed in a workshop organised by the National Institute of Advanced Studies, Bangalore. The main conclusions are:

- Health workers have become accountable to people
- A large number of village leaders have got interested and involved in health programmes. This has a great potential to improve the health activities.
- Utilization of medicines has improved.
- Improvement in the fulfilment of targets of National Programmes is not yet visible (Is it an objective?)'
- There is a lack of clarity about administrative matters and line of command.
- Reports and data have suffered.

What emerges from these discussions?

- If health services are to be run to fulfil the aspirations and needs of people and not according to the needs perceived by the health department, Panchayat Raj in health can be a welcome initiative.
- Village population and leaders will need lot of education on health matters as well as on planning and administration to be able to assert the rights as well as to carry out responsibilities. The orientation activity should involve voluntary organizations.
- Health department and workers will need even more education to change their attitudes towards village people and to be able to work with and under them. This is going to be the toughest and the most crucial aspect which will decide success or failure of the concept.
- It should be ensured that health departments support this idea rather than sabotaged it and then sits in the chair of judgement to pronounce it dead as it had happened in the case of the CHV scheme. Serious stakes must be created for the department in the fate of this proposal.
- Instead of targets, education of village leaders should be used for maintaining harmony between the local needs and the national priorities.
- The transfer of power, if done half heartedly, will certainly fail.
- There may be some small size corruption and mismanagement at local level. While trying to the utmost to avoid and correct it, we should be prepared to accept it to some extent as a part of the percolation of democratic process.
- The idea must be tried on pilot basis in different states before making it a National Policy.
- If village leadership once experiences this power and responsibility, it will build up it's own political pressure through the political parties for more role and responsibility. Then the 'decentralization' will not be at the mercy of Planning Commission or Health Department, but will become a major political demand.

The concept of Panchayat Raj in health services has potential of actualising Health By the People. But in the ultimate analysis any such transfer of power involves struggle. Are people aware and activated enough to wrest this power from an organised bureaucratic system with deep interest in retaining its present control?

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ground, to appreciate the rationale for Panchayat Raj and to adjust themselves to the new working environment. In the interim, for lack of a proper understanding of their respective responsibilities on the part of both officials and the elected representatives, strains have developed and programme implementation has suffered in some areas. Yet another sensitive issue has been the nature of relationships between Head of departments and regional officers and their counterparts in the districts in regard to technical control and supervision. How does one reconcile the administrative autonomy of the ZP administration with need for continuing technical support? A system with multiple lines of control is difficult to operate. But there is no simple and neat solution. What it calls for is an appreciation of the total perspective on the part of officials at the middle and higher levels.

8. As mentioned earlier, one cannot hazard the statement that with the ushering in of Panchayat Raj, there has been a perceptible improvement in the level of performance of the rural health services. Indeed this reflects the overall situation. While some of the ZPs settled down to work quickly and the results have been commendable, several ZPs still display an excessive concern with procedural on petty issues which use up a considerable part of their time or with transfers and postings. There is also, understandably, more interest in and enthusiasm for brick and mortar programmes of high visibility than on the relatively unexciting task of maintaining in proper order institutions and activities already on the ground. The classification of public expenditure as 'Non-Plan' and 'Plan' seems to give the impression that the former is unimportant. There is inadequate recognition of the fact that the bulk of expenditure incurred by the Panchayat Raj bodies is on the maintenance and upkeep of institutions, services and programmes which are already in operation and that expansion of an existing service or introduction of a new activity under 'Plan' can only be incremental in character. One hopes that, with the passage of time, the elected representatives in the Panchayat Raj institutions will have a better appreciation of their role and functions.

9. A specific point pertaining to the Karnataka set up which may be briefly referred to is the imbalance between the two executive tiers, the district and the mandal. With its small converage in terms of area, limited resources (financial and manpower) the Mandal has hardly any direct role in rural health administration, as in many others areas. Unless this structural imbalance is corrected, the process of decentralisation will get frozen at the district level. This has major implications from the point of view of both the larger goals of Panchayat Raj and of ensuring greater responsiveness on the part of the local administration.

10. Alleviation of poverty and ill-health has been a major goal of the success Five Year Plans. The National Health Policy was enunciated a few years ago to give a direction to an integrated development of medical and health services in the coming years so as to meet the health needs and priorities of the country. It visualises, among other things, the establishment of a network of comprehensive primary health services which take into account the fact that a large majority of health functions can be effectively handled by the people themselves. It also lays emphasis on voluntary action. Decentralisation of political and administration power through Panchayat Raj institutions can facilitate this process. But one must take note of certain basic inherent factors, within the health system and out side, which must be reckoned with before we can expect any spectacular improvement. These are well known but bear repetition. First, inspite of policy statements to the contrary, the thrust of medical education as well as of programmes in action is still towards curative urban-based services; preventive aspects still do not receive requisite attention. Secondly, even though decentralisation of power is the underlying concept of Panchayat Raj, it does not automatically follow that the power passes into the hand of those who have concern for the poor and the underpriviledged. Studies on the caste composition and economic background of the elected representatives of ZPs and MPs in Karnataka do not evidence a loosening of the hold of the dominant landed sections of the rural community. It will take time before the power equations shift in favour of those who have traditionally remained out of the mainstream. This is of importance if health services which have the vast masses of the rural poor as their clientele are to receive adequate attention. Lastly the system of planning followed so far in the country has led to rigidities at the national and the state levels, leaving little scope for local initiative and innovation. If Panchayat Raj is to achieve its full impact, the planning procedures will themselves require decentralisation, particularly in regard to social and community services.

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Village Panchayats in West Bengal have been given specific powers in epidemic control, removal of water pollution, and maintenance of public pathways. Many panchayats have converted wastelands to revenue yielding social forestry plantations. Apart from relief works during natural calamities, rural housing programme and rural water supply are the major fields of operation of Panchayats. The rural water supply has proceeded so well that all problem villages have been covered in the decade ending 1988. Implementation of social forestry works, identification of beneficiaries for sponsorship of credit linked schemes to assist SC and ST beneficiaries and implementation of infrastructural programme for them are also taken up by Panchayats. The average funds available to a Gram Panchayat during 1987-88 were Rs. 1,87,000, which included Rs. 9,300 as taxes raised and Rs. 10,000 on account of assigned programmes.

Source: Indian Express, 11/6/89.

The Community Health Care System
A Model for Health Services in Panchayat Raj

Dr. N.H. Antia* and Kavita Bhatia**

Background

The ICMR/ICSSR report "Health for All: An Alternative Strategy" had recommended a model in which the majority of preventive, promotive and curative health services could be decentralised and function within the 100,000 population level. This is not only technically, logistically, economically as well as culturally feasible but most desirable. Only thus can we ensure that adequate services would be readily available to the people. In the present top-down system people are seen only as 'targets' to whom services are to be 'delivered'. The ICMR/ICSSR report proposed an alternative model rooted within the community, compatible with the people's perceptions and needs and hence ensured their involvement in their own health.

As a result of the ICMR/ICSSR model being accepted by the government there has been a considerable increase in the rural health infrastructure in terms of buildings and personnel. Unfortunately there has been no commensurate improvement in the health services nor the health of the people. A number of factors have been responsible for this situation. Instead of the bottom-up type of services starting at the village level where the people are intimately involved in their own health care, the service has remained a top-down bureaucratic exercise divorced from and without accountability to the people. The obsession with Family Planning (FP) targets and the coercive measures employed has not only failed to achieve the FP goals but has also demolished the routine health services and alienated the health personnel from the people. There is not only a gross disparity in the allocation of public health resources to the rural population but even these very limited resources are grossly maldistributed within the rural areas with 85% being spent on salaries leaving hardly anything for medicines, transport and other services.

There are no easy solutions to this situation. The individual, the community and the health professionals, each have a distinctive and definite role to play in improving the health of our nation. Unfortunately, the roles of the individual and the community have been sidelined. This has largely hampered, if not actively dissuaded the people from being involved in their own health and its care but also in utilizing and demanding the health services operated for their welfare. The top-down delivery approach has also inculcated a feeling of dependency on the government and despondency as a result of its failure. It has sapped the will to self-help.

The Community Health Care System

In actual fact the majority of the preventive and promotive as well as curative services are best undertaken by the people themselves with the support of the health services not in reverse as is at present. The role of the medical professionals lies in the imparting of relevant information and knowledge in a simple and practical way, which people can understand. Apart from the large scale example of China we haye several voluntary health organizations working in our own country, which have clearly demostrated that a people based health care model is entirely feasible and far more effective in meeting the health needs of people and hence of the country.

A modification of the original ICMR/ICSSR model named the Community Health Care System (CH Care system) is presented in Table 1.

Community Based Health Care Model

Population level	Health Unit	Percentage care
5 million (city)	Tertiary Care Hospital	0.25
1 million (district)	District Hospital	1.75
	COMMUNITY HEALTH CARE SYSTEM	(98)
1 lakh (Block)	Senior Medical Officer (PSM)	
(Panchayat samiti)	**COMMUNITY HEALTH CENTRE**	
	Preventive: 1 PSM doctor; 4 Health Assistants; 1 Statistician	Curative: Rural Hospital 60-100 beds + dharmashala with 4 basic specialists
20,000	**PRIMARY HEALTH CENTRE** 2 doctors 2 nurses 10 beds	13
2,500 (Gram Panchayat)	**VILLAGE HEALTH UNIT**	80
500	1 Multipurpose Worker (F)	
500	1 Village Health Worker (F)	
	1 Dai (F)	

The Community Health Care System in Panchayat Raj

The essence of the ICMR/ICSSR model was that the people must not only be actively involved in their own health care but that the entire health services at the 100,000 population (Block/Panchayat Samiti) level should be under their administrative as well as financial control. For this the people should be provided adequate funds at their disposal. Only this can ensure peoples participation and active involvement as well as ensure accountability of the health services to them. Without this precondition no model can hope to succeed.

Panchayat Raj if implemented in its true spirit of democratic decentralization of financial and administrative responsibility to the people will provide this basic requirement as well as the frame-work for the implementation of health care at the community level which will deal with about 98% of all health problems of our people. At each level the people will be provided the resources and power as well as lattitude to modify the model to suit their local requirements eg. use a mix of the indigenous and allopathic systems, and in the purchase of medicines and supplies. No targets (such as FP) will be imposed on them but technical information and broad guide lines will be provided.

The operation of such a Community Health Care System at each level will be vested in the people and their Panchayati Raj institutions. The Panchayat bodies, especially at the Gram Panchayat level, will be supported by Peoples' Committees. These bodies will be free to consult outsiders to facilitate decision making and functioning. The health functionaries will report at each level to the Panchayat body and the financial and technical planning of the Community Health Care System will be done by the Panchayats in consultation with the available technical personnel at the Primary Health Centre (PHC) and Community Health Centre (CHC). The disbursement of salaries to other expenditure, will be through the Panchayats and the ratio of salaries to supplies at all levels of this system will be in a minimum ratio of 60:40 and not 85:15 as at present. Absolute power will not be vested in the elected Panchayat bodies alone. A stratified, representative Peoples' Committee will function with the health workers and the Gram Panchayats. Any decision or function of the Gram Panchayat will have to be ratified by this committee. The majority of the members of the Peoples' committees should be women, as will be the health workers of this village based System.

Levels of Health Care in the Community Health Care System:

The Community Health Care model does not propose rigid guidelines but gives broad directives. The ratio of population to personnel is flexible at each level and can be modified to local needs. However, there will be no transfers of staff so inimical to continuity in operation and for purposes of accountability. Inefficient staff may be warned/dismissed by the Panchayat bodies, but not imposed on another Panchayat village.

Since the majority of the population consists of women and children and most of the health problems affect them, all health workers at the village level must be women who will live and work as an integral part of the community which will pay their salary and to whom alone they will be accountable. They will work towards a common purposeful goal collaborating not only between themselves but also with the Anganwadi (ICDS) worker and the teachers of the village school. They will receive support from the PHC and CHC both of which will also be under the control of the community through the Gram Panchayat and Panchayat Samiti, and the People's Committees.

1. Village Health Unit:

Village Health Unit (VHU) comprising of one Female Multi Purpose Worker, five Community or Village Health Workers and five Dais,will function as an integrated health team for approximately 2500 unit of population. This population may consist of one village or more. Each village will have its basic unit of one health worker and dai. It will have its Gram Panchayat and a Peoples' Committee involved with its health worker and also at the Village Health Unit. The VHU team will not only inform the community about problems concerning their health but also activate and support them for action concerning health related issues like water management, sanitation and environment. They will also alert the community to the threat of epidemics and help in the control by mobilizing local resources as well as from the PHC and the CHC. This team of local health workers will also look after the majority of curative problems, not only those of a minor nature such as coughs and colds, but also of disease like scabies, diarrhoea and worms which are a major source of community morbidity. More important they will play a crucial role in the control of most of the major killing and maiming diseases like gastroenteritis, acute respiratory infections, tuberculosis, malaria, leprosy, measles and poliomyelitis. The knowledge and technology for the diagnosis, treatment and control of these disease is simple, safe, cheap and effective. Village Health Workers supported by adequately trained and motivated paramedical workers have repeatedly demonstrated their ability to assimilate and use this knowledge and technology provided it is given to them in a simplified manner which they can understand; also given encouragement and support by the health system for confirmation of the diagnosis and prescribing the regimen of treatment which they can then carry out themselves. This is because the control of these diseases while requiring a low level of technology nevertheless requires a high level of cultural affinity and constant availability and accountability to the community. For example, these village functionaries can take finger prick smears for malaria, give immunization injections as well as injections of streptomycin for tuberculosis. More importantly, they can identity, follow-up and keep track of a malaria or TB patient, or a child requiring immunisation.

The increased rapport between the female staff and the younger women of the village will also enable better Maternity and Child Health Care and in reduction of the birth rate by the voluntary acceptance of non-terminal methods by the younger women which alone can improve the present dismal situation. This can only be possible if the counter productive FP targets and pressures of vertical programmes are removed.

The successful implementation of health care at this village unit will depend to a considerable extent on the appropriate payment, training and support provided to the staff. All training including that of the Panchayat members, will be the responsibility of the medical and paramedics and within the CHC system. Initially, however, an NGO rather than the health department, may be entrusted with this task.

2. Primary Health Centre:

In this new set up the PHC will be upgraded to a well equipped 10 bedded referral centre which will coordinate and support the functioning of the 8 village health units of the 20,000 population it serves. It will have close association with the CHC (Rural Hospital) and no more function in isolation but as an integral part of the entire CH Care System.

The PHC will be well stocked and equipped to handle most of the curative load referred from the villages, including X-ray and Pathology services. Besides two doctors, the PHC will also have two nurses. There will be two health assistants (Senior MPWs) to guide the preventive and promotive aspects in the 8 village units served by the PHC. There will also be an aggregation of statistics of the village units at this level, to help planning by the Pan-

chayats and Peoples Health Committee. Only those curative cases which cannot be handled at the PHC level will be referred to the CHC. The PHC will be responsible to a body consisting of the Gram Panchayat/Committees from the VHUs and the Panchayat Samiti. This body will meet at the PHC itself.

3. Community Health Centre:

The CHC at the 100,000 level, will no more function as a purely curative mini district hospital but serve as the hub of the CH Care System with emphasis on the preventive and promotive aspects. For this it will function under the guidance of a senior doctor with postgraduate training in Community Health or Preventive and Social Medicine as its leader. The curative aspects will consist of a well equipped 60 bedded hospital further extended by a dharmashala. It will have the four basic specialities of general medicine, general surgery, midwifery/ gynaecology and paediatrics. It will also have the supporting services and staff such as an Operation theatre, X-ray unit and Pathology laboratory. It will also provide referral services to the PHCs for all problems needing such care. This would leave only a very few conditions for further referral to the district hospital whose specialists will visit the CHC at regular intervals. This CHC will be responsible to the Panchayat Samiti and representatives from all the PHCs in its jurisdiction.

Medical Professionals in the Community Health Care System:

Besides the inadequacy of the present medical education, a major problem of the medical profession working in rural areas is the cultural, academic and intellectual isolation which also affects their families. The CH Care System attempts to overcome this by maintaining close contacts and a rotating posting for the medical staff who will work and live together at the CHC and its attached PHC. (One PHC will be attached to the CHC so that the CHC does not get utilized as a PHC for the local population). There will be regular visits of specialists from the district hospitals. In turn CHC staff will visit the four remaining PHCs. This will ensure that the system works as a single integral unit. The PHC doctors and staff can in annual rotation be posted to the PHC attached to the CHC in order to obtain refresher training with the senior colleagues and maintain contact with them. The fear of professionals working under the Panchayat is unfounded for it will be in the interest of the people to respect and support those who are genuinely concerned and who look after their health. Without the imposed targets such as Family Planning and Immunization, the staff will be free to organize the local health system in conjunction with the community based on the actual problems. Statistics will be chiefly for local use and not merely for forwarding to a distant authority for compilation. Health will become a meaningful exercise involving people and not mere treatment of 'cases'.

Cost:

It is estimated that the cost of such a rural Community Health Care System would be around Rs.90/- per capita per annum. The public health expenditure was Rs. 60.37 per capita per annum on Health and Family Welfare in 1986-87 as per Health Information of India; 1989. We estimate that the expenditure on the private sector must be about double this figure. As in the case of aggregate health statistics, this aggregate per capita expenditure also conceals its heavy urban bias. Besides the urban population also has other sources like the Municipality, the ESIS and the corporate sector spending for its health. It is proposed that public health expenditure on the rural areas be increased, possibly by a reallocation of resources between urban and rural areas.

Table 2: Cost for Community Health Care System
(per capita per annum)

(in Rs)

Population Level	Health Care Unit	Per Capital Per Annum Expenditure
2,500	Village Health Centre	36
20,000	Primary Health Centres	27
1,00,000	Community Health Centres	23
	Total C.H.C System	86

The establishment of a good curative service within the community will also be the most effective way of controlling the proliferating private sector which is a major source of medical malpractices and which is increasingly diverting the limited resources of the poor from nutrition and other essential needs to unnecessary drugs and treatment.

Health Education and Health Information:

Lack of information and mystification of health and illness are the barriers which have prevented the people from taking their rightful place in the health services. Decentralization of health functions and services, must be complemented with the imparting of health education and health information including information about the health services. This will also ensure accountability of the health personnel and services. The dissemination of health education and information will be built in, in the CH Care System, as far as possible. This will also reduce the possibilities of corruption and misuse of powers and resources.

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hilly areas (eg. Assam), North- East, where good panchayat bodies are in-place (eg. Karnataka, West Bengal), where there are a large number of active voluntary agencies (eg. Gujarat), where the general atmosphere may not be conducive and where the administration is more responsive.

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(*Cont. from page 6*)

is the one where the people feel actually in control and have access to the system.

How much proportion of expenditure the village decides for itself, will be the litmus test of any proposal for decentralization.

8. Should targets be maintained in the health system?

The rationale behind targets is to maintain accountability of the health programme, and it is an easy measure of achievements, but even with the target system, no spectacular achievements can be seen. On the contrary, in the process, the general health care is also neglected. Targets, even in selected areas are non productive. Targets can also be a tool for control. Targets should be totally abolished.

9. Should there be a Family Planning programme?

There was unanimous consensus that today Family Planning is eating up most of the resources and time of the health functionaries, at the cost of every other health programme. Every other programme has become a means to population control. Due to Family Planning targets, the people have lost faith and are afraid to approach the health functionaries. Yet the Family Planning programme has not been too successful. The answer is not more of the same. Family Planning targets should be abolished. The new health system should concentrate on enhancing the health status and ensuring the survival of the child and the mother. This should be coupled with contraceptive guidance only. No convergence/decentralization will be effective if Family Planning target pressures remain on the functionaries, and the people. Even partial removal of targets would be helpful.

* Kavita Bhatia, Researcher, Foundation For Research in Community Health.

[This is a summary of the report published in "Convergence of Social Development Services Related to Women and Children", Planning Commission, New Delhi, November 1990]

Statement of Objects and Reasons

Though Local Authorities, namely, Panchayati Raj Institutions and urban local bodies have been in existence in the country for a long time, it has been observed that these institutions have not been able to acquire the status and dignity of viable and responsive people's bodies due to a variety of reasons including absence of regular elections, prolonged supersessions, inadequate representation of weaker sections like the Scheduled Castes and the Scheduled Tribes and women, insufficient devolution of powers and lack of financial resources.

2. Article 40 of the Constitution, which enshrines one of the Directive Principles of State Policy, lays down that the State shall take steps to organise village Panchayats and endow them with such powers and authority as may be necessary to enable them to function as units of self-government. While this Directive Principle applies to village Panchayats, it is felt that urban local bodies should also be organised and endowed with such powers and authority as are necessary to enable them to function as units of self-government.

3. In the light of the experience in the last forty years and in view of the shortcomings which have been noticed, it has been recognised that there is a need to enshrine in the Constitution certain basic and essential features of the Local Authorities to impart certainty, continuity and strength to them.

(Excerpt from the Constitution (Seventy-Fourth Amendment) Bill 1990.

AN APOLOGY

The publication of the FRCH Newsletter had to be temporarily suspended between August and December because of frequent change of staff. For the same reason, this issue has also been delayed. We now have a full time publications officer also who would henceforth ensure the regularity of this newsletter. Inconvenience to our readers is regretted.

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Our Experience in Teaching Methods of Health Education*

Vaishali Vaidya *

The ignorance about one's own body and its functions and needs is all pervasive. The need to dispel ignorance and to meaningfully reach out to the goal of "Health for All" through scientific tempering of young minds comes in a most interesting way in the school health education project. This project, sanctioned by the Ministry of Human Resource Development (Dept. of Education), New Delhi, began in September, 1988. The main objectives of this project are:

1. To give accurate information about health and health care and several physical disorders to teachers and through them to students and to develop simple teaching methods, experiments, demonstrations through visual media, while imparting information.
2. To remove the fear complex regarding health and illness.
3. To create constructive interest regarding personal health as well as that of the community.
4. To introduce people to the available medical services and simultaneously to dissuade them from over-use of medicines and injections.

The following forms a record of our experience during the pilot phase of this project, carried out with the students and science teachers of class V - C of Nandadeep Vidyalaya, Bombay. There were definite reasons to select this particular class. We felt that the students from class I to IV were too young for our project. There was no point in disturbing students from class VIII to X as they are normally burdened with a good deal of academic studies and they also have to struggle a lot for the competition created by our education system. Besides, we felt that students of class V are more curious, receptive and impressionable; hence they would respond better to our project. 'C' division of class V was selected as the teacher-in-charge felt that students in this class are more in need of health-education as they belong to the lower strata of society and also to the economically weaker section.

Planning the Curriculum

The curriculum evolved through discussions with knowledgeable persons and observations regarding students' interest. It covered the following:

1. Evolution of the human species.
2. Human anatomy and physiology.
3. Different types of illnesses and disorders.
4. Personal hygiene. cleanliness and medical check-up.

Imparting Knowledge: Methodology

"I hear and I forget,
I see and I remember
I do and I understand."

The main characteristics of effective teaching are developing the subject in a manner and at a pace consistent with the children's calibre and effective utilisation of available educational aids. Simulation of real life experiences with class-room teaching adds to dynamism in learning. We therefore tried to give stimulation of three basic levels at experience, namely cognitive, affective and connotative by dividing each lesson in three parts:

a) lesson imparting knowledge and stimulating thinking power,
b) appreciation lesson and,
c) Skill lesson.

Looking critically at the present traditional teaching methods we found that lessons were aimed at information mainly at the cognitive senses. While use of aids and experienced teachers give a notion of skillful teaching, it prevents a dialogue between the teacher and the taught and blocks spontaneous expression. The usual apology is that a definite syllabus is to be 'covered', that too for examinations, so the methodology must be oriented towards that goal. To overcome these barriers of formality, we have minimised the lecture method and followed something closer to "group teaching", involving group discussions and seminars.

While introducing a topic we encourage them to narrate their real life experience in their own way. Our premise was that as personal a subject as health education should be developed from the children's own experience. Indeed they vied with one another in telling of common ailments

* Vaishali Vaidya is on the research staff of FRCH. She is a teacher deputed to this project. Other members of the team in the School Health Education Project are, Mohan Deshpande, a medical doctor and Prabha Salgaonkar, having a background in literature and journalism.

★ This is the eited version of the original Marathi article translated by Sudha Naraune.

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like colds, fever, typhoid etc. It then became easier to orientate the children towards a scientific way of looking at them. We extended their experience by adding selected bits of information. We feel that children are not totally ignorant. They imbibe many things outside the school curriculum by their observation, conscious or otherwise and by intuition. They also sub-consciously analyse their experience. This is an abstract process which we felt should be concretised in order to make learning more meaningful. Further, it seemed that this way the children understood their experience better and got more interested in learning.

Another aspect which required sensitivity was the use of terminology. We tried our best to use simple, common words and explained in detail difficult words.

Audio and visual aids such as pictures, charts, slides, films were used in a limited way as adjuncts to discussions. Often we would call for a volunteer whose body was used as a teaching aid. For example, while discussing blood circulation, we persuaded a small boy to come forward and to remove his shirt. We drew a diagram of the heart on his chest with a sketch pen. Our goal was to have the children identify their own bodies with the body discussed in the text book, and also to remove any feeling of shame regarding one's body. Most people consider audio-visual aids to be necessarily expensive. We have tried to make a small dent in this assumption by using our own body as the best educational aid in health education.

Experimentation formed another important aspect of our methodology. For example, while explaining blood circulation we asked each child to hear and count the heart-beats of his/her neighbour by means of a stethoscope which they found fascinating. This naturally created quite a flutter in the class. It was no more an orderly 'dead' class; there was a good deal of activity which included listening to the heart-beats, counting them, helping one another to find the correct place to monitor them etc.

The Enquiry Training Model

It is an accepted fact that schools today are nothing less than factories. Bound by rules and regulations and taught to cram uncritically towards achievement in an exam-oriented system the desire to ask questions is simply obliterated. Being trained to uncritically abide by rules and accept only what is offered, the child grows up passively accepting atrocities and injustice even in later life.

This thinking prompted us to create a model whereby children could be motivated to think, ask questions and act on their own. In the enquiry training model formulated by us, a subject was put to the children in a story form. On the basis of this problem children were told to ask questions to the teacher and get the solution. A condition was that only such questions should be asked whose answers would be either yes or no. Surprisingly, these students who were supposed to be of average intelligence were able to ask twenty questions one after another in a particular direction. Eventually they found the correct answer with the help of rational, logical thinking. The lesson which was about malaria was a sort of model lesson for both teachers and children on how to learn by question and answer method. Besides, the practical advantage to the teacher was that s/he did not have to do much except to reply 'yes' or 'no'. On the other hand children had to be very alert in thinking about particular kinds of questions with the specific condition. Even those children who were supposedly not bright and were generally disinterested got involved in such activity and started asking questions. At times their questions were incorrect and irrelelvant but what was important was the fact of their participation.

We also learnt a good deal while teaching. Firstly, we learnt that teaching is possible without bringing pressure, coercion or beating. We also realised that what children say is never entirely wrong. We tried to remove their doubts while orienting them to action.

Demonstration and Experience

We should be able to utilise to some extent in our daily life whatever we learn and the information we collect in health education. It was felt that we can inculcate some good habits and attitudes through group activity. Hence we organised a demonstration of nutritious diet. We prepared a mixed dish of sprouts in the school itself with the help of the children. At home they normally do not relish sprouts in raw form. But this dish was a great success possibly because they all participated in its preparation; also it was very tasty due to ingredients that were mixed together. They also enjoyed eating together. Later they prepared the same dish at home and gave us the feedback on the reactions of their elders. In our action-oriented projects we did not miss out a single opportunity to peep into children's minds. They wrote short notes on the above mentioned mixed dish and through that they also gave vent to their complaints about parents.

Creative Outlets

Children have a mind of their own. They have their views and opinions on different events and issues which need serious consideration and an outlet for expression. This gave us an idea to start a periodical "Dhashtapushta", meaning robust. Teachers were not too enthusiastic about this venture because of their diffidence regarding their students' creative abilities. Yet, we went ahead and found the response from children encouraging. We did not impose middle class values in assessing the quality of writing, which was sometimes grammatically incorrect, shabbily written. We looked beyond, at the thoughts conveyed and praised the specially good articles in the classrooms. We tried to see, why, despite such creativity they fell short of expectations in classroom assignments — Marathi teachers commonly complained that children did not write good compositions. Students gave very coherent and revealing reasons:

- topics for essays are uninteresting
- there was a compulsion to adhere to specific topics
- since teachers focussed on grammatical errors rather than on understanding their thought processes the pages were covered with red marks which are very discouraging
- a candid, objective assessment of their own laziness.

Thus, while creating an atmosphere whereby children could express themselves freely and also to look at

(Contd on page 4)

In Defence of Cheaper Neurosurgery

Dr. C. Vidyasagar*

It is generally thought that neurosurgery is expensive, needs very sophisticated equipment and specialised surgical units. These statements are only partly true. It is possible to treat nearly 50% of neurosurgery patients at a district or rural hospital where facilities and personnel are available to undertake general surgical procedures. A general surgeon who has a brief specific exposure to neurosurgery and who has a small additional set of instruments which are locally available can effectively perform many of the neurosurgery procedures without compromise to the safety of the patient's life. In many situations the patient will have a better chance for survival if he is treated at the local hospital. Many patients, in their attempts to reach neurosurgical units, die, due to delayed medical attention.

Trauma accounts for nearly 30% of neurosurgical admissions. Head injuries following road traffic accidents seldom occur in the vicinity of the major hospitals located in the cities. Taluka and district hospitals are far more accessible for the serious multiple organ trauma which occurs on our highways.

Contrary to the general opinion, only 2% of all head injuries develop extradural haematoma, while compound depressed fractures occur in about 10% of such injuries. CT scan is not necessary to the diagnosis of an extradural haematoma. Deteriorating level of sensorium and drop in the pulse rate are the most consistent parameters in suspecting an extradural haematoma. Similar findings also frequently occur when oedema is developing in the injured brain. A few burr-holes (2 on each side) will quickly solve the problem. While burr-holes are life saving procedures in the former, they do not cause any adverse effects in the presence of cerebral oedema. A couple of plain x- rays of the skull (AP and lateral) taken with a 60MA machine if available, can be very informative. If there is a linear fracture and if such a patient develops extradural haematoma it is mostly likely to be under the fracture. Plain x-rays will also indicate the presence of compound depressed fractures. Thus both the common surgical complications of head injuries can be effectively diagnosed by clinical observation and by the help of simple radiography alone. Closed depressed fractures do not generally need correction.

Use of the CT scan to identify contusions for diagnosis of acute intracerebral haematomas, respirators, intracranial pressure monitors and other similar expensive methods have not produced sufficiently improved results to justify their cost and efforts.

Spinal injuries are best managed non-operatively. The process of shifting patients to a specialized center for better treatment often aggravates the problem. Decompression of the spinal cord and fixation of spinal fractures have not produced encouraging results even in specialised centres.

About 15% of all neurosurgical operations are performed for hydrocephalus. Tuberculous meningitis and congenital aqueduct stenosis with or without myelomeningocele are responsbile for nearly 90% of infants (before the age of three years) who present with an enlarging head circumference. An outpatient clinical examination is often sufficient to arrive at a diagnosis. If further confirmation is necessary, one can introduce about 20-40 cc of air into the ventricles and the plain skull radiography to guage the ventricular size. Air is a safe contrast medium and gets absorbed in course of time. A ventriculo pseritoneal shunt is the standard procedure for all these types of hydrocephalus. Since the ventricles are dilated, introduction of ventricular catheter is a very simple procedure and is very safe. Hydrocephalus secondary to intracranial tumours are difficult to suspect as these infants are normal at birth and manifest neurological features only after 3-4 years of age. These children need specialised units for management.

Brain abscesses secondary to chronic ear infection occur frequently (5-10%). They are generally located either in the cerebellar hemisphere or in the temporal lobe - on the side of the ear discharge. Patients are often very ill and die unless the abscess is drained fast. Blind exploration with burr-holes on the side of the ear discharge have saved many lives. Attempts to send these patients to CT scans at great distances have often resulted in avoidable tragedy (the author has personally evacuated a temporal lobe abscess in a child in a cardiac ICU on clinical evaluation alone. CT scan could not be done due to non-availability of an ambulance and breakdown of the CT scanner!).

Intracranial tumours are difficult to recognise without the help of sophisticated radiography. Now-a-days it would be simpler to get a CT scan than attempt angiography under difficult conditions of distirict hospitals. Once the nature of the tumour is established further management will have to be decided by the physician and the patient.

A large malignant tumour often needs a burr-hole biopsy to establish the diagnosis followed by radiotherapy. Extensive excisions of malignant lesions in the brain have not, on the whole, produced correspondingly good results in keeping with the effort and cost involved. Tuberculomas which comprise 10-15% of all tumours can be effectively treated by modern anti-tuberculosis chemotheraphy under proper supervision without surgery. A district surgeon can manage these patients if he has a close contact with a neurosurgical unit.

Back pain is common in the rural population. In a study conducted by the author (sponsored by Karnataka Council for Medical Research) it was found that the causes of backache in the rural population were similar to those of the urban population. Psychosomatic problems and pelvic infections were the common causes in the rural patients. These can be adequately treated at the district hospital level. In the above study of 100 patients only two had evidence of disc prolapse indicating that "not all backaches are due to prolapsed discs". Diagnosis of lumbar disc prolapse does not necessarily require CT scan or

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myelography. In a study of 135 patients, the diagnosis of disc prolapse and the level of the lesion were arrived at by clinical examination and plain radiography (except in one case). The pre-operative diagnosis including the level of disc prolapse was found to be correct in all these patients at surgery. The surgical skill for the procedure can be acquired by a general surgeon. The author has a young general surgeon associated with his team who is now confident to do disc surgery after a brief exposure to the surgical procedures (six operations).

Tuberculosis of the spine forms a third of all compressive lesions of the spinal cord. Adequate clinical evaluation and a plain x-ray are sufficient to establish the diagnosis. Postero-lateral costotransversectomy achieves spinal decompression by draining off the pus. The surgical procedure is often made simple by the tissue destruction which guides the surgeon to the area of compression.

All the above procedures can be performed in a general surgery operating room. The total cost of additional equipment required is about Rs. 6000-7000 and it would need about three months training to equip the general surgeon with the necessary skills to undertake the above procedures. Many young neurosurgical trainees feel that unless very expensive equipments are available effective surgery cannot be performed. On a recent visit to the world famous Montreal Institute of Neurosurgery, the author was amused to see the senior neurosurgeon using the old fashioned Hudson's burr to perform a cranotomy. When the author asked the surgeon why he was not using a more sophisticated pneumatic tool, he turned round and said, "What is wrong with this? It is safe and does the job well". The author once (1979) trained a group of district surgeons for a period of six weeks in the management of head injuries. Within a period of one year there were at least six instances where these district surgeons were able to save patients who would have lost their lives if they had been transferred to a distant neurosurgical centre.

While it would be ideal to treat all neurosurgical patients by neurosurgeons in specialised centres, we are very far from these ideal conditions. Adequate and safe services closer to their homes will certainly benefit the majority of our people, especially those living in rural India, who are either late or never reach specialised urban centres.

Let me end by quoting Dr. T.E. Udwadia in his presidential address to the Association of Surgeons of India "By all means we must have advanced and prestigious institutions on par with the best in the world, but let us not measure our surgical prowess or progress only by the number of CT scans we have." ●

"The cost of one CT scanner could absorb the total health budget of some small countries. CT is not an immediate need in many parts of the world; it should not even be considered except where there is already very good health care throughout the country".

[Source: WHO Scientific Group, No 22 Dec 6, 1987].

(Contd. from page 2)

themselves critically and honestly without fear of judgement, we tried to establish rapport with them.

We feel that we have achived quite a lot through these exercises. At the same time we are aware that much more could have been done.

(i) More demonstrations should have been organised.

(ii) Systematic notes should have been obtained from children and some more information should have been offered to them.

(iii) Complete medical check-up of all children should have been done during the three year period.

(iv) Deeper study of various teaching methods should have been undertaken.

(v) So far only one meeting with parents could be organised. More such meetings should have been held. Also personal contact with more parents should have been established. Home visits could be conducted with only 10-15 families.

Our shortcomings were inevitable because of certain reasons:

(i) The curriculum was not pre-planned in detail. It was taking a definite shape through discussions in the classroom, but it was not possible to plan and implement it on the spot.

(ii) Since we were outside teachers we could not get the required number of periods in the school. Each time due to some programmes in the school, periods could not be allotted to us. When we revisited the school after a few weeks revision took a lot of our time and delayed our proceeding further.

(iii) It is necessary to divide the whole curriculum into small parts in order to study and to make use of various teaching methods. As this was not done, we were unable to discuss teaching methods with experts in this field.

The lessons learnt from the pilot phase in Nandadeep Vidyalaya equipped us effectively to conduct the teachers training programme for health education. This formed the second phase which began in August 1990 and continued uninterrupted over one year. Thirty-four teachers, both from rural as well as urban schools have completed training and started health education activities in their respective schools. This project has covered 34 schools, 20 of which are located in Shahapur taluka (Dist. Thana), some in rather remote villages in the Sahaydari ranges.

Looking Ahead

The project has now reached its third and final phase which mainly consists of detailed follow-up studies and evaluation. This phase will continue for two years and end with the publishing of manuals for teachers and students, for imparting health education. ●

Lokseva Aushadhalay, Malshiras

(A Rational Drug Counter Managed by People)

Manisha Gupte *

"Lokseva Aushadhalay" was inaugrated on March 8th (International Women's Day), this year, by Dr. N.H. Antia, Director , FRCH. Dr. Vishwas Rane of Ratnagiri Chemicals who is actively involved with the rational drug therapeutics movement presided over the function. Dr. Anant Phadke of Lok Vidnyan Sanghathana (People's Science Movement) and Dr. Anil Pilgaokar, National Convenor of Medico Friend Circle, also actively involved with ACASH, Bombay, were the chief guests. Dr Nerges Mistry of the FMR, Bombay, Ms. Soonoo Engineer from a peace group in Canada and seventeen women from a Mahila Mandal organised by TDSS, Pune also attended this inaugural function.

For several reasons this tiny drugstore is interesting and is therefore worth reporting upon.

I. The Idea: Some researchers of the FRCH are engaged full time in an action research project which imparts health education in 18 villages of the drought-prone Purandar tehsil of Pune district, 60 kms. away from Pune city. Since the Government Community Health Guides no longer have their basic medicinal kit, some of us thought that it would be a good idea to keep such simple medicines with local people. The majority of peoples' day-to-day ailments would then be taken care of. However, on official enquiry we found that no medicines can be stored or sold without acquiring a license from the Drug Commissioner.

Disheartened, in June 1988, we presented our dilemma in the Medico Friend Circle Core group meet at Wardha. The enthusiastic response from the friends gathered there was overwhelming. We were urged not to give up the idea of starting this rational drug counter because at that time there was no such experiment wherein the rational drug movement retailed drugs to the consumer directly. (In July 1989, SEWA Ahmedabad started a rational drug counter in Ahmedabad city). Besides, this counter was to be based in a remote hilly village and would be handled by trained rural colleagues. The dynamics of its genesis and working would be of interest to the health movement, too. Anil Pilgaokar immediately offered to train us to start such a venture. Accordingly, from September 1988 he started coming to Malshiras. During the first six months he came thrice and taught us for 2-3 days each time. As the enthusiasm and interest grew, from April 1989 he started coming once every month. The training was declared as "enough" by him and the group in October 1990.

II. The Training: Anil laid down certain ground rules before the training commenced.

i. The counter would sell only rational drugs.
ii. The drugs would be sold under generic names only.
iii. We would not charge more than 8-12% on any of the drugs.
iv. The drugstore would be run on participatory principles.
v. We would not assume that people cannot understand complicated and technical aspects of science. Thus we would teach fundamental concepts of biochemistry and pharmacy even if that meant long months of study.
vi. Ultimately, the drugstore would become a consumers' cooperative, without external financial aid.

With this idealistic blueprint, the actual academic training started around October 1988. Seven persons, including the author of this article, attended the sessions. The idea was to train actual functionaries in the drugstore. Eventually, a few of our trained personnel would even appear for the D.Pharm examinations, so that the drugstore would be truly run by the local people themselves.

Each extended session of training (which spanned over two to three days) comprised broadly of the following:

A. *The Academic Aspect:* For two months, inspite of the excitement of waiting to start a local drugstore, when the students realised that they were to learn microbiology, biochemistry, genetics, (infact most of them had heard these names for the first time), they feared that they would get so confused that they would probably poison the clients.

Painstakingly, both for tutor and students, the first few sessions crawled at a snail's speed. Often, the entire session would have to be repeated not once, but thrice. Finding the Marathi equivalents for technical jargon was a tough job. Simplifying cell biology in the abstract was a daunting task. Confusion at various levels was being gently clarified: why did one have to learn cell wall synthesis to understand the action of penicillin? Aren't micro-organisms smarter than us? Are all bacteria dangerous? Are enzymes living organisms? Confusion was giving way to alert curiosity. For the fist time in the learning career of the participants, one could ask any questions however silly they sounded. Everyone was learning to respect drugs; such small tablets, aren't they really clever?

Sessions of role play were being introduced. How would the micro-organism invade? How would the human being respond? How would the micro-organism retaliate? How would drugs intervene? Could drugs "disguise" themselves? Lessons were full of analogy-the enzyme was our spanner that did work more efficiently, protein synthesis was taught as a series of rolling wheels of different sizes. One of the participants who is also our vehicle driver was ecstatic. The following week he pointed out to a car's number plate that read "DNA". When the cell "wall" was being built and penicillin disguised itself and entered it to eventually destroy this almost finished wall, a love-hate relationship with drugs was growing. In great enthusiasm we debated as to whether we should use the "strongest" antibiotics (broad spectrum) to successfully treat a disease. The moral that emerged: you don't hire a lion to frighten

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a pesty mouse because the lion may eat you up for dinner, as well.

All said and done, the completed course graduated from the digestive system to the endocrine system. This is not to say that all of us remember everything that we learnt. Neither does it mean that each one understood every concept that was put across. However, each one has lengthy notes that can refresh one's memory from time to time. Our homework included the preparation of ready reckoner charts which listed out the names (generic and brand), indications, dosage, contraindications, interactions and side effects of each drug that we studied. The total number of drugs covered were around 35.

B. *Management:* This section included the day to day handling of the forthcoming drugstore. How to order drugs, where to order them from. Readers are probably aware that there are very few drug companies that manufacture rational drugs under generic names. LOCOST pharmaceuticals in Baroda is one such unique group. Managed by socially conscious individuals they market drugs in wholesale only to voluntary agencies for whom profit is not the main motive. Ratnagiri Chemicals, a private concern, is another example. Naturally, we decided that the main bulk of our purchase would be from these groups.

Training in management also included billing, accounting, receipting. How much money was required to start Lokseva? (We started with Rs. 5000/-). How many drugs to order and how to decide on quantities required? What is SWOT analysis. How to determine break-even points? What non-drug items should we sell so as to support the drugstore financially? What product mix was necessary? These and other questions were raised, discussed and debated upon. The name "Lokseva Aushadhalay" was democratically elected from among 40 proposed names.

C. *Ethics:* It is this section that really determined the "spirit" of the drugstore. Why should we not sell irrational drugs, unnecessary combinations, tonics and cough mixtures? Why should we uphold the movement for rational drug therapeutics? If Dr. Arun Bal is victimised in Bombay, does it concern us in Malshiras? Should Analgin be banned? These formed the broader politics and ethics of the drug movement. At the same time smaller pertinent issues were also raised. Why should we use simple and cheap packaging? Should we create an artificial demand for drugs? Why not sell banned or "bannable" drugs for example, analgin? Should we make profit on people's illness? How much profit is ethical? How to pay 'decent wages' to our worker(s)?

To avoid the domination of any one participant over the drugstore, an upper limit for donations/fund raising was put. No single person could raise or contribute more than Rs. 200. To avoid domination of local caste/class groups, no local villager was allowed to pay more than Re. 1 as a membership to the Lokseva fund. These funds would help to buy drugs. (LOCOST gave us excellent credit facilities). The dream is to start local vending units at weekly village bazaars. Alas, the problem of acquiring such a license, once more!

III The License: We found out that if we wished to run a full fledged medical store, we needed to have a full-time D.Pharm trained person. No such individual was available in the village. So we decided to obtain a restricted licence, which would allow us to keep a simple array of drugs, ointments and liniments. Fortunately, the Drug Commissioner in Pune was supportive of our venture and after four months of applying, we got our license in August 1990. By then, to our great delight, T. Krishna (who was earlier coordinating LOCOST activities) had decided to join the Malshiras team; infact he joined us in November, 1990. Krishna holds a B.Pharm degree and we could easily have taken advantage of this fact to get a full fledged license. The group however decided to set a precedent and to acquire a restricted license, arguing that every small group wanting to start such a counter may not get D.Pharm or B. Pharm colleagues.

IV. The Space: At Malshiras, the researchers of FRCH have started Mahila Sarvangeen Utkarsh Mandal (MASUM), which trains women from oppressed castes and from economically deprived backgrounds to attain self-employment. MASUM then lent to Lokseva a large room on its own premises in the village at a nominal rent of Rs. 25 per month. Eventually, in repetition of the story of the camel and the Arab, Lokseva plans to expand on these premises to start a full fledged pathology laboratory (the training by Dr. Nerges Mistry has already started; again the participants of Lokseva enrol for another academic course!) and a women's health centre.

Lokseva Aushadhalay, in official terms is now one month old. Like the multitude of Indian children it may die before it reaches its first or fifth birthday. Surviving as a drugstore that doesn't make huge profits (for eg. an Aspirin tablet costs 10 paise in Lokseva as compared to brand name aspirins that cost 50 paise per tablet outside) is not easy. Ethics and ideals may not contribute to financial security. Fortunately, it is the spirit of Lokseva that is more important than the registered shop itself. What one has gained in terms of experience and values will hopefully outlive the physical structure of Lokseva Aushadhalay. ●



Irrational combination.

Planning for Poverty in India

Ramesh Awasthi *

Over three decades of development planning have hardly had any far-reaching impact on poverty in India. It would be interesting to review the change in the government's approach to poverty over the last seven Five-Year Plans.

Poverty and the Five Year Plans

The removal of poverty was not a specified objective of planning in India in the first three Five-Year Plans of the Nehru era, although a fifteen year prospective (1961-75) to secure minimum living standards was worked out by the Perspective Planning Division of the Planning Commission.

The First Plan (1951-56) was based on community development and rural extension as the method with emphasis both on intensified agricultural production and provision of basic amenities.

In the Second Plan (1956-61) cooperative farming for agrarian reorganization was the focus and the problem of local participation came to the fore as a result of Balwant Rai Mehta Committee's evaluation of the Community Development Programme.

The Third Plan (1961-66) proposed a 3-tier model of democratic decentralisation at the levels of village, block and the district with corresponding layers of administration.

The basic premise or the explicit dream of development planning in that era was development along socialist lines to secure rapid economic growth with reduction in disparities of income and wealth. The emphasis therefore was on prevention of concentration of wealth and creation of values of a free and equal society.

After three years of Plan holiday, when the Fourth Plan (1969-74) document was prepared, the conflict between growth and redistributive justice was very much in the forefront. It was being debated the world over that the 'Midas touch' of growth is not all pervasive and that 'trickle down effect' was a myth.

By that time however the urban elite and the Indian capitalists had developed strong vested interests in the sectarian character of 'growth' benefitting only the upper strata of the society. Probably that is why the growth model was not questioned. Instead, aggravating poverty was given window- dressing through a talk of 'emphasis on the common man, the weaker sections and the less privileged'.

Anti-poverty programmes became a part of planning in India when 'Garibi Hatao' became a central political slogan for electoral battles in the country in 1971. Exaggerated concern for the poor by politicians, planners and academicians dominated the scene in the 1970s and it continues to be so even in the 90s.

The Fourth Plan, for the first time, introduced a beneficiary oriented programme like the SFDA (Small Farmers Development Agency) which later included MFAL (Marginal Farmers and Agricultural Labour) so as to assist them to benefit from the green revolution. In 1971-72 a crash scheme for rural employment was introduced for creating employment for 1000 persons per year in each district. This continued in 1972-73. The Fifth Plan (1974-79) quantified the concern for the poor into neat numerical targets and promised to raise the average monthly per capita consumption of the poorest 30% of the rural population by 60% (in real terms) in five years from 1973-74 to 1978-79.

The Fifth Plan had a bad run. Political exigency overtook the planning process. The drought of 1972-73, massive inflation of 1973-74, 20 point programme of the Garibi-Hatao creed and the new anti-poverty schemes of the emergency period shattered the plan and the change of power in 1977 brought it to an abortive end. However, the Fifth Plan had called for integration of all development and employment generation programmes and introduced the concept of Basic Minimum Needs Programme.

The Sixth Plan (1980-85) document admitted that "so far, it has not been possible to make a major dent on poverty on account of the inadequate rate of growth of the economy, uneven distribution of income and consumption as well as high rate of growth of population. The reduction in poverty should, therefore, receive the highest priority in our development." (p. 21)

A programme of target group-oriented, household based, anti-poverty packages superimposed on the same growth model has constituted the government approach to fight poverty since the launching of the Sixth Plan and the same approach was continued in the formulation of the Seventh Plan.

The development strategy of the Seventh Plan aims at the direct attack on the problems of poverty and unemployment with an admission that the programmes for poverty alleviation should be regarded as supplementing the basic plan for overall economic growth, in terms of generating productive assets and skills as well as incomes for the poor.

The problem of poverty at the level of target groups comprising of marginal farmers, landless labourers and artisans is attributed to lack of enough income generating assets, lack of skills necessary for gainful employment or for self-employment and lack of wage employment opportunities, (unskilled manual wage labour) for those who have neither assets nor these skills.

This micro-level analysis of the causes of poverty has formed the basis on which most anti-poverty have been designed notwithstanding various adhoc populist programmes introduced from time to time.

Poverty in India

The main features of the poverty problem in India are -

1. Poverty and inequality are linked issues and an effective instrument to eradicate poverty should therefore

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* The author is on the research staff of FRCH. The above article is based on a study carried out by him titled, *Understanding Poverty: The Touchstone of New Economics*, the report of which was documented in 1986.

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have teeth to tackle both poverty and inequality simultaneously.

2. Although the initial conditions presented to us (by semi- feudal and colonial exploitation) to start with planned development were characteristic of a high degree of social and economic disparities, poverty in the form as it exists today is definitely an essential product of the development model that we have adopted after independence.

3. Poverty situation has surely been aggravated by slow overall growth but a faster growth rate would not automatically bring about better life for the poor because of discriminatory distribution built into the system.

4. Poverty is not an issue of growing numbers. A programme of strict enforcement of population control measures among the poor is not an answer to poverty. Rather poverty is a major constraint in implementing the population control programme.

5. While the mainstream growth process is throwing out the poor (of whatever little entitlements they were holding) on to the periphery of the economic system, poverty cannot be eliminated by a National Malaria Eradication type programme through a spray of anti-poverty programmes.

Schemes for Poverty Alleviation

A) The Integrated Rural Development Programme (IRDP) is basically an asset endowment programme aimed at creating income generating assets in the hands of the poor so as to develop self- employment in a variety of activities in primary as well as secondary and tertiary sectors.

The IRDP, contrary to what the name implies, does not involve any plan or conception of overall/integrated development of the block/village neither does it integrate the poor (target beneficiaries) with the overall development process/plans.

It does integrate some other anti-poverty programmes like the Training of Rural Youth for Self-Employment (TRYSEM) which aims at skills improvement and the Development of Women and Children in Rural Areas (DWCRA), in the sense that funds for these programmes come from the IRDP allocation.

B) The National Rural Employment Programme (NREP) launched in October 1980 became a regular Plan programme from April 1981 with the aim of generating wage labour mainly during the seasonal gaps between the crops season. Another wage employment scheme, especially for the rural landless called, the Rural Landless Employment Guarantee Programme (RLEGP) was introduced from 15th August, 1983. Though the guarantee component of the programme has not been introduced even to a limited section of the target group and in practice therefore, it in no way differs from the NREP, it continues as a separate programme chiefly because it was announced by the late Prime Minister from the historic Lal Quila in her Independence Day address to the nation in 1983.

The very basis of these programmes is founded on the tacit admission that a large number of people are left out of the normal run of the development process but it does not accept that the poor are deprived of their means of existence by the mainstream growth process itself. Without going into the causes that have created a state of deprivation in terms of assets, skills and wage incomes for a large section of our population, this micro-analysis reduces to victim-blaming that the poor are poor because they have obsolete or no assets and no relevant skills. i.e., the cause is rooted in them and not in the system.

(C) The Minimum Needs Programmes (MNP) introduced in the Fifth Plan is also based on implicit acceptance that the large number of people who have poor incomes also have poor access to the basic needs and services for an accepted minimum level of living and therefore their minimum needs have to be taken care of through special efforts by the State.

The Limitations

Since these programmes ignore the basic mechanism through which the poor have been driven to the state of absolute deprivation the following consequences are unavoidable:

(I) The acute symptoms may be pacified here and there for a short while but the problem cannot be solved unless the causes are tackled.

(ii) The programmes will continue to be ad hoc in nature and continued expenditure would be needed to maintain the poor in a state of being lifted above the poverty line.

(iii) The forces (of the mainstream growth process) which have caused asset and skill alienation among the poor continue to operate on the life of the poor. Therefore these programmes either fail to reach the poor or whatever reaches them, in the absence of backward and forward linkages, does not yield the desired results, i.e., a sustained income enough to maintain the family above the poverty line. These consequences are evident from the numerous evaluations conducted of the anti-poverty programmes, by various government and non-government agencies.

G. Parthasarathy (EPW Vol. XX (48), Nov. 30, 1985 pp. 2125- 2128), while stressing that rural poverty is rooted in the system in which the poor are deprived of assets and incomes rightly points out that "poverty alleviation is a political process involving use of resources and of technology for the benefit of the poor and there is *need for the poor to gain control over the institutions vested with decision making at the local level for such use*".

Zilla Parishads and other Panchayat bodies created under Community Development Programmes have become the hotbed of politics and factional intrigues. These bodies, as of today, are the vehicles of rural elitism with anti-poor bias. Handing over or linking up of the implementation of anti-poverty programmes to these institutions, even with some representation of beneficiaries on these bodies, is not going to change the situation even marginally.

The irony is that all the poverty alleviation programmes go on in the name of welfare. In the welfare approach there is a tacit admission that:

- the society will continue to be divided in two sectors, the growth sector and the poverty sector.
- in the normal run of the system the growth will bypass the poverty sector.
- for the growth sector all laws of capitalist growth continue to hold good.

- Some surpluses from the growth sector will be spent on the welfare programmes for the poverty sector.

Welfare itself has become a big business with politicians, officials and the rural elite pocketing most of the benefits.

Continuing lack of commitment to the anti-poverty programmes is evident from the poor resource backing that these programmes have received. Total expenditure in the Sixth Plan for the poverty alleviation programmes was Rs. 4,004.95 crores (against an outlay of Rs. 3,900 crores) which amounts to a meagre 4.1% of the total public sector outlay of Rs. 97,500 crores. In the Seventh Plan, inspite of so much noise about 'sharper focus' on poverty alleviation, the outlay was maintained more or less at the same level of 4.28% of total government sector outlay of Rs. 1,80,000 crores which comes to Rs. 7,705.24 crores (details given in table below).

TABLE Anti-Poverty Allocations

(Rs. in crores)

	VIth Plan		VIIth Plan	
	Centre	Total	Centre	Total
1. IRDP & related programme	788.39	1661.17	1864.38	8478.99
2. NREP		1843.78	1250.81	2487.47
3. RLEGP	500.00	500.00	1743.78	1743.78
Total		4004.95		7705.24
As percent of total Govt. sector Plan Outlay		4.1% (of 97,5000)		4.28% (of 1,80,000)

(*Source*: VIIth Plan document.)
Note: Sixth Plan figures represent actual expenditure whereas for the Seventh Plan allocation figures are mentioned.

Even for this expenditure the planners had to offer an apology, probably to the industrial vested interests. Page 22, para 14.2 Sixth Plan (1980-85) reads - "the provision of free or subsidised services through public agencies is expected to improve the consumption levels of those living below the poverty line... *This integration of social consumption programmes is necessary to accelerate growth* and to ensure achievement of Plan objectives."

The planners were more explicit in the Sixth Plan 1978-83 document, Vol. III, p. 141, para 4.21 reads - "the broad strategy (of 7% big increase in investment) that is proposed in employment intensive activities like agriculture and allied activities, irrigation and infrastructure like power and roads and minimum needs like water supply, health, primary education and housing will stimulate the demand for a wide range of mass consumer, intermediate and capital goods."

Therefore, in the overall strategy of planned development the expenditure on poverty alleviation or Minimum Needs Programme is seen as a public welfare expenditure which would generate temporary wage employment and increase the demand for consumption goods and hence, to an extent, relax the demand on industrial expansion.

Illusion of 'Garibi Hatao'

After examining the situation in the country and the government approach with regard to planning and implementation of the anti-poverty programmes, one comes to the conclusion that the entire gamut of poverty alleviation programmes is a total hoax being played in the name of the poor. It only amounts to doling out an illusion to sections of the poor that if not they, some others in similar conditions are being helped and that they should keep waiting for their turn or eventually curse their own fate if they fail to take benefit of the IRDP assets given to them. Paulo Friere calls it false generosity of oppressor—giving the oppressed too little to alter their material well-being, but enough to suggest that those in power are taking positive action on behalf of the poor.

Increasing the allocation for the anti-poverty programmes or repeated appeals by heads of the government for efficient and faithful implementation of these programmes cannot tackle the problem of poverty. Poverty of such dimension that engulfs half of the rural population cannot be eradicated by a peripheral activity that these anti-poverty programmes have come to be while the entire economic planning is directed to the goal of high rate of overall economic growth.

With the poor caught in the oppressive power structure at the village level, corrupt and elitist bureaucracy coming from the better off sections of the society that despises and exploits the poor, and the economic growth which is generating more wage labour than what industrialisation can absorb, the prospects are that by the year 2000 A.D. we will have many more marginalised poor falling off into the dark ditch of starvation. malnutrition, disease and death.

Our point here is not to oppose poverty alleviation or overall economic growth but to bring to the fore the issues of social justice: With all this overall economic growth and in the name of welfare of the poor are we really helping the poor? Are we moving towards creating conditions in which the poor will have access to skills, resources and opportunities to satisfy their basic needs? If the poor ever get a say in planning, will they tolerate, even for a day, the growth model, which enriches the elite and keeps the poor waiting for four decades without any share in the fruits of growth? Will the planners of today plan in the same way if they were living a life below the poverty line? ●

POVERTY IN INDIA

According to an *Operations Research Group (ORG)* demographics study 61 per cent of the households in rural india have fallen below the poverty level against a national average of little over 50 per cent. Of these, 27.5 per cent have a monthly income of less than Rs. 350, while only 3.4 per cent have a monthly income of more than Rs. 2,500.

[Source: Economic Times 13-12-90]

Social Indicators of Development, 1989, published by the World Bank also presents a telling situation of poverty in India—56.5% of the population is illiterate (corresponding figures for females, 71.1%) 49.3% children (under 5 years) suffer from malnutrition, the doctor: patient ratio is 1:2521.

[Source: Times of India, 31-1-90]

The Unknown Health Worker

Audrey Fernandes *

Kashibai, part time attendant, greets one with an outstretched hand. She insists on carrying your bag, because that is what she is used to doing. Behind the Auxiliary Nurse Midwife (ANM), carrying the immunisation kit, she is always there. She sits outside the door, while one talks to the ANM and once in a way you are reminded of her presence when the ANM asks her to buy *poha,* or sugar for tea, or to clean up some vessels, etc.

One often thinks of the ANM as the final grassroot health worker. But essential to her, in terms of work and support is the part-time attendant. This is the woman who occupies the lowest rung of the health worker ladder. She has often been doing the same job for years together. She lives in constant hope that she would be recognised as a full time government employee, that she would get the status and benefits that these employees enjoy. Kashibai, from Beed district said, "I joined in 1972 at the time of the big drought. I was sent to Mali-Chincholi, a PHC away from my village, in Beed district itself. I worked there for 8 years, after which I got transferred to Paithan. I have been transferred 8 times. In each place I had to rent a room for Rs. 20-25."

She continues, "Look at us, we get Rs. 80/- only; if we went for agricultural work - the daily wages are Rs. 10.00. We cannot do that as we go for home visits early in the morning and come back at 1:00 pm. Sometimes it is 2:00 or 3:00 even. And what does the government pay us - Rs 3.00 per day! The nature of the job they are required to do, though termed 'part-time', keeps them from taking up any other gainful employment. As a result they become overly dependent on the ANM. Very often they act as domestic servants in the ANM's house, cooking and washing clothes, cleaning vessels and running errands for her, dependent on the meal an ANM may provide, or the occasional saree.

One ANM, when talking about how the village men cat-call, or ask embarassing questions about FP spacing methods, mentioned that she never replied to any of these taunts, but her attendant did. She recognised every one in the village and would call them by name and give them a fitting reply. This was by and large the rule with most ANMs we met, especially in Wardha district. They often said they did not go for home visits without the part- time attendant. Even if there was a delivery call during the night an ANM would not step out of her house until the part-time attendant came along. For most ANMs, the part-time attendant is a source of strength, valued for the company and support offered.

To ANMs newly posted in a sub-centre the part-timer provides information, introduces her to the village and helps her get sterilisation cases. She also acts as protector against elements in the village who might attempt to harass a newly appointed ANM. ANMs related that Medical Officers often, while sending an ANM to a 'troublesome" sub-centre, warn the part-timer, "If anything happens to sister (meaning ANM) I'll hold you responsible."

Often, because of the many years of experience that an attendant has, she knows the tricks of the job better than the ANM. Though mostly illiterate, she knows the names of the medicines, recognises them and often doles them out too, if the ANM is absent or busy, She is also more adept at convincing women about undergoing a tubectomy. She talks their language and they trust her has one of them in every sense - being from the same village (except in Beed district where part-timers are also transferred) she wears the same kind of saree, talks the same coloquial language.

In Wardha, many ANMs, when asked what problems they were facing in their jobs, replied that the salaries of their attendants were very low. As a result attendants avoided accompanying the ANM on home visits, preferring agricultural work. Most ANMs don't feel confident about going alone through fields and jungle tracks.

Some ANMs, though, have a very condescending attitude to their part-timers and use the 'lokseva' idiom to extract more work from them. An illustrative conversation:

Part-time Attendant (PTA): We get paid so little. It's better to work as agricultural labourer.

ANM : Don't talk like that! You are bound to get benefits in future. See us, we also started with Rs. 125 per month. Did we not benefit?

PTA : When did you work for Rs. 125?

ANM : During our training - this was our stipend! Think this to be your stipend. Besides, you are doing service to people; is there anything bad in that?

When asked what made her take up the job, Kashibai related, "My husband used to constantly pick fights with me. I thought it was better to earn some money - and leave the village. He wanted that. He then remarried. I now have nobody". What was disturbing was that a very large proportion of these women had been deserted by their husbands, or were widowed. This negative status adds to their need and dependence on the job.

In one PHC in Wardha the part-time attendant employed in the PHC, earned Rs. 80.00. Her husband had deserted her and she had three small children to look after. She said she had to clean the operation theatre, sweep and swab the whole PHC, and clean the toilets. She came to the PHC everyday. She hoped to be made permanent. In Beed, a full-time attendant at the PHC said that she had worked for 16 years as part-time before she was made full time. Her mother had worked as part-time for 22 years before that.

Another part-time attendant, under the mistaken notion that we were government personnel, complained to

(Contd. on p.12)

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UPDATE ON FRCH PROJECTS

1. **Arogya Shikshan Kendra (ASK):** A field based health education project supported by ICMR. It covered 18 villages in Malshiras (Purandar taluka, Pune district) PHC area. The project includes a wide range of activities covering health education, self-employment (for women), public information service, and very recently a retail drugstore for rational drugs (detailed report on page 5).

2. **Health Financing and Costs: Comparative Perspectives:** A descriptive and analytical study of cross-national trends in the financing and delivery of health care covering 22 countries representing different socio-economic and political systems, viz. the less industrialised economies, the centrally planned industrialised economies and the industrialised capitalist economies.

3. **Private Sector and Privatisation in the Health Care Services:** A report recording the phenomenal growth of the private sector in health care, the role of the state in this growth and its implications for achievement of the Alma Ata goal.

4. **Kasare - Self Help Development:** An effort at motivating people in five villages towards self development following the Ralegan Shindi model.

5. **School Health Education:** This project enters its final follow-up and evaluation phase. Detailed description of this project is contained in the article on page 1.

6. **Study of Auxiliary Nurse Midwives and Doctors at the PHCs in Maharashtra:** Covers four districts in Maharashtra and studies six non-tribal PHCs from each district and three tribal PHCs in Pune district. The study focus on socio-economic background of ANMs and doctors, their role expectation, performance, satisfaction/dissatisfication, and problems of ANMs. It also assesses their training vis-a-vis their performance.

7. **Study of Household Health Expenditure in Madhya Pradesh:** After the study of household health expenditure in Jalgaon district (Maharashtra) this is a study in two districts, Sagar and Morena, in Madhya Pradesh. It aims at understanding household health expenditure by disaggregating the components and analysing its differentials based on the three geographical seasons, socio-economic strata and on social geography.

8. **Some Issues in the Community Participation in Health Care Services:** A review paper attempting to analyse the meaning of community participation and the socio-economic-political obstacles that have stood in the way of such participation in health care services as envisaged in the Sixth Five Year Plan Document.

9. **Study of Health Expenditure in India:** Sponsored by the ICMR this study was completed in three phases. The first covered household expenditure patterns for health care, the second made an analytical documentation of State health services in India while the final phase made an exploratory study of the private sector covering general practitioners as well as the corporate sector.

10. **Study of Urban T.B. Clinics:** Focuses on in-depth case studies of T.B. clinics in Bombay. The study looks at the health functionaries as well as patients with the idea of understanding constraints and identifying possible interventions in the effective implementation of the T.B. control programme.

11. **The Community Health Care System:** FRCH team is in the process of evolving a detailed model which aims at the convergence of the different prongs and substitute with curative, preventive, promotive health services, in the delivery of rural health care and health education and information.

12. **The development of PVC Footwear for Insensitive feet of Leprosy Patients:** A project to devise a prototype of mass production of footwear which would be mechanically sound as well as aesthetically acceptable for leprosy patients with anaesthetic feet and moderate deformities of the feet.

The above gives a brief idea the projects of FRCH. More detailed reports about each projects are compiled in the FRCH Annual Report, 1990 available at FRCH, 84-A, R.G. Thadani Marg, Worli, Bombay - 400 018, on request.

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Contd. from pg 10)

us that we were only paying attention to the problems of the ANMs and neglecting the part-time attendants. In her own words: "Nobody thinks of us. If we went for wage labour we would get Rs. 12.00. per day. What we get is not enough for even the S.T. fare to the PHC. What can one buy in Rs. 80.00? And, the ANM I work with does not pay for bus fares when I travel with her. When my husband fell sick with paralysis, she gave me medicines and then asked me for the money."

The DHO office in Wardha informed us that part-time attendants are employed under two heads. Those under the MCH programme were paid Rs. 80.00, and those under the FP programme Rs. 50.00. But when asked many attendants were not aware of this differentiation. They said that they had got Rs. 80.00 for 5-6 months. After that they were getting Rs. 50.00. In a few cases we heard that after their salary was reduced to Rs. 50.00, they actually got Rs. 40.00 for the earlier mistake, as Rs. 10.00 was being cut every month, as arrears!

In Wardha, there had been an attempt to unionise part-time attendants. Some attendants went for the meeting, escorted by their ANMs. Some said the ANMs had given them the money for the ticket to Wardha and back. Also for the union membership fee of Rs. 11.00. Other attendants when asked whether they had attended the meeting replied angrily. "What union are you talking about? How do we go? Do you think we can afford bus-fare to and fro? And Rs. 11.00 for membership? What will be left from Rs. 50.00?

And so, they continue to work. Like bullocks pulling a cart. Carrying the immunisation kit, the ANMs hand-bag, cooking for her, looking after patients after a tubectomy, looking after the ANM when she is alone, protecting her when she is on home visits.

The slogan, "Health for All" sounds glorious. But unless the lowest rungs in the hierarchy of the health delivery system are empowered and their vital link in the achievement of this goal recognised, the slogan may well fall by the wayside on its bumpy ride in the health wagon. ●

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HEALTH FINANCING AND COSTS
A Profile of Japan

Sonya Gill

FRCH Newsletter, July -- August, 1990, had carried an article, 'Health Financing in the Developing Countries' by Shirish Kavadi, which gave an introduction to the study, 'Health Financing and Costs: comparative perspectives with special reference to India', which was sponsored by the WHO. Beginning with this issue, five non-thematic issues will each carry one profile based on the country reports prepared for this study.

Japan has a statutory health system that ensures universal coverage and good quality care at reasonable costs. Since 1961, when universal coverage (as against the earlier voluntary schemes) was implemented, there has been a progressive expansion of medical benefits and greater equity in the distribution of health care resources. This country report briefly reviews the universal health care system in Japan, that has been one of the major factors underlying the rapid improvement in health status.

Health Status

Japan, with a population of 122.2 million (1987), has achieved remarkable improvements in the health status of its people over the past three decades (Table1) . By 1986 life expectancy of the average Japanese (75.2 years for men and 80.9 years for women) was the highest in the world. Total mortality is considerably lower (6/1000 population) than in other countries, while its infant mortality rate of 5.2 deaths was the lowest in the world.

In the 1920s and 30s and immediately after the war, the health conditions in Japan were characterized by a high incidence of communicable diseases, particularly tuberculosis and gastroenteritis and high maternal mortality (160-180/100,000 births). Between 1955 and 1980, all these health indices improved rapidly, i.e. within a period of just 25 years and by 1986, mortality in all age groups and due to all categories had shown a significant decline. However, rapid industrialization and urbanization since the 1960s have given rise to environmental problems such as pollution, overcrowding and shortage of housing and inadequate sewage and garbage disposal systems. The rise in coronary heart diseases, cancers, suicides and accidents reflect these environmental conditions.

TABLE 1: HEALTH STATUS - JAPAN

Year	Crude Birth Rate (per 1000 pop.)	Crude Death Rate (per 1000 pop.)	Mortality Rate: Infant per 1000 births	Mortality Rate: Maternal per 100,000 births	Life Expectancy At Birth (years)
1960	17.2	7.6	30.7	49.0(1980)	68
1986	11.4	6.2	5.2	15.0	78

Source:Japan Statistical Year Book, 1988.

Universal Health Insurance

Pre-World War II Japan had established limited compulsory health coverage for the industrial work force in 1927 and voluntary health insurance for the self-employed rural and coastal population by 1938. These limited social security provisions for medical care were modified and made compulsorily applicable for every Japanese by 1961. The scope of medical benefits was also established by law and includes all ambulatory and in-patient care, diagnostic services, drugs (specified in a list approved by the Ministry of Health and Welfare), dental care (including most dentures), all appliances except eye-glasses and transportation. However, preventive examinations, screenings and normal child delivery are not covered but appear as benefits in some of the better-off employment based insurance schemes.

Thus, while health insurance is universal and covers the cost of a wide range of needed medical services, the Japanese system is neither uniform nor equitable. This system, in fact, consists of two altogether different programs. The first is the Employee Health Insurance (EHI) scheme covering 62.4% of the total insured population (1985). It has 7 separate plans for different categories of the employed population, e.g.. employees of large corporate firms, seamen, employers in medium and small enterprises, civil servants and government employees, school

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teachers etc., and is financed through contributions by both the employer and the employee. However, the contribution rate and its division vary from scheme to scheme. The EHI uniformly meets 90% of the medical costs for the beneficiaries and 70% for the dependents.

The second program, the National Health Insurance (NHI), covers 37.6% of the population and consists of regionally based insurance plans, administered by local governments and municipalities in cities, towns and villages, for the non-employee population (agricultural workers, the self employed, construction workers, doctors, employees at small-scale places of work, farmers etc.). The NHI provides a lower coverage of 70% of health care costs imposing 30% cost sharing on its members. It is financed in equal proportion by a special NHI tax on the insured households (levied and collected by local governments) and central government subsidies. The difference in insurance arrangements and the larger user charges in the NHI means that a greater burden of the costs is borne by the self - employed and the rural population as compared to the urban and organized employment sector. The EHI scheme is at a considerable advantage as regards the amount of income available to both employers and employees to finance a health insurance scheme. Moreover, the health standards of employees in the larger industrial enterprises tend to be better than in rural occupations which again places the EHI at a financial advantage over the NHI scheme.

Health Expenditures and Cost Containment

With growing demand for medical care, Japan, like other industrialized affluent countries, is faced with rising medical care costs. While Japan has been a lower spender on health care, (Table 2) whether measured in terms of the GDP share of 6.7% in 1986, (lower than the OECD - Organisation of Economic Cooperation and Development - average of 7.3%) or in terms of per capita health spending of US $831 (significantly less than that of USA: $ 1,926, Canada: $ 1,370, Sweden: $ 1,195, and W.Germany: $ 1,031.), it has, nevertheless, had one of the highest growth rates of health expenditures from 1960 to the present. These trends partly reflect the rapid growth and affluence of its economy.

TABLE 2 : NATIONAL HEALTH EXPENDITURE 1960-1986

Year	Total Billion Yen	Per Capita U.S. $	Public Expense. to Total expense %	Total Expense to G.D.P. %
1960	409.5	-	60.4	3.1
1970	2496.2	66.85	69.8	4.1
1980	11980.5	451.38	70.8	6.0
1986	17020.0	830.09	72.9	6.7

Source: Sawamura, H. Recent developments in medical care delivery systems in the region. National expenditure of Japan, 1969 OECD, Health Care systems in Transition, 1990

Rising expenditure has reopened the question of how to finance health insurance and raise additional resources. The policy debates have however, given less thought to modifying medical services and practice patterns, such as regulating the duplication and excessive utilization of high cost medical technology or separating medical and pharmaceutical services to curb doctors from over prescribing and dispensing expensive drugs to increase their profits, than to achieving fiscal stability. In a multiple insurance system, it is the tax funded scheme (NHI) which is under greater pressure to curtail demand and find alternatives to public subsidies. The main policy measure adopted has been to impose and increase user charges. This raises a fundamental question about social policy objectives in the capitalist welfare states: does not the less well-off and medically more needy population (the 37% covered by the NHI) have the right to more public funds in one of the world's most affluent economies? User charges, it must be noted, meet less than 10% of the total health cost in these countries, with the exception of the USA. In the latter, direct household spending accounts for 25% of health expenditure as it is the only OECD country lacking a universal health care system and extensive public coverage. The level at which user charges have been imposed in Japan will hardly modify medical needs or raise substantial funds. It may however prevent the lower income groups from taking adequate health care. A more thorough-going solution will be to have a single health insurance program for the country as a whole; but those enjoying higher standards under the better-off EHI scheme, have opposed the pooling of resources.

Japan also created a separate financing system for the retired elderly in 1982, so that the NHI would not be burdened by the rapidly rising aged (above 65 years) population constituting 10.6% in 1986 and estimated to rise to 23.6% by the year 2020. The employment based schemes have been made responsible for partly financing the growing demand for geriatric care. Small user charges have been imposed, overturning the 100% free coverage provided since 1973.

Health Care Services

Medical care is largely provided by private practitioners in family owned clinics and hospitals. Investor owned health facilities are prohibited and the larger hospitals are public institutions. In 1986, there were 9,699 hospitals and 79,369 medical clinics. The ratio of 1,492 beds per 100,000 population (Table 3) is one of the highest among industrialized countries. Since 1985, the Prefectural (state) governments are required by law to develop regional and local health plans in order to contain excess hospital bed capacity and achieve balanced distribution of services. While in overall quantitative terms, Japan's medical care system has attained a high standard, problems of maldistribution characterise the remote mountainous areas and rapidly urbanizing regions.

TABLE 3: HEALTH DELIVERY

Year	Physicians	Nurses	Dentists	Beds
	Per 100,000 population			
1960	117	-	-	912
1970	134	79	10	1266
1980	231	335	11	1374
1986	339	381	15	1493

Sources: Japan Statistical Yearbook, 1962 and 1986.

The health insurance system, while ensuring universal coverage, also provides a framework for regulating the price of medical services. Japanese physicians are paid on a fee for service basis which, in turn, is based on a uniform fee schedule for the entire country. The fees established through negotiations between the government, the medical profession, and the insurance associations are for a particular service or procedure,

(Continued on Page 8)

HEALTH POLICY CONTENT IN MANIFESTOS

An Analysis

Alex George

Though elections are generally contested on the basis of only one or two issues, they compel the political parties to come out with their manifestos, setting forth their positions on a wide range of aspects which have a bearing on the nation's development. Thus, of late, apart from education which used to occupy a position of importance in manifestos, other social sectors like health, environment, women and child development, are also beginning to catch the attention of those who prepare the manifestos. But a mere gaze from the political quarter is hardly sufficient for these important sectors.

The following article presents the health component in the current manifestos followed by some observations. The manifestos discussed here are those of the main political parties and alliances, viz. the Samajwadi Janata Party (SJP), the National Front (NF), the CPI, the CPI-M, the Indian National Congress(I) and the Bharatiya Janata Party (BJP).

The Samajwadi Janata Party (SJP)

The SJP pledges to correct what it calls the "distortions in the nation's investment priorities" and to work towards providing the basic necessities, in which it includes health and education along with food, clothing and housing. In addition the party promises to supply drinking water in each village of the country by the end of the VIIIth Plan. The SJP also puts forward "a new approach to population growth by clubbing together awareness campaign, health facilities, nutrition and family planning."

The National Front (NF)

The Front believes that preventive, promotive and curative health care need an inter-sectoral approach and that the existing imbalance in public spending should therefore be corrected by:

a) enhancing the community's own preventive / promotive capacity by imparting knowledge related to nutrition, health and hygiene,
b) strengthening the health care infrastructure to reach remote rural and tribal areas and urban slums,
c) taking health services to the people through community level networks linking health workers and facilities to other service systems,
d) giving first service priority to mother and child health considering their vulnerability during pregnancy and early childhood, and,
e) promoting, on a priority basis, those health services which address the most common causes of illness and death.

The Front also commits itself to removing the basic causes of the high rate of population growth and in particular, to eliminating rural poverty which it regards as the main obstacle to regulating family size. It intends to take urgent steps to expand family planning knowledge and services, as a part of a social movement linked to their broader approach to equity and basic developmental needs and to aim at a higher quality of population.

The Communist Party of India (CPI)

The CPI is for an extensive free health program and for increasing the budget allocation for health. The party also offers to improve health services in all district and primary health centres with linkage to the district centres.

The Communist Party of India, Marxist (CPI-M)

The CPI-M promises improved primary health services in the rural areas with the adequate supply of medicines. The party also offers to implement a people oriented national drug policy.

The Indian National Congress (I)

In its 'first 100 days in power', the Congress(I) promises to extend drinking water supply by exempting from taxation the profits invested in the same. 'In the first 365 days' as the party puts it, they intend to hand over the primary health centres to panchayat bodies at taluka samiti levels and provide funds directly to them. It also aims at building 1000 *Sulabh Shauchalayas* every year. The party's target for the 'first 730 days' is to set up in every state capital either in the private or joint sector, a multi-disciplinary high quality institute of medical sciences with a hospital. Another target which the party promises to fulfill in the first two years is to establish and enforce standards of noise pollution.

The Bharatiya Janata Party (BJP)

The BJP aims at introducing an integrated system of medicine by bringing together Ayurveda, Siddha, Unani, Homeopathy, Chromopathy, Naturopathy and Allopathy. Compiling and publishing ancient wisdom on health care, and encouraging Yogasana in schools, follow in the order of prominence. The party promises to give an annual health check-up to all students and to set up in every village a health care centre with emphasis on mother and child care. Increased production of milk and proteinous foods are also planned. The party promises to take adequate measures to "promote the production of poor man's grains like jowar, bajra, and ragi." It also intends to replace the 60,000 brand name drugs by 250 generic formulations and ban amniocentesis.

On the population front, the BJP intends to adopt a National Population Policy (NPP), if necessary even through legislative measures. This will make family planning information and facilities available to the people and will involve voluntary organisations in creating awareness. Another component of the proposed NPP is to integrate family welfare programs with other community welfare programs. All the same, the party does state clearly that it plans to introduce both incentives as well as disincentives to promote the 'voluntary adoption' of the 'two child' norm.

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Some Observations

That the SJP lists health as one of the five basic necessities is commendable. So also is their new approach to family planning, combining awareness building, health facilities and nutrition. Yet, it has to be pointed out that the party does not carry a comprehensive health policy anywhere in its manifesto.

The National Front's emphasis to improve the "preventive/ promotive capacity of the community" demonstrates an acceptance of the people's own ability to take care of their health to a considerable extent. This marks a change from the conventional development thinking where people are seen merely as ignorant recipients of developmental information. Yet it has to be pointed out that the curative capability of the people, which was demonstrated in experiments such as the Mandwa health project, has not been given any attention. This means that the curative part is left entirely to the medical profession. The Front's attempt to link health workers and facilities with other service systems indicates a holistic approach to health care within the framework of developmental services in general. The Front also makes a welcome shift from mere population control to expanding family planning knowledge and services as part of a social movement within the broader framework of their approach to equity. Yet one must hasten to add that the National Front also does not contemplate any structural change if the above commitments are to be implemented.

Both the Communist Parties do not have much to say on health. Though the CPI calls for a free health programme and increased budget allocation for health and the CPI-M calls for a people oriented national drug policy and improvement of rural primary health care, both the parties apparently reflect a lack of grasp of the finer aspects of health policy formulation.

Though the Congress(I) promises to introduce popular measures such as extending drinking water facility and constructing 1000 *Sulabh Shouchalayas* every year, the party still gives prominence to the high profile sophisticated medical technology, as indicated by its plan to establish a multi-disciplinary high quality centre of medical services attached with a hospital in every state capital. Since these centres are to be set up in the private or joint sectors, it will also amount to further privatisation. Moreover, since we already have several such centres in the country, should not the provision of primary health care to remote rural areas be the first priority? The party's intention to hand over the primary health centres to the panchayats is laudable. But, the attempt to fund them directly from the centre nullifies the idea of such decentralisation.

The major thrust of the health component of the BJP manifesto is to revive the Indian systems of medicine, particularly Ayurveda, and to integrate them with Allopathy. However, modalities of this integration have not been indicated. The schemes to give an annual medical check up to all students and to start a health care centre in every village with focus on mother and child health is commendable, but again, no thought seems to have been given to make such village centres more functional than at present.

The intention to increase milk production seems to be related to the party's plan to ban cow slaughter which is mentioned elsewhere in its manifesto. In itself, the idea to increase the production of milk and proteinous foods is to be welcomed. But the point however is, how will this enhanced production of milk and proteinous food stuffs be made available to the public, especially the poor, at affordable prices? There is no mention of introducing a price policy which will bring them within the reach of the poor.

While the BJP plans to increase the production of "poorman's grains like jowar, bajra, and ragi", it is hoped that the poor will also be provided with adequate quantities of wheat and rice. The party's promise to introduce generic names instead of brand names is laudable, but the question remains as to how the BJP plans to bring down 60,000 brand names straightaway to just 250 generic names as promised by them. How do they intend to tackle the formidable lobby of the pharmaceutical industry? Their claim to ban amniocentesis is very radical, but it would be interesting to see how the party goes about implementing it in the BJP ruled states of Madhya Pradesh and Rajasthan, where amniocentesis and female foeticide are emerging as growing phenomena. The BJP's statement that it intends to introduce disincentives to promote the voluntary adoption of the "two child" norm is likely to lead to coercion. Other components of its population policy such as involving voluntary organisations in creating family welfare awareness and integrating family planning with other community welfare programmes are not altogether new.

Conclusion

On the whole, it may be pointed out that an important social sector such as health is not on the priority list of most of the political parties. But what is more striking about all manifestos is that, none of them mention anything about structural reforms of the health sector, such as universal health care, regulating the growth of private sector in the field and bringing accountability into the public sector. Most manifestos suggest only peripheral reforms within the existing framework of the health sector, a framework which has clearly failed to provide health to the vast majority of our people, especially to the poor in rural areas.

BRANDED AND GENERICS

It has been estimated that generic prescribing could save the NHS 30-50 million Pound sterling a year straight after being introduced, and 100-150 million Pound sterling, after 4 or 5 years.

The logic of generics is compelling: 95% of the drugs on the WHO Selection of Essential Drugs can be bought as generics - because their patents have expired; Research and development spending on the drugs the Third World poor need has mostly been recouped.

The drug industry allocated only 1% of research and development spending to poor world diseases in 1980 - i.e. about half as much as it costs to develop just one new drug.

Current research mostly ignores Third World needs: Out of 87 diseases specific to poor countries, there are vaccinations for 10, satisfactory drug treatment for 23, but no drugs at all to treat 32 disease and the remaining 22 can only be treated with very unsatisfactory drugs that have serious toxic side effects.

Source: Prescription for Change - Virginia Beardshaw, The Hague, 1983,as carried in Health Action International's Guide to Rational Health Projects. pg.73

HEALTH POLICY IN THE FIVE YEAR PLANS
A Critical Overview

Sunil Nandraj

Health infrastructure development in India clearly shows that the pattern of growth of the health sector has only contributed to its underdevelopment. The three high growth areas of medical education, pharmaceuticals and private practice, coupled with the backwardness of the health care services specifically and the overburdened economy in general, has only added to this misery. The beneficiaries of such a development have been the enclave sector - the metropolis urban-entrepreneurial economy. In contrast, the health care services in the periphery, like all other sectors of the economy, remain backward; what little exists is both of difficult access and poor quality.

It was not until 1983, that India adopted a formal or official National Health Policy. Prior to this, health activities of the state were formulated through the Five Year Plans and the recommendations of various Committees. In the Five Year Plans the health sector was broken into schemes which had targets to be fulfilled. Each plan had a number of schemes and every subsequent plan added more or dropped a few.

In the fifties and the sixties, the entire focus of the health sector in India was to manage epidemics. Mass campaigns were started to eradicate various diseases. These separate country-wide campaigns with a techno-centric approach were launched against malaria, smallpox, tuberculosis, leprosy, filaria, trachoma and cholera. Cadres of workers were trained in each of the vertical programmes. The National Malaria Eradication Programmes (NMEP) alone required the training of 150,000 workers spread over in 400 units in the prevention and curative aspects of Malaria control. (1)

The policy of going in for mass campaigns was in continuation of the policy of colonialists who subscribed to the precept of modern medicine that health could be looked after if the germs which were causing it were removed, thus ignoring the socio-economic dimensions of various diseases viz. poverty, inadequate nutrition, clothing and housing and the lack of a proper environment. National programmes were launched to eradicate diseases. The NMEP was started in 1953, with the aid of the technical cooperation mission of the U.S.A. and technical advice from the World Health Organisation (WHO). Malaria, at that time, was considered an international threat. One of the most important activities of the programme was DDT spraying operations. The tuberculosis programme involved vaccination with BCG, clinics, domiciliary services and after care. The emphasis however was on prevention through BCG. These programmes depended on international agencies like UNICEF and WHO for supplies of the necessary chemicals and vaccines. The policy with regard to communicable diseases was dictated by the imperialist powers as in other sectors of the economy. Along with financial aid came political and ideological influence. The entire policy framework, programme design and financial commitments etc. were decided by the experts of various international agencies.

The Mudaliar Committee report in 1961, recorded that the disease control programmes had some substantial achievements in controlling certain virulent epidemic diseases. Malaria was considered to be under control. Deaths due to malaria, cholera, smallpox, etc. were halved or sharply reduced and the overall morbidity and mortality rates had declined. The death rate had fallen to 21.6 per 1000 population for the period 1956-61. The expectation of life at birth had risen to 42 years. However, the tuberculosis programme had lagged behind. The report also stated, that, for a million and half estimated open cases of tuberculosis, there were not more than 30,000 beds available (2). The Mudaliar Committee further admitted that the basic health facilities had not reached at least half the nation. The Primary Health Centre (PHC) was not given the importance it should have received, right from the start. Most of the PHCs were understaffed, a large number of them were being run by Auxiliary Nurse Midwives (ANMs) or the public health nurses in charge. The fact appears that doctors were going into private practice after training at public expense. The communicable disease programme was given top priority in the first two plans. But the primary health centres, through which the gains of this programme could be maintained were given only tepid support. In the process, the rural areas had little or no access to them. The condition of the secondary district hospitals was the same as the PHCs. The report showed that the majority of the beds and other facilities were located in the urban areas.

The committee, with regard to medical human power, suggested measures to improve the service conditions of doctors and other personnel in order to attract them to the rural areas. The committee makes a mention that except for a substantial increase in the number of doctors, the number of other categories of health personnel was still woefully short of the requirement. The committee insisted that medical education should get a greater amount of the financial allocation from the central government. This was in clear contradiction to its finding that the doctors were not willing to go to rural areas. In what way, therefore, would a greater number of doctors being trained mean more access for the people?

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The IIIrd Plan launched in 1961 discussed the problems of the provision of the PHCs and directed attention to the shortage of health personnel, delays in the construction of the PHC buildings and staff quarters and inadequate training facilities for the different categories of staff required in the rural areas. The 'doctor' syndrome loomed large in the minds of the planners and increase in the supply of human power in health meant more doctors and not other health personnel. By the end of the IIIrd Plan it was felt that the doctors were not going to the rural areas or serving in the government primary health centers. While the IIIrd Plan gave serious consideration to the need for more auxiliary personnel, no mention was made of any specific steps to reach this goal (4). Only lip service was paid to the need of increasing auxiliary personnel, but in the actual training and establishment of institutions for these personnel, inadequate funding became the constant obstacle. On the other hand, the proposed outlays for new medical colleges, establishment of preventive and social medicine and psychiatric departments, the completion of the All India Institute of Medical Sciences and schemes for upgrading the departments for post graduate training and research in existing medical colleges, continued to be high (3). The urban health structure continued to grow and its sophisticated services and specialities continued to multiply.

The IIIrd Plan gave serious consideration to suggesting a realistic solution to the problem of insufficient doctors for rural areas; stating "that a new short term course for the training of medical assistants should be instituted at an early date;" undertaking health education as a serious national programme was stressed (5). In this plan, a rapid increase in the numbers of PHCs was witnessed but their condition was the same as the Mudaliar Committee had found at the end of the IInd Plan period. Due to the vertical nature of the disease control programmes, we find a huge army of workers. The delivery of services continued to be done by special uni-purpose health workers. Therefore we find that in the same geographical areas, there was overlapping and duplication of work.

The health programme that shot into the limelight during the IIIrd Five Year Plan was Family Planning (FP) and Population Control. India is the first country in the world to adopt, in 1951, a policy of reducing population growth through a government sponsored family planning programme. In the first two Plans the family planning programme was mainly through voluntary organizations under the aegis of the Family Planning Association Of India (FPAI). Faced with a rising birth rate and a falling death rate, the IIIrd Plan stated that "the objective of stabilising the growth of population over a reasonable period must therefore be at the very centres of planned development" (5). It was during this period that the camp approach was tried out and government agencies began to actively participate in pushing population control. There was a fundamental change in India's health policy. This policy change, though it had its own inner compulsions, was more due to the influence of foreign agencies.

The IVth Plan, which began in 1969, after a 3 year plan holiday, continued on the same line as the IIIrd Plan. It lamented on the poor progress made in the PHC programme and recognised again the need to strengthen it. It pleaded for the establishment of an effective machinery for the speedy construction of buildings and improvements in the performance of the PHCs by providing them with staff, equipment and other facilities. It was reiterated that the PHCs base would be strengthened along with sub-divisional and district hospitals who could be referral centres for the PHCs. The importance of the PHCs was stressed to consolidate the maintenance phase of the communicable diseases programmes. This acknowledgement was due to the fact that the entire epidemiological trend was reversed in the incidence of malaria cases, which rose from an annual incidence of100,000 cases between 1963-65, to 149,102 cases in 1966 (7). This was admitted by the Planning Commission. Family planning continued to get an even greater emphasis with 42% of the health sector plan allocation going to it.

It was in the Vth Plan, that the government ruefully acknowledged that despite advances in terms of the infant mortality rate going down, life expectancy going up, the number of medical institutions, functionaries, beds, health facilities, etc., were still inadequate in the rural areas. This shows that the government acknowledged that the urban health sector had expanded at the cost of the rural sector. This awareness is clearly reflected in the objectives of the Vth Five Year Plan which were as follows :

1. Increasing the accessability of the health services to the rural areas through the Minimum Needs Program (MNP), and correcting regional imbalances.
2. Referral services to be developed further by removing deficiencies in the district and sub-division level hospitals.
3. Intensification of the control and eradication of communicable diseases.
4. Affecting quality improvement in the education and training of health personnel.
5. Development of referral services by providing specialised attention to common diseases in rural areas.(6).

The method by which these goals were to be achieved were the MNP, the Multi Purpose Worker (MPW) training scheme and priority treatment to backward and tribal areas. Major innovations took place with regard to the health policy and method of delivery of health care services. This was envisaged through the MNP. It was an integrated package approach to the rural areas. The plan further envisaged that the delivery of health care services would be through a new category of health personnel to be specially trained as multi-purpose health assistants.

The multi purpose worker scheme was launched with the objective of retraining the existing cadre of vertical programme workers. The various vertical programmes were to be fully integrated with the the other health care programmes. Further, in 1977, a major innovation in health strategy was launched- a programme for training village based health auxiliaries called the Community Health Volunteers (CHV) scheme. These were part time workers selected by the village, trained for 3 months in simple promotive and curative skills both in allopathy and the indigenous systems of medicine. They were to be supervised by the MPWs. This step was taken on the recomendations of the Shrivastava Committee (Study Group on Medical Education and Support Manpower), in 1975. The main recommendations of the committee concerned having part-time health personnel selected by the community from within the community. They would act as a link between the MPW at the sub-centre and the community. With regard to medical education the committee cried for a halt to the opening of new medical colleges.

This was also the period of the 'Emergency' and the peak of

the population control programme. Family planning which started with an insignificant outlay in the Ist Plan, was now taking away 50% of the outlay of the health programmes.

Inspite of the realisation on the part of the planners and the policy makers that most of the investment being made in the health sector was going to the urban areas, human power, medical facilities, water supply and sanitation facilities, etc. continued to grow in the urban areas, where only 30% of the population was residing. Even within the urban areas a disproportionately large chunk was being appropriated by the privileged classes, as is evident from the social consumption patterns.

In the Vth Plan, water supply and sanitation got a greater emphasis. It was one of the important objectives of the MNP to provide drinking water to all villages suffering from chronic scarcity of water. The outlay for water supply during this plan period was Rs. 10,220 million, i.e. nearly as much as health and family planning taken together(6). The provision of safe water supply and basic sanitation are either absent, or grossly inadequate for the vast majority of the population of both the urban and rural areas of India. The major diseases which affect the Indian population, such as diahorrea, amoebic dysentery, cholera, typhoid and jaundice, are water borne. These diseases are also carried and spread due to the lack of basic sanitation. To alleviate this problem, the National Water Supply and Sanitation Committee, (Simon Committee) was formed in 1960, to review the progress made under the national programmes in the first two Plans. The report came out with the finding that the states themselves lacked data and information regarding the magnitude and nature of the problem. It stressed the need for immediate survey and investigation to obtain correct data on the existing conditions in both the urban and rural areas on which future planning and implementation could be based. It strongly recommended that by the end of the IIIrd Plan, minimum drinking water must be provided to all villages in the country(8). This did not happen even till the end of the VIIth Five Year Plan.

The VIth Plan was, to a great extent, influenced by the Alma Ata declaration of 'Health for All by 2000 AD' and the ICSSR-ICMR report. The Plan conceded that "there is a serious dissatisfaction with the existing model of medical and health services with its emphasis on hospitals, specialisation and super-specialisation and highly trained doctors which are availed of mostly by the well-to-do classes. It is also realised that it is this model which is depriving the rural areas and the poor people of the benefits of good health and medical services" (9).

The Plan emphasised the development of a community based health system. The strategies advocated were:

a. provision of health services to the rural areas on a priority basis.
b. the training of a large cadre of first level health workers selected from the community and supervised by the MPWs and medical officers of the PHCs.
c. no further linear expansion of curative facilities in urban areas; this would be permitted only in exceptional cases dictated by real felt need or priority.

The Plan emphasised that horizontal and vertical linkages had to be established among all inter-related programmes like water supply, environment, sanitation, hygiene, nutrition, education, family planning and Maternal Child Health (MCH). The objective of attaining a net reproduction rate of 1 by 1995 was reiterated.

This Plan and the VIIth Plan too, appear to be radical departures from their predecessors. But the story is the same - progressive thinking and inadequate action. Whatever new schemes are introduced, the core of the existing framework and ideology remain untouched. The underprivileged get worse and the privileged get a better deal. The status quo of the political economy is maintained. In fact, the VIth and VIIth Plans have provided a fillip for strengthening the existing status quo, with a focus on privatisation.

The National Health Policy (1983) was announced during the VIth Plan period. It was in no way an original document. It accepted in principle the ICSSR-ICMR report's recommendations, as is evidenced from the paragraphs which are common to both documents. But beyond stating the policy there was no effort to change the health situation for the better.

A new dimension added in the VIIth Five Year Plan is to give special priority to new medical technology, especially biotechnology and electronics and "development of specialities and super-specialities pursued with proper attention to regional distribution"(10). The special attention that AIDS, cancer, and coronary heart diseases are receiving and the current boom of the diagnostic industry and corporate hospitals, is a clear indication of where the health sector priorities are.

Right through the Seven Five Year Plans, the planners and policy makers have never discussed the private health sector which provides two-thirds of the health care in the country. Hence plans and policies are bound to be limited in their impact.

The influence of international agencies in policy making and programme design, both within and outside the plans, is very evident. Right since the Ist Plan, one can see the presence of international aid agencies, who, with a small quantum of money,

UNEQUAL DISTRIBUTION OF HEALTH RESOURCES

The World Health Organization estimates that in many Third World countries 70% of the population has no access to organized health services or to supplies of essential medicines, dispensed by trained healthworkers.

All the money spent on public health services in 67 of the poorest developing countries (excluding China) adds up to less than the rich countries spend on tranquilizers alone.

To provide the entire rural population of India with clean water by the year 2000 would cost an estimated 277 million Pound sterling a year (excluding time consuming and costly technological and maintenance problems to be overcome). This sum is not far from the 250 million Pound sterling calculated to have been invested in the Indian drug industry in 1977. Investment in drug production brings immediate financial return; unlike clean water for poor communities.

Source : Prescription for Change - Virginia Beardshaw, The Hague, 1983, as carried in Health Action International's Guide to Rational Health Projects. Page 74

international aid agencies, who, with a small quantum of money, are able to inject large doses of ideology. It cannot be a coincidence that almost every health programme that the Indian Government has taken up since the Ist Plan, has been anticipated by some international donor agency.

In conclusion, it can be said that the neglect of the public health sector is an issue larger than the government policy making. The latter is the function of the overall political economy. Under capitalism only a well developed welfare state can meet the basic needs of its population. Given the backwardness of India, the demand of public resources for the productive sectors of the economy (which directly benefit capital acccumulation) is more urgent from the business perspective than the social sectors; hence the latter get only a residual attention of the state. The solution for satisfying the health needs of the people therefore, does not lie in the health policies and plans alone. Rather, it is a question of structural changes in the political economy that can facilitate implementation of progressive health policies.

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(Continued from page 2)

including cost of materials such as drugs, laboratory tests and injections and do not vary with the skill of the physicians or the prestige of the hospital. As every Japanese is covered compulsorily, the majority of practitioners are registered (by the prefectural government) as insurance doctors and dentists. Privately purchased care and private insurance are an insignificant feature of health care in Japan.

In recent times the government has attempted to influence clinical practice (primarily as a cost containment measure) by revising the fee schedule in the direction of giving preference for out-patient care and home care rather than costly hospitalization. It has also attempted to develop a referral system and curb the extensive use of laboratory tests. Since the delivery system is private and characterized by independent physician entrepreneurs, the competition between clinics and hospitals to attract patients is intense, as clinic based physicians do not have hospital admitting privileges. Without any organized referral system, clinics and hospitals often offer similar services, duplicate equipment and maintain excess capacity. While the Ministry of Health and Welfare is encouraging the cooperative use of technology such as CT scans, this is totally voluntary and no certificate-of-need procedure to regulate technology purchases has been developed. The Japanese delivery system is today on the threshold of developing new modes of provision based on home care, domiciliary care, visiting nurse services and chronic illness treatment in order to adequately meet the demand for geriatric care and to keep its costs under control.

The Japanese system of social insurance has become a model for the provision of universal health care coverage for many of the middle income capitalist societies of East Asia, most notably South Korea. The latter is in the process of establishing separate insurance programs for different sections of population, employees in large corporations,public sector employees, self employed rural communities,etc. in order to achieve compulsory coverage for every citizen. A pluralistic insurance system based on separate funds is most strongly supported by the affluent sections whose employment in large enterprises entitles them to higher employer contributions and higher level of benefits. Such a system is also favoured by the medical profession as it allows them to retain a strong hold on the private delivery system.

However, for populous, agriculture based societies such as India, Indonesia, etc., where the majority of the population is self-employed or in the unorganized sector and large numbers are below the poverty line, the question is whether an insurance model would provide an effective and equitable access to health care. Perhaps a tax based (either central or local government revenue) national health service, along with proper planning and distribution of resources and services, would be a surer road to universal coverage for these societies.

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MISUSE OF MEDICINE

N.H.Antia

There is no field of human endeavour where misuse of privileges, authority and funds can be entirely eliminated. Hence society devises methods for limiting such misuse in the form of rules, regulations and legal measures even though enlightened self monitoring and self restraints are ideal. What differentiates professions from trades is that the former not only possess special knowledge and skills but also evolve a code of conduct and ethics to monitor their own members. This is in order to ensure not only the level of technical competence but also the obligation to the society which has entrusted them with responsibility and has placed its trust in them. The medical profession has enjoyed a uniquely privileged position because of their technical skill as well as the intensely personal relationship which develops between a doctor and his patient, whereby the latter puts his/her entire faith in the doctor who not only cures but also cares and consoles the patient as well as the family. The epithet 'noble' is symbolic of the love and respect that this profession has enjoyed over the ages, which is somewhat akin to that of the priest.

It is unfortunate that there is now a rapid deterioration of this happy relationship between the profession and society at large and a degree of suspicion and mistrust pervades this relationship today. Before we blame the profession as a whole, let us not forget that there still exists the same relationship between the family physician and his clientele; only that this breed is rapidly diminishing as a result of the new, impersonal and materialistic trends which affect not only this profession but also the rest of society of which they are an integral part.

The wholesale adoption of the western model by our policy and decision makers after independence, based on an alien culture and its science and technology has shaken the entire social and economic fabric of our society and distorted age old values associated with our civilization and its culture. It has polarized our society with a small, wealthy, elite group marginalising the vast majority whose life is being increasingly degraded, as clearly observed by the burgeoning urban slums. While this western science and technology has given the knowledge and technology to provide for the basic needs of everyone on this planet, yet, because of its very materialistic nature and lack of a human and moral basis, it is used chiefly as a tool for aggrandizement and exploitation. Such misuse is not only restricted to the western nations where it has originated, but is also rampant in the poor countries, in the hands of those who have been able to obtain access to this technology. The gross misuse of such knowledge and technology in the field of medicine is demonstrated by the fact that the most simple, cheap and efficient aspects of the cure and control of communicable diseases (which still remain the major health problem for the vast majority of our people, especially the poor) are neglected and undue emphasis is paid to the most expensive, complex and cost ineffective diseases like cancer, heart-stroke which affect the small, affluent sections of our society. This clearly demonstrates that the dominant consideration in the import and use of such science and technology is dictated by the requirements of the rich and that of the medical profession rather than the needs of the vast majority. In the process, medicine is being converted from a profession to a lucrative trade in human suffering; an area where consumer resistance is at its lowest.

The gross overproduction of doctors, drugs and sophisticated medical instruments and that too of the wrong type has ensured that malpractice has been built into our present health system. Unfortunately, over the years, this has become an accepted form of medical practice by both the medical profession as well as the public. This is further compounded by the absence of any regulatory measures like public information and education on health and suing for malpractice, as exist in the USA and many other western nations.

In the case of the urban rich this is demonstrated by the unnecessary, excessive and even dangerous investigations and medications, inclusive of surgery, and the pressures to impose the latest and most expensive glamour technology imported from the West regardless of its appropriateness. Also, the patient or the public is seldom informed of the attendant dangers which are reported in Western journals, leave aside the far greater shortcomings in our own limited experience. Due to availability of easy money, the rich are unwittingly at the greatest peril of iatrogenic (doctor made) diseases, as is demonstrated by the mushrooming 'five star' urban hospitals with the latest specialities, the latest scanners and the latest drugs and operations. Intensive care units are indiscriminately used, even for terminal care patients, who now have to end their life in stark aseptic conditions monitored by the latest gadgets, rather than in an ordinary hospital bed or preferably in the home, surrounded in their last moments by loving and caring relatives and friends. Each one of these facilities have their specific limited use, but when unintelligently or deliberately pushed to their limits by

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those trained as technical robots or for satisfying their monetary greed, these "wonders" of modern science prove to be counter productive, if not actually harmful.

The growing middle class has now been caught in the cleft stick between providing the latest medical care like renal dialysis, kidney transplant and coronary bypass surgery for their loved ones and being pauperized in the bargain. Many search for a good, old fashioned family doctor, who is now in short supply, or turn to other cheaper and more acceptable alternative systems such as Ayurveda and Homeopathy. Without insurance and adequate financial resources, the thought of illness has become a source of anxiety and neurosis for this rapidly enlarging section of our society.

For the vast majority of the poor who live in villages and urban slums, this poses an entirely different problem. While the middle class are their role model they can hardly conceive of using the private hospital with its specialists or even the nursing home for their medical needs. And yet they too have been hooked by the medical profession, albeit by those in the lowest rungs, to the universal injection as a panacea for all ills. The 'blunderbuss' therapy of Rs. 20 or more for a so-called 'cocktail' injection consisting of an antibiotic, corticosteroid, vitamin B, anti-histaminic and analgesic is now familiar even to most villagers, leave aside the older 'heat' producing injection of calcium gluconate. The public hospital, whose mal-functioning was so starkly revealed by Justice Lentin, remains their last resort. Fear of these institutions now drives them to small, unhygienic private nursing homes, often after a preliminary visit to the moneylender. The government Primary Health Centre, which was designed to serve the preventive, promotive and basic curative health needs of the 70% of our population that lives in rural India, has ceased to undertake any of these functions as a result of its almost total devotion to Family Planning and its accessories like Immunization and MCH. Shrouded in secrecy, the PHC is unaccountable to the people for whom it is meant.

What is it that has lead to this lack of accountability of the public sector and the exploitative nature of the private one? The answer lies clearly in the inappropriate Western model that has been chosen for the development of this country. While we may forgive Nehru for being enchanted with the post-war euphoria for Western science, the continuation of the use of this model, that too in its worst aspects, despite ample experience to the contrary, can only be ascribed to the selfish and exploitative nature of those who continue to promote and operate this form of development.

The Hippocratic Oath

... I will prescribe regimen for the good of my patients according to my ability and my judgment and never do harm to anyone. To please no one will I prescribe a deadly drug nor give advice which may cause his death.....

.....If I keep this oath faithfully, may I enjoy my life and practice my art, respected by all men and in all times; but if I stumble from it or violate it, may the reverse be my lot.

Excerpt, as contained in "Medical Negligence", S.Raghavan, The *Free Press Journal*, Apr. 13, 1980.

Illness : A Lucrative Business

".....a common public opinion is that patients trust their physicians technically and personally but not economically,..... The harshest judgment comes from some medical economists who bluntly state that the ethical ideals of the Hippocratic Oath are out-moded and mythical..... The doctor-patient relationship is a commercial transaction that should be regulated by the rules of the marketplace,.....normal business activities such as aggressive advertising, paying in advance, and undertaking profit-making enterprises that are unrelated to direct provision of physicians services are all clearly legal and good business practice. But, are they ethical? Are they primarily in the spirit of what is best for the patient?"

Excerpted from the presidential address by Frank C. Spencer, (M.D., FACS, New York), to the American College of Surgeons, as carried in the *ACS Bulletin*, November, 1990.

It is regrettable that this type of medical practice now poses a threat to the health of our people. The public health colleges produce doctors who are mostly trained for, and work in, the private sector. It is inconceivable that any sane politician honestly believes that private medical colleges, which levy a capitation fee of several lakhs in declared and undeclared monies, are for the benefit of the rural masses. The mad rush for securing the highest marks for admission to government medical colleges, or paying high capitation fees by the rich, for their children who cannot get into the former colleges, does not demonstrate love for the health of the people but a clear indication of the extent of safe monetary returns that this profession ensures them. The type of medical education and even worse, the values inculcated in them are directly opposed to the health needs of our people. Permission to produce 60,000 drugs and formulations (costing Rs.3,600 crores), when the WHO lists only 258, is surely not for the benefit of the people but that of the pharmaceutical industry and those who give them licenses on the basis of kickbacks. The multinationals who control the major drug companies and increasingly, the medical instrumentation industry, do not come to India for the health of our people.

The medical profession and the associated health industry have the unique opportunity to trade in an area where consumer resistance is at its lowest, as a result of fear and ignorance. Public ignorance and absence of consumer resistance is demonstrated by the fact that malpractice insurance premium of doctors in India is Rs. 100 per annum, while that in the UK it is over 1200 Pounds sterling, and for certain specialities in the USA over $ 60,000 per annum. This is not to advocate legal action as the optimal way for improving the health services, but under the prevailing conditions of increasing material values and human greed, public awareness and threat of legal action remain

IRRATIONAL AND UNETHICAL MEDICAL PRACTICES

Mohan Deshpande

In recent years the press has been abundantly covering hitherto unreported and under reported cases of malpractice in the medical field. Undoubtedly, these and many more unreported cases will have to be fought in the legal courts, which in turn, will hopefully have a deterrent effect on the medical profession. This will also make people at large aware of their health rights to some extent.

Much goes under these press reports of overt malpractice and negligence. This consists of a bulk of irrational medical practices which are invisible and seldom brought to light owing largely to ignorance of people and a smart combination of tactics and the skills the profession possesses collectively. Moreover, to locate and to identify irrational practices needs quite a good knowledge of medicine and its practice. Since the effects of these irrationalities are neither immediate nor severe enough on the patients, they are rarely complained about. Even if a patient suspects an irrationality, he/she usually refrains from asking for clarification. He/she is simply a stupefied victim of so-called 'faith'.

Usually medical doctors, even those rational in their own practice, do not come forward to report such irrationalities even though in private they would express their dissatisfaction about the increasing commercialization in their profession. Some even try to protect fellow professionals under the pretext of protecting the medical fraternity. There is also a false notion prevailing amongst doctors that it is 'unethical' to divulge information on such matters to the 'lay' public. There are attempts even to justify the wide-scale unscientific and irrational practices on grounds such as, it is being unfair to isolate the medical profession to blame leaving untouched the general social atmosphere of rampant corruption at every level. Some tend to blame the professional (or business ?) competition or the dog-eat-dog health bazaar (too many doctors ?) as if these are entirely extraneous to their profession and thereby justify the so-called 'survival instinct'.

Irrational practices can be grouped in the following categories:

A) While actually treating/investigating patients,
B) While diagnosing the ailment,
C) Concerning the relationship with the drug industry,
D) Concerning other doctors,
E) Miscellaneous.

While actually treating/investigating patients

1) *'Injection' practice:* irrational or over use of this mode of drug administration, for profits.
2) *'Steroid' practice:* using steroids (reserved for life saving purposes and intractable diseases) for simpler ailments, for quick relief. The doctor also provides a (false) sense of well-being to the patients. This attracts more patients to him.
3) *Irrational use of antibiotics* notwithstanding their long term severe effects like tolerance cross-resistance etc.
4) *Using banned or bannable drugs:* the profession cannot absolve itself from its responsibility to update knowledge of recent research and government/legal decisions.
5) *Using sub-standard drugs for dispensing:* These drugs are usually available in local markets in bulk quantities produced by various ill-known companies.
6) *Prescribing tonics,* milk powders, protein powders.
7) *Injecting B complex* for a variety of ailments where injectable vitamins have no role to play.
8) *Using intravenous (I.V.) fluids* when not indicated. *Using I.V. calcium gluconate* for various non-specific indications.
9) *Use of anabolic steroids* (even injectables) for growth/gaining height etc.
10) *Using drugs (especially from other 'pathies)* without proper knowledge of their pharmacology. This applies not only to heteropathic practice but also to allopaths using allopathic drugs which are banned or bannable. The newer drugs and their information reach doctors sometimes through unethical and un-scientific literature from the drug industry with reports of contrived trials. There are also wide ranging empiricisms (e.g. 'no side effects') in the use of brand prescriptions from the Ayurvedic industry.
11) *Unnecessary investigations,* both invasive and non-invasive. This is not a 'defensive' practice. The sole aim is profit.
12) Unnecessary admissions/surgery.
13) Refusing to treat seriously ill/dying/leprosy/HIV positive patients/accident victims.

While diagnosing ailments

Usually the following diagnoses are thrown to patients:- Weakness, low blood pressure, backache, white discharge due to weakness, deficiencies, psychosomatic illness etc. Creating cardiac neurosis: patient is not a heart patient in reality but is made to believe she/he is.

Concerning drug industry

1) Accepting samples and gifts from drug industry causing both overt and unconscious obligation to prescribe.
2) Accepting and not verifying information coming from drug industry. One such example is the use of high potency combination B1 B6 B12 for a variety of illnesses ranging from weakness to serious nerve-brain disorders.
3) Engaging oneself in false, fabricated research for drug industry.

Continued on page 8

Mohan Deshpande is a medical practitioner who is also a researcher with FRCH, Bombay. The above is a slightly modified version of the paper presented in the workshop. *'Medical Malpractice; what it is and how to fight it"* organised by Medico Friend Circle (Bombay Group) in 1991.

EDUCATIONAL INTERVENTION IN MEDICAL MALPRACTICE

Amar Jesani.

The term Medical Malpractice (MM) encompasses a very broad (perhaps entire) area of inappropriate medical practices. The Bombay Group of Medico Friend Circle tentatively proposed a working definition (1990) of MM for its workshop on this topic as, 'a variation from the normally acceptable, scientific and average standard of medical practice at a given point of time'. There may be many shortcomings in this definition (readers are invited to suggest their alternatives) but, for the time being it will serve our purpose, because the subject of this article is to discuss the strengths and weaknesses of educational intervention intended to bring about appropriate changes in the doctors medical practice so that it becomes acceptable, rational, scientific of minimum average standard, ethical and free from possible negligence.

Why educational intervention?

We believe that there is a strong case for advocating continuous, scientific education of all practicing doctors. How can one object, in principle, that all doctors must be continuously educated so that the quality of medical care provided by them can be of optimum standard? In fact this is a truism universally accepted as an essential ingredient of medical ethics. Unfortunately in our country this component of medical ethics is violated by the profession as it has hardly any effective mechanism to provide systematic continuous education. As a result doctors' reading habits are found to be abysmally inadequate to do justice to their role in medical care.

There is another compelling reason for advocating educational intervention. Although there is no systematic study available on the medical 'competence' of Indian doctors, certain indirect indications show that `incompetency' among Indian doctors is shockingly high. For instance, in two studies of prescription practices of private general practitioners in Bombay city by Uplekar (1989a, 1989b), for the FRCH, it was found that a majority of them had grossly inadequate knowledge of drug treatment for two highly prevalent diseases; leprosy and tuberculosis.

The structure and practices of the medical profession raise further doubts. In 1986 we had 7,63,437 qualified doctors of all systems of medicine. Of them about 42% were allopathic and 58% were non-allopathic. While in the developed countries, scientific criteria to assess competency of allopathic doctors are well developed, we have nothing to go by to judge the competency of non-allopathic doctors. In fact, we are almost sure that there will be divergent views about the methodology used to assess the competency of non-allopathic doctors. Secondly, cross system therapeutic practices are highly prevalent. It is generally accepted that a majority of non-allopathic doctors regularly use allopathic drugs and devices. With the ayurvedic drug industry coming of age, the use of ayurvedic drugs by allopathic doctors has also substantially increased. In this use of cross system therapeutics, it is obvious that the prescribing doctors have grossly inadequate scientific information on what they prescribe. Lastly, the problem of doctors' incompetency is a universal one. Even in countries where the profession is better organized, internally regulated, and has strong emphasis on continuous education, a significantly high proportion of doctors are found to be incompetent. For instance, in the UK, 10% to 15% of independently practicing doctors are estimated to be incompetent (Smith, 1989). A Canadian study in 1988, found that in their sample, 15% of family practitioners and 2% of specialists, had serious deficiencies in medical records or care (Smith, 1989). In our country, at least 3/4th, of all practising doctors are independent practitioners having no regular continuous medical education. Only a fraction of them subscribe to standard scientific journals. The prevalence of incompetency among them is, of course, anybody's guess.

In short, inspite of non-availability of hard data, the doctor's ignorance/lack of information on the scientific therapeutics need no further elaboration. The socially conscious doctors and others have therefore strongly argued that this ignorance or gap in information is greatly responsible for many irrational practices or malpractices by doctors. Due to lack of information, doctors also fail to critically evaluate information provided by commercially vested interests like pharmaceutical companies. As a result, many have suggested that malpractices be classified under two broad categories; intentional and unintentional. The former is deliberate MM indulged in with a motive, such as augmenting one's income. The latter is supposedly due to ignorance. A typical argument for the latter is, why should a private doctor prescribe wrong medicine for tuberculosis when it is not going to help him to hold the case. That is why educational intervention is considered useful, particularly to remedy unintentional MM.

Another strong argument advanced for educational intervention is that individuals in the profession have inflated egos and are very sensitive to criticism. Positive educational intervention would help some sensitive and ethical individuals to see reason and thus to change their behaviour. Also, since such intervention would not generate extreme negative reaction, it would help win over some to the cause of rational practice. After this is accomplished, it is believed that tactics can be used against those who refuse to 'shed their ignorance'.

Undisputedly, these arguments are highly logical, clear, and straightforward. However, these arguments are clinically too precise to explain the actual reality. It is indeed tempting to put high prevalence of MM and lack of continuous education into a one-to-one, direct relationship. But this relationship is highly complex with many other variables more crucial in determining the prevalence of MM. The need for continuous education is not only because the MMs are highly prevalent but that even if it fails to make a significant dent in the prevalence of MMs it is still badly needed for many other reasons. The point being emphasized here is that though educational intervention is necessary, its mere presence is not a sufficient condition to bring about a lasting change in the behaviour of doctors.

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Limits of educational intervention.

In our country some voluntary efforts have been made to change doctors' behaviour through education. Most of such efforts are in the field of drugs and pharmaceuticals. "Dear Doctor" letters, along with educational material on the rational use of drugs, information about hazardous, banned and bannable drugs, appeals against the use of drugs such as high dose estrogen-progesterone (EP), fixed dose combinations and so on have been circulated amongst doctors. In addition, certain categories of drugs (anti-diarrhoeals, tonics) have been studied for their rationality and reports have been compiled and circulated amongst doctors. These are highly commendable voluntary efforts and we have been participating in them in various ways.

However, to what extent do they make a dent in the MMs? Unfortunately, none of these efforts were adopted for experimental research by institutes. Most of these reports were by activists, done with the full conviction that such things ought to be done, irrespective of the extent of the immediate impact that they would make. Further, some important attempts were part of a wider campaign to get a particular drug banned, as the campaign against the high dose EP drugs. It was not a simple educational campaign but a definitive campaign to get the drugs banned on the ground that these are irrational and hazardous. Thus, there was no scope to wait for the results of the educational intervention. The ultimate ban on EP drugs was, in fact, brought about despite the lack of support from the profession!

Most systematic research on improving prescription practices through educational intervention is done in the developed countries, particularly in the USA, as the vagaries of the market in health care has made that country cost-conscious. But all experimental researches carried out there, on this subject, are also not scientifically rigorous. In a review of such services, Soumerai, McLaughlin and Avorn (1989) found that almost one third of them were inadequately controlled studies. They found that 85% of the inadequately controlled studies reported positive findings as compared to 55% of well controlled studies. They also found that in several studies, the control groups showed positive improvement due to the effects of other factors. (**Note:** in the control groups there was no educational intervention).

There are seven categories of educational approaches used in various studies reviewed by them. They are:

1) Dissemination of printed educational material,
2) Reports of patient-specific lists of prescribed medicines,
3) Group education including conferences, lectures, seminars, tutorials,
4) Feed back of physician specific prescribing patterns,
5) Reminders at the time of prescribing,
6) One-to-one education,
7) On going clinical pharmacy services.

Going through the above list we realize that:

(a) some of them are clearly suitable in the hospital set up and very difficult to implement in the case of independent private practitioners,
(b) some are very cumbersome, for instance, providing reminder at the time of prescribing may need a highly computerized set-up,
(c) some may be very costly such as providing one-to-one education by a visiting physician, and so on.

On scanning through some of the study reports we find that the method of providing doctors with mailed, printed material is the least effective method whereas the one-to-one education of the physician by a visiting physician is the most effective method. Perhaps this is the chief reason why the pharmaceutical industry uses an army of medical representatives who can change the doctor's prescription behaviour through one-to-one education. In any case, it will be the height of irrationality to create another army of visiting physicians for providing rational drug education.

Those who propagate the idea of rational prescribing most often depend on the method of providing doctors with print material. Studies of this method however, show disappointing results. At the same time it is found that the provision of printed material could create a necessary condition for trying other methods out. Further, studies using a patient care protocol to guide doctors at the time of examining and treating patients, show that the protocol makes a great difference in the behaviour of those doctors who participate in formulating such a protocol. That is, a participatory exercise in creating educational material is more important than in the use of the same educational material for other doctors.

What influences prescribing behaviour?

When we talk about alternative rational drug information, it is necessary for us to understand the role of such information, on the prescribing behaviour of doctors. A rational enquiry into the prescribing behaviour of doctors would reveal a very dominant phenomenon called 'the non-pharmacological basis of therapeutics', (Avorn et al, 1982). It is this phenomenon which makes educational intervention, which is chiefly centred around rational pharmacological information, less effective. Avorn et al (1982) argue that "irrational drug choices are made frequently, despite the availability of ample empirical evidence counseling otherwise". In a study of doctors they found that "although a vast majority of practitioners perceived themselves as paying little attention to drug advertisements and 'detail men' (commonly used term for medical representatives) as compared with papers in the scientific literature, their beliefs about the effectiveness of index drugs revealed quite the opposite pattern of influence in large segments of the sample".

Thus, in actuality, what a doctor normally does in treating patients is customary behaviour that is routinised, habitual and automatic. Such customary behaviour is formed with the influence of history, locality, peer groups and above all, environment and the system within which medicine is practised.

When sufficient weightage is given to the factors which actually condition prescribing behaviour of doctors, we find that the role of simple information dissemination or education is grossly limited. Kenhouse and Jacoby (1988), in an article reviewing the subject, argue that the 'customary behaviour' of doctors is likely to change only in the presence of a motivating trigger. Such information has a useful role only in conditions which are introduced to change the environment in which medicine is practised.

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PRIVATE HEALTH SECTOR
Regulation and Control

Ravi Duggal

Prevailing Situation.

The private health sector consisting of general practitioners, nursing homes and hospitals, employs two thirds of the medical manpower and is responsible for two thirds of the total expenditure on health in this country. Despite this there is hardly any regulation of the practice in this sector of health.

This is indeed surprising, because such activity cannot be carried out without registration. The medical professional has to be registered with the Medical Council, which is a statutory body that last set the standards of medical practice — 'discipline' the professionals, monitor their activities and check any malpractices. The doctors who decide to set up their own clinics as well as hospitals, nursing homes, polyclinics etc. have to register with the respective local body.

The problem with the above is that the controlling bodies are virtually non-functional. The reason for this is not only lack of interest but also weak provisions in the various acts. They are also heavily influenced by the private health sector.

Another agent in the private health sector which needs to be regulated further is the pharmaceutical industry. As a chemical industry, this agent is regulated to some extent but as a participant in the health sector, it operates virtually unregulated.

In view of the existing health situation and practices, regulation of those who provide the nation's health care is an urgent neccessity. Regulation exists in other sectors, so why not in health? This is especially needed as consumer resistance is at its lowest in this field and therefore lends easily to malpractice.

How to regulate

a). Medical practitioners:

Each medical practitioner is registered with the respective state Medical Council. Presently, beyond this registration the Medical Council does not concern itself with the practitioner, unless some complaint is made and a prima-facie case is established. The Medical Council and other related bodies, in consultation with the health ministry, must regulate the following areas of health practice: (This is only a selective list).

i Monitoring that only registered practitioners practice medicine.
ii Assuring that clinics have minimum standards of quality by setting standards for the same. (This should include X-ray, CT scan and pathology laboratories.)
iii Making maintenance of patient records compulsory and accessible to patients.
iv Auditing of prescriptions of the doctors in relation to the diagnosis.
v Determining a fixed tariff of charges that patients pay to doctors.
vi Providing continuing medical education to all those who practice medicine. For instance, a `summer' refresher course every three to five years should be compulsory for all practitioners and their license renewal should be dependent on this.
vii Regulation of geographical distribution of setting up practice to correct the urban-rural disparities. (We feel that as of present there is adequate medical humanpower in the country and it only needs redistribution.)
viii Annual return of patients treated; some minimum data to be maintained and filed with an appropriate authority.

b). Nursing homes and hospitals:

Similar to the practitioner, regulations need to made for setting-up and running of hospitals and nursing homes. Minimum quality standard, nurse:doctor ratio, patient:nurse ratio, proper location of premises, geographical distribution, fixed reasonable tariff charges, proper medical records, maintenance, filing of minimum data returns, properly qualified and adequately trained personnel for jobs assigned, prescription auditing, medical auditing etc.

c). Pharmaceutical industry:

i The pharmaceutical industry must be allowed to manufacture only rational drugs in required amounts with clear priorities in favour of essential drugs. All irrational and non-essential and dangerous drugs must be banned.
ii Branding of drugs must be prohibited.
iii There is every reason for a progressive nationalization of the pharmaceutical industry.
iv The regulatory body for the pharmaceutical industry must be the Health Ministry and not the Ministry of Chemicals.
v The practice of canvassing drugs through pharmaceutical (medical) representatives should be banned.
vi A National Formulary should be evolved with generic drug names becoming the basis of prescription writing.
vii Continuing pharmacological education of doctors should be through the Medical Council or other such statutory body.

d). General regulations:

i To prevent unnecessary concentration in urban especially metropolitan areas, state subsidies, soft loans, must not be given to those wanting to set up practice, or hospitals and nursing homes in these areas. Such loans should be restricted to rural areas and taluka towns.
ii A tax on private medical practice and private hospitals and nursing homes must be levied. This tax should be the highest in metropolitan areas and the lowest in rural areas. Private hospitals should not be allowed to be operated as

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Ravi Duggal is a researcher at FRCH, Bombay. The above formed a part of a larger note on the private health sector, presented by FRCH to the Planning Commission in April, '90.

MEDICAL MALPRACTICE AND THE LAW *

The issue of medical malpractice is dealt with by the rules governing medical negligence, which forms a sub-branch of the law of negligence. These come under the Law of Torts which offers civil redressal in the form of compensation. "A person is said to be negligent when s/he acts without due care in regard to the harmful consequences of her/his action". A physician surgeon or other member of the medical profession, if he has not exercised reasonable care in the treating of a patient, may be liable to a negligence suit. While the degree of care to be exercised depends on the facts of each case, it is generally presumed that the test is the standard of the ordinary skilled person, exercising and professing to have that special skill.

Duty of care

Once a doctor accepts a patient, the principle of exercising reasonable care becomes applicable, whether the doctor accepts fees or not, and whether the doctor is a private practitioner or public servant, general practitioner or specialist. A person who offers medical advice and treatment, impliedly undertakes that he/she has the requisite skill and knowledge. Such a person owes to the patient certain duties, of which the following are important:

a) Duty of care in deciding whether to take in a case.
b) Duty of care in deciding what treatment to give and in diagnosis.
c) Duty of care in administering the treatment.
d) Duty of care in answering a question put to him by a patient when he knows that the patient intends to rely on his answer.

A breach of any of these duties will support a suit by the patient.

Forms of medical negligence

Medical negligence may assume a variety of forms. These include:

a) negligent diagnosis,
b) negligence in operation,
c) failure to listen to a patient's complaint,
d) negligent administration of a wrong drug,
e) negligent exposure of the patient to risk of infection,
f) negligence in advice about the risk of an operation or negligent failure to warn the patient of such risks,
g) negligence in post-operative care,
h) inadequate supervision or inadequate staff in the nursing home.

Hospital/nursing home liability

Private as well as public hospitals (including charitable hospitals) are liable for the negligence of their employees. In a landmark American case, (Darling vs Charleston Community Hospital, 1966), the judges held:

"...The present day hospitals, as their manner of operation plainly demonstrates,do far more than furnish facilities for treatment. They regularly employ, on a salary basis, a large staff of physicians, nurses and interns, as well as administrative and manual workers....certainly the person who avails himself of the hospital facilities expects that the hospitals will act on their own responsibility".

Pleadings

In any suit claiming compensation for negligence, the plaintiff must plead and prove three things:

i) The defendant owed a duty of care to the plaintiff. (Exact situation must be mentioned).
ii) The defendant had committed a breach of that duty. (How such breach was committed must be clearly stated)
iii) The breach of duty resulted in an injury. (The cause effect relationship must be definitely brought out.)

As in the above, while the onus to prove guilt lies with the patient, in some cases, due to a number of reasons (such as incomplete information given by a doctor etc.) it becomes difficult for the patient to provide sufficient proof. In certain of these cases, when circumstances make it quite obvious that negligence, in fact, has been the cause, the doctrine of *Res Ipsa Loquita* (the thing speaks for itself) is applied. This doctrine has been extensively used in "swab cases" where after an operation, an instrument is left inside the patient's body.

Damages

Damages are classified as special andgeneral. Special damages include pain and suffering, loss of expectation of life, loss of amenities and the injury itself. General damages refer to pecuniary loss, such as loss of earnings, legal expenses, loss of pension rights, loss of marriage prospects, and loss of opportunities for gainful employment.

Conclusion

At present, litigation in case of medical malpractice is not widely prevalent. But the trend is catching on, especially in urban areas. While litigation in itself, may not serve to wipe out malpractice, the threat of legal recourse can certainly create conditions compelling accountability on the part of the medical profession. Needless to say, the extent of utilization of legal recourse would be pre-determined by its accessibility as well as the extent to which demystified information reaches the masses.

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*The article above has been compiled from the following:
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Continued from page 3

Concerning other doctors

Accepting / offering 'cuts' (percentages) for referring / treating / investigating patients.

Miscellaneous

1) Giving false certificates, falsification of reports e.g. pathology, post mortem etc.
2) Advertising
3) Not preparing case papers records, not making them available to the patients.
4) Overcharging: There is no standard/prescribed price for medical care nor are there stipulated rules and regulations for monitoring. There are no grades given to dispensaries/nursing homes. The price of health care is guided by such factors as professional competition, crowding of doctors in a locality, patient's income and living standard, needs and greeds of doctors etc.

There is a minuscule section of doctors who are guided by ethics and rationale against the dominant market forces which usually control the attitude of doctors. It is necessary today to widen this circle of conscious, ethically motivated doctors and thus reverse the tide which threatens to wash away the noble principles on which this profession is supposed to be based. ●

The British Connection

About two-thirds of the world drug sales are controlled by big trans-national drug companies in West Germany (Hoechst, Bayer), Switzerland (Hoffman, La Roche, Ciba-Geigy, Sandoz), and USA (Merck, Pfizer, etc), all with subsidiaries in the U.K.

Source: Prescription for Change, Virginia Beardshaw, as carried in HAI's *Guide to Rational Health Projects*, pg.74

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In conclusion one can say that MMs exist not simply because there is a dearth of easily available rational and scientific literature but often inspite of it. The fight against MMs therefore, cannot be just an educational effort but must address to more fundamental factors which decisively shape the environment in which medicine is practised.

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Continued from page 6

trusts or societies which give them cover for tax relief. They should be treated as corporate bodies. Hospitals operating 'research centers' must be audited and their tax reliefs questioned.

iii A social audit of the health sector must be an ongoing activity of a statutory body which should be created for this purpose.
iv A tax on the international migration of doctors.
v Embargo on private practice of those receiving state financed medical education by part training at civil/rural hospitals or PHCs. This should be combined with a long term change of relocating medical colleges at the district centers.

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HEALTH FINANCING IN ZAMBIA

Shirish Kavadi

This article is second in the series from the study: "Health Financing and Costs: Comparative Perspectives" (No.1 Japan).

In 1972 President Kenneth Kaunda declared that "by the end of the decade, health care will be free to all people and health institutions will be within easy reach of every Zambian".Two decades later Zambia has yet to attain the goal of universal and quality health care. Inequity in the health care delivery system persists. The reasons are two-fold:

(1) the proclivity of policy makers towards hospital care, modern medical technology and urban medical services;
(2) structural constraints imposed by a dependent economy.

An important factor influencing the satisfaction of basic needs in Zambia is the country's high level of dependence on the outside world. Fluctuations in the international market get reflected in similar vicissitudes in the Zambian economy, affecting the government's capacity to spend on public programmes and services.

Health Status

The apparent improvement in certain basic health indicators such as crude birth rate , crude death rate, infant mortality rate, child death rate and life expectancy (see Table 1) in the post - independence years, mainly due to national programmes of immunization, does not describe the complete picture of the health situation in Zambia. Since the mid-1980's health conditions have, in fact, deteriorated somewhat with the general decline in the economy. There has been a fall in health and nutritional status leading to a significant increase in morbidity and mortality in both urban and rural areas. UNICEF has estimated that the share of child deaths (under fives) attributable to malnutrition in Zambia rose from 29% in 1977 to 43% in 1983. Mortality caused by malnutrition for 1-14 age constituted more than 62% of the total mortality in 1984.

Another major cause of high child morbidity and mortality are gastro-intestinal diseases which have increased recently due to the drought conditions affecting large parts of Zambia and rapid growth of squatters' settlement near pre-urban areas. They made up 19% of the total outpatient care and 10% of mortality in children, in 1982.

TABLE 1: HEALTH STATUS -ZAMBIA

Year	Crude Birth Rate (per 1000 population.)	Crude Death Rate	Child (1-4yrs) Death Rate	Infant Mortality per 1000 live births	Life Expectancy average for both sexes
1970	49.6	20.1	25.2	125.6	44.6
1987	50	13	15(1985)	80	53

Source: World Tables, Vol. 2, 1983, UNESCO Statistical Digest 1987, World Health Statistics Annual 1985, World Development Reports 1983, 1987, 1988, 1989, Sixth report on World Health Situation, 1980.

Health problems in Zambia, as in other developing countries, are mainly related to the problem of poverty and insufficient social development. Rapid inflation, population increase, a forced migration to urban areas and drought conditions have affected large areas of the country. Large sections of the population continue to live in poor conditions and without basic amenities such as a protected water supply or a proper refuse collection and disposal system . The epidemiological pattern reveals that a high proportion of death and illness is due to common environment related diseases such as diarrhoea, malaria, malnutrition and measles.

Health Services: distributional imbalances

The colonial health services were oriented towards curative medical care, had a heavy urban bias, used sophisticated medical technology, depended on expatriate health personnel and were racially discriminatory, emphasising European health care alone. Policy makers in independent Zambia have inherited this propensity for an urban based hospital and elite oriented health care system. In 1964, Zambia attained independence and Kenneth Kaunda, leader of the United National Independence Party (UNIP), took over the reins of the government. The government's official ideology of Humanism - a mix of socialist tenets and Gandhian ideals- committed it to a socially just and egalitarian society,

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To fulfill its objective, the government gave a major thrust to provision of primary health care in the rural and under-served areas. Basic health services were decentralised and efforts were made to coordinate the preventive and curative health sectors. Certain other measures, such as the passing of legislation to regulate private medical services and the integration of mission hospitals and health centres into the national health services were also undertaken.

To ensure availibility of free health care, the government embarked upon a programme of rapid expansion of rural health centres and district hospitals, which was greatly facilitated by a fast developing economy with Zambia enjoying one of the highest GDPs in Africa. Between 1972 and 1976 in particular, there was a substantial increase in the number of health care units, with five new hospitals and 62 health centres/clinics coming up, thereby increasing bed capacity by 2,340.

Despite the significant gains made in the setting up of new health units, geographical maldistribution of health facilities remains and the problem of unavailability of and inaccessibility to health care persists. This may be attributed to the bias in the apportionment of facilities by the government. Certain provinces such as the Copperbelt, Southern and Western provinces (areas where copper mines are situated) received preference in the location of facilities whereas the Northern Province (the most backward) showed the lowest increase in the number of health care units.

This urban bias is further revealed in the financial allocation to the health facilities. An examination of the allocation in the Recurrent Budget 1980-82 shows that disproportionately large shares went to the headquarters, training and research at the University Teaching Hospital (UTH), Lusaka. The Copperbelt Provinces and Lusaka shared 41 percent of the recurrent allocation while UTH alone used 40 percent.

To reduce dependence on expatriate personnel, the training of health personnel was given priority by the UNIP government. A medical school and some nursing schools were established to train Zambians. The situation began to gradually improve after independence so that, by 1987, there were 880 doctors in all. More and more nurses, midwives and other middle - level technical health personnel, such as medical assistants and health assistants, received training.

TABLE 2: MEDICAL PERSONNEL

Year	Physicians	Nurses	Dentists
	----- -- Per 100,000 population	--- -- --	
1970	7	21	0.84
1975	10	51	0.57
1980	12	16	0.61

Sources: World Health Statistics Annual 1977 & 1983, Tables 1 & 3, pp. 16 & 19, Tables 17 & 18, pp. 482 - 490.

However, the increase in health personnel, as seen in Table 2, has not kept pace with the increase in population. The tendency to take up jobs or set up practice only in the urban areas is quite pronounced, both amongst doctors and auxiliary health workers. Around 76% of the doctors are located in the developed cities and provincial capitals in the Central, Copperbelt South Provinces or in Lusaka, the nation's capital. Unequal distribution of doctors is also evident from the wide variation in the doctor/patient ratio which ranges from 1:500 in the Copperbelt Province, to 1:25,000 in the province of Luapala. The urban bias common among the paramedical personnel is exemplified by the presence of 80% of the nurses in the large towns and cities.

The government has attempted to encourage rural staffing. For instance, nurses under training are required to sign an agreement to work for a certain period in a rural area. However, on the whole, there has been great difficulty in finding modern health personnel to go to the rural areas for the reasons stated above.

The Problems Of Health Finance

Zambia today faces a conflict between the equity objectives of a humanist - socialist political programme and the crisis of its economy. External assistance has increased, merely reinforcing its existing dependence on the external world. The aid has entailed certain policy reforms within Zambia, which are not consistent with the overall ideology of humanism. The implication of the increasing external funds is that the programme, directions and policy decisions are being influenced by external priorities, targets and objectives.

In the 1970's three external but inter-related events contributed to the deterioration of Zambia's economy: the fall in the international price of copper; the simultaneous rise in oil prices and the world economic recession. Drought and the consequent reduced agricultural output worsened the situation in the eighties. The combined result: a low level of production and export earnings, adverse terms of trade, a foreign exchange crisis and shrinking government revenue. Zambia was forced to turn to borrowings from the International Monetary Fund and the World Bank to finance budget deficits and maintain public services.

The IMF prescribed stringent economic reforms to bring about structural adjustments in the economy. The various austerity measures included devaluation of the currency, (*1980 - 1 Kwacha = US$ 1.27, April-May 1987 - 1 Kwacha = US$ 0.125*) wage freezes, price decontrol, the abolition of government subsidies to essential commodities, and the curtailment of expenditure on public services. These austerity measures brought no relief. Instead they lead to a high rate of inflation.

In Zambia, the sources of health care finance are the central government, the mining companies, missions, foreign donors, and the private sector. The government's commitment to provide free health care was demonstrated when it abolished user fees in both government and mission facilities in 1969, although, in the private sector these user charges continued. The government has an extensive subsidy programme to ensure health care to the under-privileged and the deprived segments of the population. The mission and mine managements function within a grant-in-aid system, under which the government provides a substantial portion of their operating costs. More than 60% of the total cost of mission services is met from government aid. In 1980-81 the government provided missions with 6.6 million Kwacha, more

than half their expenditure on health care. In the same year, the government paid mining companies 80,000 Kwacha, as reimbursement for health care services to indigents; this was approximately 2.5% of the total health expenditure incurred by the companies.

International financial assistance in health care increased over time since 1979. In 1983 more than 24% of total expenditure incurred by the Ministry of Health came from external donors. In view of the extremely tight economic and financial conditions prevailing in the country, it appears that Zambia's need for international support will continue and increase, with the corollary that foreign funding agencies will attempt to influence Zambia's health policy. To illustrate, as a condition to the IMF aid in 1988, the government introduced a user fee scheme under which all expatriates must pay fees for health care, while for Zambian nationals, fees are restricted to services categorised as "non lifesaving".

On the whole, health sector financing has been seriously affected by the crisis in the Zambian economy. Even though total annual Ministry of Health expenditure increased, it was only in nominal terms, for when measured in real terms it actually declined. When measured using a deflated price index for gross domestic expenditure and adjusting for Kwacha devaluation, the health expenditure declined by 17% between 1970 and 1981. The real government per capita health expenditure fell from 21.9% in 1970 to 8% in 1985, the decline being of some 37%. It has been estimated that the real value of Zambia's health budget of 1986 was only a quarter of the 1983 level.

Under the IMF programme, the share of the health sector in the government budget has declined. There has been a curtailment in the total funds allotted to the health sector. These cuts brought down the recurrent health expenditure from K. 85.8 million in 1976 to K. 72.6 million in 1981, while the reduction in capital health expenditure in just one year, was 88%, from K. 11.1 million (1982) to K. 1.3 million (1983). Capital projects have come to a virtual halt. Indeed, no new hospital has been put up since 1974 owing to a lack of funds. However, between 1978 and 1985, a total of 162 health centres were built with Swedish International Development Agency (SIDA) and European Economic Community (ECC) assistance, attesting to an increasing reliance on external sources to set up health care units.

The proportion of the health budget expended on essential drugs, primary health care and maintenance of health facilities also witnessed a marked decrease. An evaluation of PHCs carried out in 1984 showed that the services at rural facilities were quite poor. Almost 24 of the 32 health centres covered by the survey had no anti-malarial drug available for treatment. Supplies of other essential drugs were also noted to be inadequate throughout the country.

There was inadequate distribution of fuel and funds for vehicle maintenance. In 1982, only 26% of the total 550 vehicles were in working condition and only a few of these could be used due to a lack of fuel. Conditions in the rural health centres have steadily deteriorated. Though urban-based hospitals also experienced shortages of drugs or personnel, they received priority attention, especially the central hospital and U.T.H. and concerted efforts were made to maintain their services.

The economic crisis and the devaluation of the Kwacha, have also adversely affected the employment of physicians. Salaries and wages declined, having failed to keep pace with inflation, leading to large scale resignation of doctors from government services and, in some cases, migration. Although the majority of doctors who left were expatriates, there were also a few Zambians who resigned to set up private practice. In comparison with the number of doctors who resigned, a smaller number was recruited. For instance, in 1984, 140 physicians resigned from government service while only 115 were recruited. Since 1981, over 400 physicians resigned, reducing the available staff in 1985 to 520, some 291 less than the 811 posts available. It was estimated that by the end of 1987, Zambia fell short of some 549 doctors.

Summing Up

The health care situation in Zambia is typical of a developing country. While it is a fact that structural limitations have hampered the development of the health delivery system thus making universal health care a distant goal, the need is to look beyond these limitations to understand the true nature of the problem.

The government's inability to attain its goals with regard to health care arises out of a general lack of political will. Although publicly committing itself to creating a fair and just society, the government has not demonstrated the political will required to bring about such a society and to overcome existing biases and prejudices. This is reflected in the State's continued pursuance of the colonial pattern of development, when it should have jettisoned the colonial model in favour of one that was compatible with its "humanistic" concerns.

Internal finances for health care are unavailable or inadequate and therefore the development of health services in the last decade has been largely dependent on foreign funding agencies. Aid received from external sources has been both conditional and specific. Solutions induced from abroad, (especially from international aid agencies) to ameliorate the health care system have, in fact, had the reverse effect. Introducing user charges when the patient's purchasing power is low has only meant making health care inaccessible to the people. Succumbing to the pressure of external agencies is once again a manifestation of the government's inability to assert its political will. As long as the path of health care development is dictated by priorities of the local elite and those of foreign agencies, Zambia has little hope of achieving equity in health care.

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A MATTER OF SURVIVAL
How Auxiliary Nurse Midwives (ANMs) Cope Within The System.

Aditi Iyer.

Sister Renu*, a Rajput woman, was deserted after 14 years of marriage. Her husband, a taxi driver in Bombay and 18 years older than herself, had an affair with another woman. Sister Renu's life, which had previously revolved exclusively around conjugal and domestic duties, now began to change dramatically. In the past, when she wanted to teach in a primary school, the choice had been denied to her by her pregnancy and her husband's refusal to grant her permission. Now after 14 years and 4 children, with nothing but a 10th standard education and no experience in working outside the home, she was compelled to find ways to support herself and her children. This was in the mid 80's when the "Health For All" slogan resulted in an expansion in the health infrastructure. She heard of the Auxiliary Nurse Midwives' (ANM) course and though she knew nothing of what the job involved, she recognised the potential of being economically self-sufficient. This was a regular job, something she needed very badly.

Sister Sulochana*, an independent minded and spirited Gond woman, took to nursing to protect herself from some of the uncertainties that surrounded her unhappy marriage. Of the two options available to her, with her 10th std. education, the ANM course was more accessible: there were no fees to be given and the low grades did not disqualify an applicant. Besides, there was a demand for women in the health services at that time. Sister Sulochana applied for the course and got in. She decided to hand over almost her entire salary to the family at Nagpur, so that the economic benefits of her job would pre-empt opposition from her husband. The job meant a lot to her and she was prepared to do anything to keep it from slipping away from her.

Economic Participation and Status

The relationship between participation of women in the labour force and a qualitative improvement in their status is not a direct one. The capacity of women to enter and compete in the labour market is constrained by social relations within which they are embedded, namely,

1. prevailing social norms relating to the suitability of wage labour vis-a-vis domestic responsibilities,
2. the structure of familial relationships that do not always accommodate their changing economic role,
3. current norms about what constitute "appropriate" occupations for women, and
4. the structure of their roles and status positions within occupations.

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When ANMs like Sister Renu and Sister Sulochana are pushed into the labour market, their social and economic positions are guided precisely by these forces. Their jobs support the futures of the others in the family but have a very conservative role to play in any change of their status within it. Further, given their administrative and functional status within the health services, a new set of limits are set on the lives and work situation of these lower level functionaries. This article strings together the experiences of a few ANMs as they try to cope with a system which supports them on the one hand while creating a new set of contradictions on the other.

Varying Expectations

ANMs are supposed to look after the health needs of the people in their sub-centre villages. Sister Shanta*, who works in Beed district, had every intention of living in her sub-centre village when she was transferred there. However, she had to abruptly reverse her decision even before she could move in with her belongings. Almost immediately after her first visit, a member of the Panchayat propositioned her. "If you do as I tell you to", he said, "I'll see that you do not face problems in completing family planning work". Sister Shanta realised what was on his mind and quickly decided that staying in the village was not only improbable but also impossible. Ever since, she has lived alone in a neighbouring village and takes care to keep her divorce a secret from all but a few people. She has also come to believe that women have a reputation like glass: fragile and easily broken.

Adding to some of the problems that ANMs face in the community, is the task of doing family planning work - a programme that has been increasingly strengthened over the years. The bureaucracy places a high premium on the completion of FP targets. This is often at variance with what people expect from health services and ANMs. Given the distances that need to be negotiated in order to reach a dispensary, people look towards their ANMs for their supply of medicines. However, stocks of basic medicines are, most often, insufficient and ANMs are not adequately trained to deal with slightly more complex illnesses. While their jobs depend on fulfilling FP targets, they also need to build up some credibility in the community in order to protect their reputation and themselves from the village leadership, which could use FP targets as an excuse for harassment.

The target approach has set up the practice of de-personalised involvement. Of the four districts that we visited, - Pune, Beed, Wardha and Ratnagiri, - this was particularly evident in Wardha and Ratnagiri.

Sister Lata*, who works at Wardha, is just one person among several others vying for "cases". The teacher, *talathi*,

(village revenue official), *gram-sevak*, (the village official for overseeing development activities), the second medical officer, and the compounder, are under the same compulsions to fulfill targets. This sets up a market situation at the village level where the price for an operation is set according to the competition prevailing at the moment. For ANMs this works out to Rs. 200 per case as her personal contribution, in addition to the official rate of Rs. 130. Further, this practice is fully endorsed by the authorities at the PHC who are more interested in seeing that targets are completed while turning a blind eye to the mechanisms that are set up in the process.

Sister Lata, however, is lucky. She pays an average of Rs. 100 per case. She ensures this by looking after every need of those who live in her sub-centre. In order to ration stocks, she gives her patients less than the prescribed dosage - 2 tablets instead of 4, - often having to juggle between the few alternatives that she has. She conducts every delivery, and personally sees to it that women come for ANC (ante-natal care) and PNC (post-natal care) clinics. She is thus looked upon as being a person who can be trusted for the provision of health care. While nobody goes back empty-handed after approaching her, she establishes her position in the community and makes her family planning work an easier and cheaper task to handle.

Some ANMs like Sister Lata tend to draw the link between family planning and other duties, so that they perceive their involvement in deliveries, immunization, ANC / PNC as pre-conditioning factors for motivation.

Further, in the target approach, women - especially mothers or those potentially capable of becoming mothers, - are of special interest. By emphasizing the family planning and MCH (Maternal and Child Health) programmes the bureaucracy employs its women health workers to circumscribe the scope of motherhood within those definitions that are approved by the state. This distorts the relationship between the health worker and her community and creates problems for her.

Sister Renu, who had a difficult time adjusting to the life of a working woman in Pune district, was faced with some truisms when she set out to explain the need for sterilization to some tribal women. They confronted her -- "You do not want us to have 2-3 sons. Alright, give us your's then". Sister Renu's son, who was just getting over the turmoil in the family following his father's departure, was upset on hearing this. Later she had a hard time assuring him that she did not intend to send him away.

On the same issue Sister Shanta takes a moderate view as she looks at problems within the system. She says, "if targets are removed, some ANMs will work, others won't. Targets are needed but the authorities should be less rigid about them than they are now. The way targets are enforced, the pressures they create, make ANMs do *khota kaam* (perpetuate falsehoods). Instead of spending so much money on Copper-Ts, all of which may never be used, the government should supply adequate medicines and injections to us".

On the other hand, based on her experiences, Sister Renu questions the system within which she is being made to function. She states categorically, " I'll tell you the truth. Where I work, people have no demands from us. They work so hard that they have no time to think, let alone ask for health care. They have no time to be sick. What they need is a release from poverty, not family planning!" Sister Renu accepts the tribal way of life and is accepted as being one of them.

For Sister Sulochana, however, FP has threatened her career for ever so long. When she joined the services as a temporary member of the staff, her tryst with the programme had only just begun. After working for 15 months and completing one case, she was asked to leave. For Sister Sulochana, this meant a loss to her new found freedom. She did not have a union to go to for redressal and so she fought her battles alone. With the help of her neighbours who were lawyers, she successfully filed a case in the high court. Yet, while the proceedings implicated her "non-performance" and "begged" for reinstatement, they did nothing to question the target approach to health work.

Since her reinstatement, Sister Sulochana concentrates her energies on surviving within the system, having been a victim of it once. She concentrates on family planning to the virtual exclusion of all other activities. As part of her motivational strategy, she promises and conducts follow up services which take the form of weekly injections of B-Complex (which she administers with her own syringes without always taking care to sterilize the needles after each prick).

Sister Sulochana has maintained a satisfactory record of cases but is still issued 6 monthly orders. Having completed only 1 year of the one and a half year Step Ladder Course, she is ineligible for permanency in service. What is more, she seriously doubts the probability of being deputed to the training school for the remainder of the course due to her past experiences with an affronted bureaucracy.

Facing the Situation

The work situation of ANMs, rife with contradictions, has evoked varied reactions from them. Mainly, it is a question of survival. Sister Sulochana and Sister Renu have reflected upon their role as health workers and experience some alienation. The reasons for this, however, are very different. Whereas Sister Sulochana sees no benefit in doing work, apart from family planning, as it holds no personal rewards, Sister Renu senses that her role is both irrelevant and unbeneficial to the people whose welfare is dear to her. Unfortunately, her reflections, invaluable as they are, have to be subsumed to the more routine preoccupation of distributing oral pills and condoms to a population that is caught up in the more crucial battle of survival.

Sister Lata and Sister Shanta, on the other hand, have channelised some of their anger into practical avenues. Both of them take an active interest in their union and have won a few small battles through them. Workers unions in Beed and Ratnagiri have provided some solidarity but have not looked beyond the confines drawn up for nursing within medicine. Given these limitations and the mammoth task of building up communication links with ANMs who are separated from each other geographically, their victories are transient and their battles are never quite finished. Perhaps this may change once ANMs begin to look beyond the hurdles that lie immediately before them and question the assumptions that underline all that they do in the village community. ■

COMMUNITY HEALTH AND MEDICAL GRADUATES

Sheela Rangan, M. Uplekar

Internship is a very crucial period in the training and development of a doctor - this is the period when knowledge gained during the 4 1/2 years of medical education is enriched through the addition of skills acquired by the practical application of this knowledge.

Over the years, however, this crucial learning phase has regressed from vital compulsory training into a compulsory ritual. Consequently, practical skills are learnt by those who are genuinely interested, while a majority treat this period as a year long holiday. Since no definite curriculum exists, various departments continue to use the interns for clerical purposes and as general all-round workers.

This insidious trend needs to be arrested, and hopefully reversed, in order to make the internship training period more productive in the preparation of well trained doctors who should be competent to function in the community and should also have some knowledge of managing either a Primary Health Centre or general practice.

The Study of Interns

Against the background of the much discussed and well recognized need for reorientation of medical education, to make it more responsive to the health needs of the community, we conducted a study of fresh medical graduates commencing their internship training in one government and two municipal medical colleges in Bombay. The objective was to assess a fresh intern's knowledge about some essential aspects of community health care, which is supposed to be covered in the undergraduate medical curriculum. A questionnaire was administered to probe into their knowledge of basic health information, their understanding of some public health problems and primary health care, essential drugs and rational drug use.

The questionnaire was administered by us in two of the colleges at the time of an orientation programme on internship. In the third college, the department of Preventive and Social Medicine (PSM) undertook to administer the questionnaire on our behalf. At the outset, the interns were explained that the purpose of the questionnaire was to get a collective idea about their understanding of community health with a view to identify areas for strengthening the undergraduate curriculum.

Ill-defined knowledge - Misplaced Priorities

An analysis of the responses of 340 interns from all the three medical colleges revealed the following findings:

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The interns' estimates of the population of India varied from 1 million to 200,000 million. About 30% of the interns were not even aware of this basic piece of information, though 77% of them knew the urban:rural population ratio. More than 70% could not give the correct definition of maternal mortality rate (MMR) but about 49% could guess the correct figure of MMR for India as 4-5/1000 live births. Eighty seven percent of the interns did not know the number of registered doctors in India, the non-response to this question being to the tune of 50%. Sixty percent of them, however, could correctly guess the approximate distribution of doctors in urban and rural areas.

Expectedly, about 70% of them were very clear about their preference to practice/work in urban areas. Turning a blind eye to the fact that doctors ultimately prefer to set up practice in urban areas regardless of where they are trained, the government continues to open more medical colleges, supposedly to satisfy the health needs of the rural population.

About 75% of the interns also indicated that they would be registering for a postgraduate degree. Surgery, medicine and gynaecology were mentioned as common preferences, while there were a few interested in specializing in subjects like biomedical engineering, genetic engineering, aviation medicine, nuclear medicine and oncology. This demonstrates how far removed are the students' specialty preference from the health needs of the Indian population. A crucial subject like Community Medicine, which was indicated as a specialty preference, surprisingly by nine interns, is generally looked down upon, in the first place, by the faculty of the college and consequently by the students too. In fact, the staff of the departments of Community Medicine themselves lack the conviction that their subject is as important, if not more, than the clinical subjects.

Forty-five percent of the interns knew that infectious diseases continue to account for a major chunk of illnesses in our country and 60% mentioned diarrhoeal diseases as top killers among children. Forty-nine percent mentioned tuberculosis as top killer among adults while 25% and 26% mentioned cardiovascular diseases and cancer respectively, which actually rank second and third in the list of killers.

National Programmes - What goes wrong

Answers to the questions on the poor performance of the national tuberculosis programme and the reasons for tetanus continuing to be a major public health problem, reflected the usual attitude of the medical profession of placing the entire blame on the patients and attributing the problems to illiteracy, ignorance, carelessness etc. Only 9% mentioned about the availability and accessibility of the health care services, problems with its delivery and with those of health care personnel. When asked what advice in their private practice would they give to poor TB patients who defaulted, only 51% suggested referring them to municipal or government clinics/ hospitals or PHCs

where they could avail of free treatment facilities -- interestingly more interns from the government medical college knew this as compared to those from municipal colleges.The rest of the interns gave solutions like offering financial aid, free drugs and referring them to social workers. This reflects the lack of interns' knowledge about the public health departments and their functioning. While the staff and students may be theoretically aware of the services available under various national programmes, in actual practice, they may not know where and what type of services are available and how they can be utilised.

Every third leprosy patient in the world is an Indian and the prevalence of leprosy in Bombay is as high as 13 per 1000.The National Leprosy Eradication Programme has been in operation for over three decades and there are clear cut guidelines available for treatment for leprosy,which are simple enough to be followed by paramedical workers. Inspite of this, when asked to prescribe treatment in the case of an adult leprosy patient, 86% of the interns could not do so correctly.

As to the question of how often, in their clinical years, had they actually witnessed Oral Rehydration Solution being administered, it was revealing to learn that 19% had never seen it while 36% had seen it less than 5 times, after having spent 1 month each with the Pediatrics department and the Preventive and Social Medicine department. This is despite the fact that Oral Rehydration Therapy, which is recognized as an important tool in reducing child mortality, has been receiving a lot of inputs towards popularisation from various national and international organisations. In fact, nowadays, there is even a move towards having Oral Rehydrating Centres attached to the Pediatric Outpatient Departments of some major hospitals.

A Question of Orientation

More than 82% of the interns did not know the true import of "Health For All by 2000 AD" and did not even mention availability of basic health care or "primary health care". To the majority it meant achieving targets like universal immunization and reduction of birth rate and a larger number answered this question by giving the WHO definition of health, which is a narrow concept, more applicable to an individual than to the community at large. But one wonders whether it is fair to apportion blame to students for failing to understand what Health For All really means , when it is actually pressure from the government for attainment of targets, especially family planning and immunization, upon the medical teachers, which gets conveyed to the students and remains on top of their minds. The concepts of Health For All and primary health care, in fact, tend to get dismissed by most of the medical colleges, apart from, perhaps, the staff of the department of community medicine. This is because they do not visualise any role for themselves in primary health care, believing it to be the sole responsibility of the department of Community Medicine. This was also one of the main reasons for the failure of the Reorientation Of Medical Education (ROME) programme which was aimed at bringing the specialists to the community setting, be it urban slums or rural areas.

The concepts of essential drugs and rational drug use do not appear to receive much importance in the medical curriculum, if the interns' responses to the questions about these are any indication. While 65% of the interns did not know the number of drugs on the WHO list of essential drugs, 24% did not know that branded drugs cost substantially more than generic drugs. When asked to write a prescription for an adult male suffering from symptoms of 'flu', 37% prescribed unnecessary oral antibiotics, 37% suggested oral anti- inflammatory drugs, 27% recommended injections of analgesic/antibiotics and 36% favoured vitamins/tonics. Forty-one percent of the interns prescribed 3 or more drugs. This practice of prescribing drugs in great abundance reflects the blanket treatment approach of our doctors. No doubt, this type of doctor and the health care model also contribute in supporting the drug industry which takes great efforts to keep in contact with these young doctors-in-the-making, right through their clinical years.

The Social Costs

Coming to the question on health economics, only 54% knew the per capita government spending on health, while their estimates of government expenditure on each medical graduate varied from nil spending to Rs. 30 lakhs, 95% being unable to guess the correct figure of Rs. 4 and 5 lakhs which is the actual social cost of producing a doctor. One wonders whether this cost is justified, especially in the light of the fact that 75% of these doctors educated at public expenditure prefer to enter the private sector, and more than 5000 doctors migrate every year to developed countries, thereby subsidising these countries by saving them the expense of producing their own doctors.

After the questionnaire had been answered, interns in two of the colleges where we administered the questionnaire ourselves, were addressed by the heads of the departments of PSM, surgery, pediatrics and gynaecology. They were given an idea about their postings, the administrative procedures like getting their completion certificates etc. A disproportionate amount of time was then spent on explaining about the amount of casual leave the interns were entitled to and how they could avail of it; in fact, this was the only part of the entire talk that was heard out by the interns without any interruptions. The addresses given by most of the professors were in the same vein - they implored the interns to abide by the rules and regulations and not create problems for themselves and for the respective departments, to enjoy the one year fully and to learn as much as possible in that order. If such are the priorities set by the teachers themselves, is it fair to expect anything different from the students ?

This was followed by addresses from representatives of three pharmaceutical companies who were sponsoring the get-together and providing refreshments in one of the colleges. These representatives congratulated the interns on their performance in the examinations and exhorted them to bear their products in mind while writing prescriptions. They also assured of continuous support from their respective pharmaceutical companies as far as providing the latest information regarding drugs was concerned. In the absence of organised Continuous Medical Education (CME) programmes for doctors today, information given by these drug companies remains the only way to get updates, which more often than not, is heavily biased. The representatives then doled out drug information literature, free drug samples and several other give-aways to the interns. The final act of incongruity was the distribution of the Hippocratic Oath printed by one of the companies which the interns were made to read out in unison.

Continued on page 8

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PRINTERS DEVIL

In the July - Aug., issue, the following may please be corrected:

pg. 2	last line of the article ends with...:"the only means for people to guard their health."
pg 8	under Books, title no. 1 to read as "Demands for Grants of Central Govt. 1988-89"

The errors are regretted. **Editor**

Continued from page 7

Reorientation - Where do we start ?

After this experience one wonders where the correction process in the present medical education system needs to be started - is it with the student community that we need to interact in order to change value systems, or is it the teachers themselves who need to be given a better social orientation ?

The need today is to introduce subjects like sociology, anthropology and health economics fairly early in the course of medical education, to help students to identify the health problems of our society, understand the influence of culture on health and disease behaviour and chart out priorities in health care. Here again, raising the age of entry of students into medical colleges and introducing a couple of years of appropriate premedical training and compulsory work experience may also help. This may result in having older and more mature students who do not look only at the glamour of the medical profession, but are really motivated to practice the profession as it should be.

Another area which ought to receive special emphasis in the medical curriculum is general practice and its responsibilities and challenges, taught preferably by a general practitioner. This would help prepare students better to perform the duties of a family physician and possibly reduce the massive number of students who today flock to register for postgraduate studies.

Apart from the curriculum changes, another very important need is to make the internship training programme more meaningful. In order to do this, it is necessary to identify definite skills to be imparted by individual departments to the interns -- basic skills which any doctor starting general practice or taking charge of a primary health centre should have. It must be made mandatory for each intern to acquire these skills before getting a certificate of completion from the respective departments after undergoing a practical test at the end of this period.

Unless such steps are considered towards reorientation of our present undergraduate medical education system, our medical colleges will continue to churn out academically bright but immature doctors lacking social orientation and unprepared to do justice to the practical challenges which lie ahead of them.

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FREE ABSTRACTING

The contents of this newsletter may be abstracted without prior permission. However we would welcome acknowledgement of the source and copies of any abstractions.

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AYURVEDA
During Freedom Movement and After

Alex George

The present state of decadence of the Ayurvedic system of medicine in India is not just due to the relatively higher efficacy of allopathic treatment. Though Ayurveda was stagnating even before the British period its current decadence is as much due to the colonial policy of subjugation of the indigenous systems of medicine as also the cultural choices of the Indian elite which set the terms of medical discourse of independent India in favour of western medicine. While colonial subjugation of Indian science was aimed at depriving the nation of its possible sources of cultural pride, both the policy of colonial subjugation of Ayurveda and its marginalisation during the post independence phase were based on certain presumptions which, in fact, was characteristic of 19th century European thought. Positivism never accepts the existence of anything which is not verified through empirical observation. The ideological aura of western science built around empirical verifiability was something against which Ayurveda stood to loose tremendously. Since too little research had been done to translate the treatment techniques of Ayurveda into the academic language of discourse of modern western sciences and it was practically not feasible to subject an entire system of medicine to the rules of verifiability of western science, it became far too easy to brush aside Ayurveda as queer. Seeing itself as rational, scientific and universalistic, western medicine defined itself in opposition to the presumed irrationality and superstition of indigenous medicine.

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India's post independence experience is in stark contrast with that of China where traditional medicine has been incorporated as an integral part of health services. By the end of 1965, there were already over 2,80,000 doctors of Chinese medicine working in medical institutions owned either by the whole people or by collectives and their social status had been considerably raised. Developed courses in traditional medicine were offered in all medical schools and doctors trained in western medicine were required to take the training. By 1979 about 4 lakh hectares of land were brought under the cultivation of medicinal plants.

Nationalists' Efforts During Freedom Movement

Indian attempts at revival of Ayurveda and other indigenous systems during the colonial period started with the Government of India Act of 1819 which gave the power of local self government to the provinces and with the Nagpur session of the Indian National Congress in 1920, which resolved that "earnest and definite efforts should be made by the people of this country to popularise schools, colleges and hospitals for instruction and treatment in accordance with indigenous systems of medicine". This was followed by the establishment of committees by the governments of various provinces and principalities for revitalizing the indigenous systems. Earliest among these were the committees set up in 1921 by the Governments of Madras and Bengal provinces and by the United Provinces in 1925. They were followed by the Central Provinces and Berar and also by the Punjab in 1937, the Mysore principality in 1942, Utkal in 1946 and the Bombay province in 1947.

In the midst of these developments, the National Planning Committee established by the Indian National Congress in 1938 resolved to absorb the practitioners of Ayurveda and Unani systems into the state health organisation of independent India. However the **Health Survey and Development Committee (Bhore Committee) Report 1946**, which was to become the blueprint for the organisation of health services in free India, did not visualise a significant role for the indigenous systems. The Committee observed that it was "not in a position to assess the real value of these systems" and that on account of the paucity of time and opportunities at their disposal "it could not conduct an investigation into the problem as would justify clear-cut recommendation in respect of the part to be assigned to the indigenous systems of medicine in the organised state medical relief of the country". This omission led to criticism at the XIII

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session of All India Medical Conference held at Madurai in 1946 and later the same year at the All India Provincial Health Ministers' Conference held at Delhi. As a consequence, the Health Ministers' Conference resolved that adequate provisions be made in the Centre and the Provinces for :

(a) research in, and the application of scientific method for the investigation of indigenous systems like Ayurveda and Unani with reference to the maintenance of health and prevention and cure of diseases,

(b) starting colleges and schools for training in Diploma and Degree courses in indigenous systems of medicine and,

(c) offering post-graduate courses in indigenous systems of medicine to graduates in Western medicine.

It also reiterated the resolution of the National Planning Committee to absorb practitioners of Ayurveda and Unani into the State Health Organisation by giving them further scientific training wherever necessary. In order to suggest ways and means of attaining the above objectives, the Conference appointed a Committee under the Chairmanship of Col. R.N. Chopra which submitted its report in 1948.

Post Colonial Period

The Chopra Committee Report suggested a synthesis of Indian and Western systems, for which it felt attempts were to be made in the field of medical education. Accordingly the Committee recommended a three stage integrated training and research programme in Indian and Western systems. In the first stage of this programme papers in Ayurveda and Western medicine were to be taught side by side with some amount of comparison, but maintaining the distinctiveness of the two systems. Some of the papers suggested included;

(1) *Padartha Vignana* in Ayurveda which was to have its parallel in basic sciences in Western medicine,

(2) *Sharira* in Ayurveda with its counterpart of anatomy in Western medicine,

(3) *Dravya Guna Vignana, Rasashastra and Aushadha Nirmana* with their parallel of *Materia Medica* in Western medicine etc.

In the second stage each of these pairs of subjects were to be taught by the same teacher instead of by two previously, wherein he was expected to give a unified view of Indian and Western medicine. The final stage would result from the work in research institutes where eminent experts of Western and Indian systems would work side by side, discussing, testing, checking and verifying hypotheses and theories with a view to either rejecting or harmonising them. There could also be parallel hypotheses, which is not too uncommon in science.

The equality of status of Ayurveda vis-a-vis Western medicine, as envisaged by the Chopra Committee, was not quite granted to it in the post-independence health policy. The overbearing concern for the post-colonial Indian elite was of being left behind in the onward march toward modernisation, in which the West was perceived as the model. In tune with this approach, Ayurveda was relegated to the level of a fringe phenomenon. The mystifying ideological halo within which modern medicine operates in the health market of an increasingly commercialising economy also further ensured the decline of Ayurveda in post-colonial India.

However there were some government committees which went into the status of Ayurveda after independence. The Pandit Committee (1949) and the Dave Committee (1955) also recommended the concurrent teaching of Ayurveda and modern medicine. The Udupa Committee appointed in 1957-58, made several recommendations relating to the professional education, medical care, research and drugs. It recommended the establishment of a Council of Indian Medicine and a Council for Ayurvedic Research. The Mudaliar Committee (1961) took the view that concurrent teaching of Ayurveda and modern medicine should be stopped and only *Shuddha Ayurveda* was to be taught. It felt that the extraordinary growth and range of utility of modern medicine are due to the contributions it has received from the phenomenal growth of physical and biological sciences in recent times. Therefore a synthesis of Ayurveda and modern medicine should be through the incorporation in modern medicine of all that can be tested scientifically and proved to be useful in the Ayurvedic system. The Committee's approach was mainly one of engrafting Ayurveda on to the basic foundation of knowledge in modern medicine by starting post - graduate courses in Ayurveda for those trained in modern medicine, instituting chairs in Indian medicine in modern medical colleges etc.

From the Chopra Committee (1948) which recommended a somewhat harmonious synthesis of Ayurveda and modern medicine on equal terms to the Mudaliar Committee (1961) which recommended the engrafting of the tested out portions of Ayurveda within the modern system of medicine, itself speaks for the marginalisation of ayurveda in post-colonial medical discourse. That the so-called integrated schemes of medical education never succeeded in a synthesis of Ayurveda and Western medicine as envisaged by the Chopra committee has to be admitted. But this again was due to the market pressures

Plan Allocations for Traditional Indian Systems of Medicine and Homeopathy.

First Plan	0.40 crores
Second Plan	4.00 crores
Third Plan	9.80 crores
Fourth Plan	15.83 crores
Fifth Plan	25.07 crores
Sixth Plan	85.39 crores
Seventh Plan	129.05 crores

Source: Indian Systems of Medicine and Homeopathy, Min. of Health and Family Welfare, GOI, N.Delhi, 1988, pg. 18.

from the modern medical system which was encouraged to hold sway indiscriminately, in the name of modernisation. It must be borne in mind that the Chopra Committee report had a holistic approach towards health care in the country, which it sought to root in the scientific bases of our own cultural traditions and from there to build up linkages with the Western medicine. However the post-independence policy, took a different turn and led to the marginalisation of the indigenous system.

In a welcome departure from the predominant policy postures on Ayurveda, the ICSSR-ICMR report 1981 had recommended the introduction of a national orientation to our health care system by the incorporation of culture and traditions of the people in an unchauvinistic and rational manner. Accordingly it suggested that each indigenous system should be allowed to retain its identity and grow in its own genius, but an effort should be made to ultimately develop a national system of health care in which all different systems can make their unique contribution. The National Health Policy (NHP) which was announced in 1983 also understood the need for planned efforts to dovetail the functioning of the practitioners of the indigenous systems and to integrate their services at the appropriate levels within the overall health care delivery system, specially in regard to the preventive, promotive and public health objectives.

In spite of such policy pronouncements, in recent years the central plan outlay for Indigenous Systems and Homeopathy has never been even a full 5 % of the allocation for health. In fact in the VII Plan it was only 1.27 %. The IV Plan (1969-74) allocation of 4.72% was the highest. This vividly illustrates the near total marginalisation to which the indigenous systems have been subjected to in the post-colonial India. Due to the neglect of and poor investment in the indigenous systems both before and after independence the utilisation of Ayurveda and the number of Ayurvedic practitioners are on the decline.

Conclusion

The situation calls for studies in the receptivity of Ayurveda in the various cultural regions of the country, to get a full picture of the utilisation of Ayurvedic health care. In addition, such studies will also provide us with success stories of effective utilisation of Ayurveda in certain regions. The emerging trend of putting emphasis on the supply side of Ayurvedic health care, by financing nurseries/gardens of medicinal plants has in fact to be balanced with studies on the actually existing demand for Ayurvedic health care, backed by educational inputs wherever required. The burden of colonial¬scientistic hangover is far too heavy, such that people are happy with any injection, even of distilled water, compared to some of the effective Ayurvedic medicines

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PREPARATORY SYMPOSIUM FOR T.B.PROJECT

A preparatory symposium for the FRCH research project on "Social and Operational Constraints in T.B. Control" was organised at Pune on 2nd and 3rd November, 1991.

The purpose of the symposium was to present the Research Plan in the preparatory phase of the project before the experts and have their comments and suggestions. As policy planners, they are the real consumers of the research study. This will enhance the relevance of the study, which will be useful for policy formulation.

On the first day, after the welcome address by Dr. N.H.Antia and an introduction to FRCH by Dr. Ramesh Awasthi, Dr. Sheela Rangan gave a brief overview of research in T.B. control, which was followed by Dr. M.W. Uplekar's talk on the research and intervention needs in Tuberculosis Control. Later in the day the T.B. project team presented the progress made in the above project during the last few months by presenting a resume of the work done , sampling strategies and various research instruments prepared. In this the interview schedules, interview guides, the formats of the case study and observations to be made were presented and discussed.

On the second day the invited experts gave critical comments and suggestions on the Research Plan. This was followed by an open discussion with them, by the research team, which was very fruitful. The invited experts who participated in this symposium included, Dr. S.P. Tripathy, Director General, ICMR, New Delhi; Dr.D.R.Nagpaul, Retired Director National Tuberculosis Institute, Bangalore, and presently Hon. Technical Advisor to T.B. Association of India, New Delhi; Dr. D. Banerji, Head, Centre of Social & Community Medicine, JNU, New Delhi; and Dr. R. Prabhakar, Director Tuberculosis Research Center, Madras.

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UNDERSTANDING TRADITIONAL MEDICINE
The Meeting Ground.

Darshan Shanker

The revitalisation of traditional medical wisdom, which still caters to the health needs of a major section of our society, can play a major role in realising the ideal of self reliance in primary health care. Instead of re-educating the people with exclusively Western concepts, the healthy elements of the people's own health traditions should be strengthened and the distortions removed.

Sensible Strategy

Despite the creation of an impressive modern medicine infrastructure for health delivery services in rural areas which includes District Level Hospitals, Block Level Hospitals (for 1,00,000 pop.), Primary Health Centres (for 20,000 pop.), Primary Health Units (for 3,000 pop.) Village Health Guides (for 1,000 pop.) the percentage of the rural population actually covered by the state health services is reported to be 30% at the maximum and in certain difficult areas, as low as 3%. Bearing in mind the limitations of governmental machinery, even with additional inputs to improve the efficiency of the system, the coverage is not expected to rise substantially. In the light of such ground realities, it has become necessary to critically review the strategy that should be adopted in India in order to achieve the goal of 'Health for All'.

My thesis is that in a country of India's size, the state will never be able to provide basic health services to all, through its official machinery. The state should therefore revise its strategy for achieving this goal by 'enabling' communities and individuals to engage in 'self-help' for provision of 'primary' health care and should complement the community's own efforts by way of providing critical referral support. The basic instrument for promoting this 'enabling' role and self-help of rural communities should be a culturally sensitive programme of "health education". A realistic goal to aspire for by the year 2000 AD should be a provision for an enabling scheme of 'health education to all' rather than the present goal of 'health services to all'.

In the above context it will be discovered that traditional health culture has a tremendous role to play, as India has perhaps one of the richest ethno-medical traditions in the world. They are based on widespread local knowledge and resources. mostly plants, but also animals and minerals. Self reliance in primary health care is possible if it builds up on this heritage of the people of India.

Traditional Medical Wisdom : two streams

Traditional Medical Wisdom expresses itself in two streams, the empirical stream at the folk level and the codified stream at the *shastric* level. The former is of the nature of traditional beliefs, norms and practices based on experience and passed down via an oral tradition. It is located in the villages of India. It may be called the '*Lok Swasthya Parampara*' (LSP) or 'Peoples' Health Culture'. The LSPs are spread across the length and breadth of the country in all our rural communities. The carriers of the LSPs are millions of housewives with practical knowledge of home remedies, food and nutrition, lakhs of traditional birth attendants, thousands of bone setters, practitioners skilled in acupressure *(varman)*, eye diseases *(netra chikitsa)*, dental care *(dant vaidyas)*, poisons *(vish vaidyas)*, veterinary care *(pashu vaidyas)* and village level herbal medicine healers, especially in tribal communities, who treat a variety of common and chronic ailments.

The second stream of the traditional health system is the scientific (or `*shastriya*') level. This consists of codified and organised indigenous medical sciences like Ayurveda, Siddha, Unani and Tibetan medicine. These indigenous systems of medicine (ISMs) have sophisticated theoretical foundations expressed in thousands of manuscripts covering treatises on all branches of medicine and surgery.

Both exist in a symbiotic relationship. It is the codified stream that can assess the folk stream based on its understanding of principles of drug action, etiology, etc. and remove distortions from it. In fact, the rationale of many folk practices has been better understood within the theoretical framework of the *shastric* stream. The *shastric* stream can, in turn, learn from the empirical knowledge of the folk stream.

Resource base of Traditional Medicine

Medicinal plants form the major resource base of the indigenous systems of medicine since over 80% of the remedies are plant based. Nature has provided every micro-region with the plant species required for its local health needs. Some examples may serve to illustrate this. The plant *Ephedra gerardiana* (a Himalayan specie) from which the broncho-dilator ephedrine is derived, is typically found only in high altitude regions and the local people make frequent use of the whole of the plant to make a special tea consumed several times daily to help them breathe conveniently. There are also plant species like *Acorus calamus* (sweet flag) which have wide distribution across tropical and the temperate regions. It has important medicinal use in nervous and respiratory disorders, which occur in a variety of bio-climates. Given their tremendous potential it is imperative to implement suitable strategies for conservation of dwindling medicinal plant resources.

Different Foundations: Different Knowledge and Structure:

The Modern and Traditional sciences rest on two wholly different foundations and cannot therefore be easily compared. Indiscriminate comparisons, however, form the order of the day. To gain an understanding of indigenous health sciences like

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Ayurveda which is a 'holistic science', it is necessary to be familiar with the indigenous scientific tradition which is foundationally distinct from the western scientific tradition. Foundational differences could be better understood if there was healthy debate on alternatives in science in the Indian scientific community.

A major problem that non-western societies have to contend with in any serious evaluation of their indigenous sciences is the common claim of all western scientists and philosophers that 'after all, science is one, universal and uniquely expressed (western) paradigm'. Thus, while it may be possible to conceive of alternative methodologies, theories and practices in other domains such as music, linguistics, logic, art and politics, there is no such possibility with regard to science. Such claims smack of a dogmatism borne out of western ethno-centric world view. Beginning with such an epistemological position, it is impossible to initiate a debate on 'alternatives in science' for the very idea is dismissed as an absurdity. Given the continuing domination of the West, non-western societies are left with no option but to accept modern science and technology as the universal well-established system and to derive legitimacy for their own traditional system by demonstrating how well the latter conforms to the methodology, theory and practise of the former. There is however, an urgent need to evolve a new approach to the question of alternatives in science by first examining the Indian epistemological position on the issue. This would indeed be possible if scientists, philosophers and scholars of the various Indian *shastras* interested in examining this question seriously are given sufficient encouragement.

Different foundations in medical sciences naturally give rise to different structures of knowledge

The foundational theories, principles, concepts and categories upon which indigenous health science is based are indeed different from Western medical science. While indigenous science is built up on the holistic perspective of the *pancha-mahabhootha siddhanta*, the western foundational theory is atomistic; while the former rests on such philosophical foundations as *samkhya, vaishesika* and *yog*, the latter rests on various schools of positivistic foundations necessarily differ in form, structure, categories and concepts. This foundational difference is reflected in differences in the formulation of theories pertaining to causation of diseases, pharmacology and drug action, dietetrics and nutrition, physiology, diagnostics, etc.

For instance, in indigenous pharmacology, better known as *dravya guna shastra*, the whole plant or its parts - the leaves, stem, seeds, root, bark, fruit, flowers - is studied in terms of its *invivo* effects on such parameters as *ras, veerya, vipak* and *prabhav* and is used as an active substance. Modern pharmacology, on the other hand, isolates the active chemical entity from the plant (or its parts) and studies its *invitro* and *invivo* effects on different parameters. Both approaches undoubtedly have their uses. The difference lies primarily in the fact that in indigenous knowledge systems, that category of knowledge known as chemistry is absent. What exists is a holistic category called *dravya guna shastra*. If we believe the absence of chemistry to be a serious lacuna in indigenous sciences, we would have to concede that the absence of *dravya guna shastra* in modern science is as serious a lacuna. The point, however, is not one of lacunae in the scientificity of either system, but the fact that these differences arise from fundamental foundational differences which make unintelligible any simple comparison of the form, structure and categories of both systems.

Terminologies and Comparisons - not easily reconciled

In any comparative study of two sciences it is imperative to have the appropriate terminology and language for a dialogue. For instance *vaatha* is often equated with the nervous system or nerve force and *pittha* with the digestive system, enzymes, hormones and the heat regulating mechanism. While such equating may work at one level, it often breaks down at other levels. For example in indigenous practice, intellection is a function of *pittha*, representing a preponderance of *satwa guna*. In Western philosophy, however, intellection would fall in the domain of the nervous system (cerebrospinal) which is equated with *vaatha* in the indigenous science.

The untenability of such an equation arises from the fact that the principles of classification belong to radically different orders. Western physiology speaks of the nervous tissue, muscular tissue, epithetical tissue, etc. The principle of classification is anatomical, based on the structure of the component parts. In the triadic classification of *vaatha, pittha* and *kapha*, the basis is biological, based on the function correlated to the three *gunas*.

Departure from the experimental method of Western science

The essence of the modern laboratory method is to isolate any problem from its environment, to eliminate its interlinkage with other diverse factors in nature and reduce it to the minimum possible number of controllable parameters. These parameters are then varied (usually one at a time) and their effects on the system studied.

In contrast, the traditional approach attempts to solve problems by taking them in their entirety together with their inter-linkages and complexities. This method of solving problems in their natural setting seems to be efficient in providing balanced solutions. Indian systems seek to systematize common sense and to make it rigorous rather than destroy its essential unity in its multi - facetedness. Thus, according to Charaka, science is dependent phenomena brought into existence by the coming together of a multiplicity of causes of which the phenomena are constituted. Again, having perceived the multiplicity of causes it uses *yukthi* to bring together appropriate actions and materials at the appropriate time and place. The traditional system thus, even in its theoretical formulation, seeks to find means of healthy living rather than dissecting it or bringing about major changes. It appears then, that while traditional sciences are indeed built upon a stupendous amount of detailed ad minute observations 'experiment' (in the modern laboratory sense of the term) perhaps does not have a clear counterpart in this tradition.

Measurement and Quantification - differences in approach

Although measurement and quantification are an important part of indigenous systems of medicine, they differ in form from the modern systems. Most measurement in the traditional

Continued on page 11

AN INTRODUCTION TO HOLISTIC MEDICINE

(Compiled Article)

Medical centres around the world are coming to understand that the human mind is not walled off from the supposedly involuntary activities of the autonomic nervous system. Medical scientists are dealing with evidence that the brain is a force in our healing process, producing or ordering the endocrine system to produce the changes in the body's chemistry. In this way the mind can govern the ability of the body not just to overcome pain, but to regulate such functions as respiration, digestion, circulation and even cell reproduction.

What is Holistic Health ?

These findings are what make the basis of holistic health care. While there are many definitions, the most accepted one comes from the Berkeley Holistic Health center, California *"Holistic Health (H.H.) is the state in which an individual is integrated in all levels of being: body, mind, spirit and emotion."* All modalities of treatment may be used in holistic health - surgery, medicine, chemotherapy, radiation, hypnosis, acupuncture, acupressure and yoga to name a few. The key is to use them appropriately and responsibly. Assuming responsibility for one's health is really the ultimate goal of holistic health. It holds that the human being is a fully coherent and integrated life support system with built-in mechanisms of balance and control. The mind is regarded not just as a biological switchboard but a centre for total management. Therefore, the mind must not be bypassed or underestimated in any healing effort.

Why Holistic Health ?

People have become aware that modern drugs can be healing, but are also powerfully dangerous. Antibiotics can be miracle drugs and also make bacteria resistant to any treatment. Each drug has a side effect which is sometimes greater than the benefits. Growing public awareness through newspaper and magazine articles and consumer consciousness groups has resulted in a growing distrust of modern drugs.

The distinct features which characterise H.H. have further popularised it amongst the conscious sections in society. H.H. is person oriented rather than disease oriented. It recognises that the patient is an active committed partner in the healing process rather than a passive recipient of treatment. It respects the valid contribution of current medical science and practice and seeks for their responsible integration with traditional and alternative healing and health programmes. Whenever appropriate it recommends use of gentle, natural forms of healing. While recognising the value of the rational, scientific approach as a tool for discovery, understanding and evaluation, it also accepts " non-scientific " approaches in some situations, especially when this results in a noticeably healthier person. There are many factors outside the province of medicine that play significant roles in undermining our quality of life - poverty, unemployment, malnutrition, mortality, crime, divorce, human unhappiness, stress: especially stress, for that causes a multitude of pathological conditions. H.H. is more ecological in orientation than allopathic medicine. It acknowledges the infinite resources available to the individual and seeks to decrease dependency on sophisticated biomedical technology.

Harmony and Balance in Medicine

The rise of allopathic medicine with its scientific approach became the dominant paradigm in the 20th century, particularly in the Western world. It viewed the world as a sort of giant mechanical machine governed strictly by rigid laws of nature. This left out the spirit both in man and in nature. It neglected, for the most part, the interrelationship between mind and body, psycho-social and biochemical aspects of the diseases. It led to various assumptions :

i) Disease was conceptualized as an outside organic entry that invaded the body and attacked a particular part.

ii) The appropriate treatment for an illness is a biochemical agent that will counter-attack the causal agent and neutralize it. So the physician's role was seen mainly as selecting a pharmaceutical or surgical intervention aiming at the afflicted part.

iii) Since bodies are considered to be essentially the same (like machines) personal consciousness was not considered to be a significant variable. So the same intervention was applied to different patients as long as the organic symptoms were the same.

iv) Knowledge regarding treatment is complex and known only to the specialist and therefore the patient is seen as a passive recipient of the intervention, preferably without interference or resistance since the doctor knows best.

The theme central to the holistic approach is individual responsibility for one's health. In the words of a patient who was healed through treatment by the H.H process :

"I made myself sick and I removed it myself. I knew why I was sick - the main cause was stress and I know now how to manage stress in a better way. I was not able to digest my food. After many investigations, I was told that my pancreatic enzyme was not being produced. I was told that nothing can be done for it and I have to live with it and keep a strict diet and continue pancreatine tablets until I die. Then I attended the Holistic Health Centre and was helped to see the real problem. Side by side with foot reflexology, diet with sprouts and stress management, within two months my pancreas started to function normally. I stopped all the medicines and started on normal diet. By taking responsibility for finding the cause, I achieved a permanent cure."

The concept of holistic approach to health is not a new one. In fact it is as old as medicine itself. Hippocrates was quintessentially holistic when he insisted that it is natural for the human body to heal itself, and that this process can generally take place even without the intervention of a doctor. Holistic medicine merely reconnects to roots and goes forward with people taking responsibility for their own health and also that of the environment in which they live. ■

This article has been compiled verbatim from the following:
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AFRICAN TRADITIONAL MEDICINE: *Concept, Practice and Policy*

Shirish Kavadi

A movement in support of traditional medicine has grown gradually over the last one decade in Africa. The growing interest is part of the search by the WHO and governments for alternative sources for delivering primary health care to the underserved rural communities in non-industrial countries. Governments in Africa, urged on and supported by the WHO, are attempting to develop the indigenous systems of medicine through research, standardization and regulation of traditional healing practices. These steps are being undertaken with a view to greater utilization of traditional medicine in national health systems.

The indigenous approach

The African approach to health is holistic, incorporating the personal, social, physical and spiritual aspects of a human being's life. The concept of illness and disease is inseparable from their religion or philosophy of life - a reflection of the African world view. Africans perceive the world as one moral universe in which humans, spirits or God(s) interact: as one in which human beings maintain a harmonious relationship with their material, social and spiritual environment; and one in which the spirits of forefathers or God(s) are guardians of the social order.

Illness results from breach of the universal moral laws. When an individual transgresses the universal moral laws he/she disturbs the natural equilibrium between him /her and the social, physical or spiritual environment. Illness is a physical manifestation of this lack of harmony between the individual and the environment. It is also retribution from God(s) or spirits who, as guardians of the social order, can take punitive action against those who infringe the moral order of a society. Sickness may also be induced by a sorcerer or the will of malevolent enemy or because a spirit has not been propitiated.

It is clear that indigenous medical system views moral health and hygiene for the immortal soul as its most important concern as against Western medicine which emphasizes physical health and body hygiene. The latter specializes in prescribing medicines, injections, or surgery. Traditional medicine differs in stressing health in its totality thus including within its ambit health problems related to the physical body, the mind-soul, the social and spiritual environment. Several types of traditional practitioners are found in Africa. However, reference is being made only to the more commonly known.

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The Spiritualist or Diviner: Spiritualists practice divination and also diagnosis through dreams and trances. They specialize in metaphysical treatment and do not normally give patients any physical examination. Spiritualists first identify the social and psychological symptoms and signs of the ailment. Later the patient is given herbal medicine.

Faith Healers: Faith healers investigate the social rather than the physical cause of the disease. They subject their patients to intensive interviewing and use social analysis to get to the root cause of the patient's illness. Apart from interview, faith healers rely on mediation, dreams and prayers for diagnosis.

The Herbalists : The herbalists, besides prescribing herbs, also assume the roles of counsellor, pharmacist and social worker helping in the rehabilitation of patients.

All the three above mentioned healers, particularly faith healers and spiritualists, treat psychosomatic diseases. They also diagnose and treat epilepsy, impotency, insanity, chest asthma, and spirit possession, bewitchment, sterility and infertility. Spiritualists and herbalists in addition diagnose and give medicine for such ailments as marital discord, rheumatism, venereal diseases, love problems. Overweight, high blood pressure, problems of unemployment, delirium, forgetfulness oedema and prevention of disasters are the other ailments which spiritualists treat. Besides those mentioned above, herbalists have cures for cough, persistent headaches, prolonged menstrual periods, abdominal pain, charms for good luck, diarrhoea, vomitting lumps, worms and child delinquency.

Apart from the practitioners referred to above, there are the traditional paediatricians and mid-wives who deal with pregnancy related illnessess and health problems of mother and children. These two, along with the herbalist, are concerned more with health problems of the human body and the physical world, than with spiritual disturbances.

Revived Interest

The WHO and African governments have acknowledged the failure of modern health services to meet basic health needs of the African people and are therefore promoting traditional medicine. Health services are characterized by inequity, inefficiency, shortages and geographical maldistribution of health resources. Large hospitals and other well-equipped health units are mainly located in the urban centres. The majority of qualified health staff - and the number is absurdly low in most countries - are similarly based. Rural areas, where 80 percent of the population resides, are underserved or without any primary health service. Existing health care units suffer from inadequate supplies, staff shortages and lack maintenance funds. Expansion and extension of health care services to the rural communities

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is rendered difficult by the lack of necessary finances. Modern health services are also particularly subject to competing demands for the available but limited resources. Since health is not a priority concern of the governments in developing countries it receives less allocation than requirement. The economic crisis of the last decade has only aggravated the problem. But ill-health is more prevalent in rural areas than urban. The rural masses are most vulnerable to illness being exposed to (the inter-linked factors of) a hostile environment, poverty, under nourishment and malnutrition. They are also ignorant of the objective causes of ill-health and of the appropriate protective measures.

One way of rectifying the situation would be to have more hospitals, dispensaries, health centres and a proper distribution of essential drugs. However, these modern health systems require sophisticated technology, specialized personnel, considerable financial investment and are hence expensive. Moreover such type of services may be inappropriate to the situation. It is common knowledge amongst medical practitioners that many diseases can be easily treated by suitably trained paramedical staff through simple methods and do not need the attention of doctors or specialists. The auxiliary health personnel only need to be accessible. This has been an important consideration in the promotion of traditional medicine.

Since 1970 there has been a growing realization that socio-economic development required a healthy labour force. A precondition to economic development was improvement in the health of the people and hence primary health care became the focal point of health care development in the non-industrial countries. But primary health care objectives could not be attained with the various inadequacies prevalent in existing national health systems.

Against this background the WHO began searching for alternative forms of health care delivery system (apart from the Western system of medicine), with African governments. WHO and UNICEF have concluded that curative medicine is inadequate and that hospital treatment, as it exists in industrial countries, is both expensive and unsuitable for the situation in the developing countries. In addition, the Western approach to health and illness and its treatment is incompatible with the African concepts of health and illness. It is argued that historical, cultural and sociological factors have identified traditional healing systems as this alternative source. Traditional medicine, it is observed, is readily available and accessible in every rural community besides being culturally acceptable. A very large section of the population, already seek treatment from indigenous healers.

After evaluating this situation, WHO has formulated a strategy which aims at using Africa's own resources, including indigenous medicine as it is currently practised. Traditional healers can offer low cost and simple treatment. Moreover being an integral part of the local culture they know the community in which they live. They can make themselves acceptable to the people. The WHO programme expects African countries to identify and exploit those aspects of traditional medicine that provide safe and effective remedies or practices particularly for use in primary health care. The scope for utilising the skills of traditional healers to achieve the minimum acceptable WHO standard of health personnel to population ratio are therefore being explored. The cooperation of indigenous practitioners is also being sought in the hope of improving and extending basic health care services to the underserved rural communities and to operationalize primary health care objectives.

Government Policy

The WHO has a coordinated programme for utilising local traditional herbal medicines and tapping the skills and knowledge of indigenous healers. Most governments in Africa, having adopted the programme, are formulating policies to operationalize it. Research projects drawing upon Africa's accumulated knowledge of traditional medicine are underway. They seek to identify the active ingredients of various plant extracts and mixes used in folk medicine. Aiming at producing a pharmacopoeia of the medicinal plants of Africa, it is expected that local import substitutes in pharmaceutical production would be obtained and the local pharmaceutical industry would be developed. Thus the governments would be able to curtail imports and save scarce foreign exchange. This would further help to reduce health care costs and it is felt the ultimate beneficiaries would be the people. The focus is on rational study of medicinal plants because that is an area which is directly accessible to scientific research. Governments, along with the WHO are fostering research into botanical, phytochemical and pharmacology aspects of traditional medicinal herbs and plants. Toxicity levels of commonly used herbs are also being investigated to determine their positive and harmful qualities. Some of the WHO supported research institutes have already made some progress in regard to making an inventory of plants, plant health control and utilization of medicinal plants.

The Medical Research Institute, Nairobi (alongwith the WHO), the Department of Chemistry, University of Malawi, (supported by the International Foundation for Science, Sweden), the Traditional Medicine Research Unit at the University of Dar-es-Salaam and the University of Zimbabwe are involved in such research programmes.

This research has helped to a certain extent on reducing the drug expenditure in some countries. Senegal has saved an estimated $ 631,000 a year in foreign exchange by developing

READER'S COMMENT

I regularly receive the FRCH bulletin. I find the articles interesting and useful, but would appreciate the bulletin more if you publish articles/comments/news items in the field of community health - in short, happennings even outside FRCH. The bulletin should reflect and respond to contemporary events, - Drug policy in the offing, safety of Ayurvedic preparations (ref; Sura), patients' rights (context; MARD strike), etc.

Ravindra R.P, Bombay.

The suggestions are well taken. In this context, we invite our readers to write for FRCH newsletter. If potential authors indicate their interests, specific articles could be commisioned.--- Editor.

and producing two low cost drugs: one a cough syrup and the other a laxative. The former is derived from an indigenous plant called *gueira* and is considered as effective as codeine based drugs manufactured in Europe, while the latter is based on the lam plant.

Mental health is another area in which research is conducted to determine the contribution traditional healers can make to the care of the mentally ill. It is felt that although Western medicine is un-surpassed in the relief of physical health problems, traditional medicine, well-versed in local psychology, is better placed to deal with some of the mental health problems of the local people. Such research programmes are being carried out in Senegal and Zimbabwe. In the former, the programme also includes several experiments in cooperation between psychiatric hospitals and indigenous healers who specialize in treating mental disorder.

Training is being imparted to some types of traditional health staff such as traditional birth attendants (TBAs), perhaps because in most African countries more than 60 per cent deliveries are conducted by TBAs. The TBA is perceived to be not just a mid-wife but a social worker and a herbalist specializing in diseases of women and children. The government of Zimbabwe has embarked upon a training programme for the traditional mid-wives in every province, conducted by the District and Rural Health Centre Staff operating at the grassroot level. Zambia has provided additional training to TBAs through UNICEF and WHO assistance. In Malawi, the Ministry of Health has undertaken training programmes for TBAs in all the 24 districts of the country hoping to provide primary health care through them to the whole population. In the Gonda region of Ethiopia it has been observed that the standard of care available to mothers and babies significantly improved after traditional birth attendants had been given a two - week training course.

Policies to facilitate a better and greater utilization of traditional healing are being worked out and planning is being done to incorporate the services of indigenous healers into national health systems. Government plans include legal recognition and organization of these practitioners to submit them to standardization and regulation. Issuing licences is one way of conferring legal recognition. It is also the most preferred legalisation method in Ghana and Nigeria where individual licenses are issued to the practitioners while in Botswana, the government has authorized the Traditional Healer Society "to regulate the practice of traditional healing, issuing licences to those whom its officers judge to be competent." Supervision and control over practice is essential to ban or eradicate the negative aspects of indigenous healing practice.

National associations are being encouraged to act as supervisory and regulating bodies. For this reason governments are encouraging the setting up of such associations. In Zimbabwe the Traditional Medical Practitioners' Act No. 38 of 1981 which gave legal recognition to the healers also established the Traditional Medical Practitioners' Council, with responsibility for supervising and controlling traditional healing practitioners.

In Zambia indigenous healers were asked by the government to form an association to standardize and control their practice. The Traditional Medical Associations in Nigeria lay down some guidelines for the practice by their members and are responsible for disciplining of erring members. Zambia and Zimbabwe have instituted registration for traditional healers, making it an offence to practice without registration. The Government of Zambia has introduced regulation to eliminate and ban indigenous healing and medicinal practices perceived to be negative or deemed inimical. The Witchcraft Act 1967 provides for penalties for the practice of witchcraft. But the government also encourages legitimate healers to institutionalize their forms of healing and thus supports the growth and development of indigenous medicine. In Nigeria, while the Federal Government is itself a long way from legalizing and utilizing traditional healers in the country's health delivery team, the governments of Lagos and Oyo states have already acted upon it. Governments are making various efforts to integrate traditional medicine into the national modern health systems. The governments of Guinea, Mali and Zaire view integration as a part of a total reform of the medical system from a public health perspective. Efforts are directed towards establishing new public systems into which traditional healers will gradually be integrated and play a defined role in the provisions of both primary and specialized health care.

Concluding remarks

There appears to be a fair degree of ambiguity with regard to traditional medicine in most countries. By and large traditional practice has been left un-regulated, it has generally not been made illegal and in countries where licensing of such practitioners does exist the effect, has been minimal.

An argument made in favour of traditional medicine is its cultural acceptability. The WHO approach however does not take into consideration the essentially holistic approach of this system because it concerns itself merely with the physical and biological aspects which form the basis of modern medicine. Besides, modern and traditional health systems are viewed as being complementary to one another. Yet this complementarity does not appear to develop into effective cooperation. The two have still to be integrated into a structure which acknowledges the fundamental legitimacy of both systems.

Wherever academic and research interest exists in traditional healing methods, specific healers are referred to or are consulted by modern practitioners and researchers, only on an adhoc basis. The problem with indigenous healers is their reluctance or refusal to part with their knowledge which is regarded as absolute secret. Being a gift from the spirits it cannot be transmitted. They do show a willingness to cooperate or have no objection to exchanging patients or information but are unwilling to working together.

An additional problem has been lack of funds. The WHO collaborative research institutes and programmes have financial and other resources. But this research is being carried out mainly by persons trained in modern medical science. On the other hand, associations of traditional healers who may wish to carry out research are constrained by the lack of resources. The Zimbabwe National Traditional Healers Association (ZINATHA), despite having both a research department and training centre, has been unable to carry out either task due to lack of funds. The WHO committee of experts on traditional medicine has maintained that the main reason for traditional medicine in some developing countries not making substantial progress as

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MEDICAL PLURALISM
Some Theoretical Problems

Dhruv Mankad

Anthropological investigations of health care practices have demonstrated that medical pluralism is the rule and not the exception the world over. Medically pluralistic societies offer a variety of alternatives of healing techniques. These alternatives not only represent different medical systems : allopathy, homeopathy or Ayurveda, they represent different ideologies, each having a separate historical and philosophical base and each providing a different theory of treatment.

While it has been argued by some that medical system itself is a cultural artifact and therefore an ideology also, it is the ideological aspect of a medical system, that presents complex theoretical problems in understanding and analyzing what is conventionally called Traditional Medicine. These problems can be broadly classified into the following categories:

1. The relationship between medical system and culture.
2. The legitimacy of pluralistic analytical concepts in medicine.
3. The problems of integration.

It has been argued that each medical system is a product of its historico-cultural condition. It is true that all organised medical systems derive their overall philosophical, ideological orientations from the surrounding culture. Thus, Ayurveda is rooted in *Nyaya Visesha* and *Samkhya*. The modern medicine, allopathy, derives its philosophical framework from positivism. It is also argued that each major transformation in the dominant framework of understanding human diseases and their treatment was a cultural transformation.

The problem that such a view throws up is that if each system is defined in its own cultural terms, can we legitimately talk of progress in scientific thought in any real sense? Can we consider modern medical theories and methods as an advance over the traditional ones ? If we indeed do so, medical systems like acupuncture, which are practised widely and effectively and do not find a place in the modern medical thought, will have to be rejected as being not a part of this march of modern science.

The other problem that such a view leads to is the ethnocentric view of the cultural artifact that a medical system is. An ethnocentric view of medical system maintains that each system can be understood and analysed on its own terms. It also maintains that a traditional medical system is a part of a culture, a way of life and thus cannot be grafted on an alien culture. Thus it considers attempts to analyse factors leading to progress in scientific thought as being futile because it considers that if traditional experiences can be analysed on their own terms, they are no more or less progressive than other experiences. For example, it is argued that it is only when we consider mastering nature as an ideal for a scientific endeavour that "western" medical science is progressive. On the other hand, it further argues, if we consider harmony between man and nature as a predominant value then the achievements of Ayurveda or Chinese medicine stand out as more advanced.

However, such a view is not without its critics. While sympathising with those wanting to do justice to the achievements of non-western or pre-modern cultures, the critics of ethnocentrism warn of dangers of falling into relativism and of denying the fundamental continuity and universality of all science. By considering the science of different cultures as totally separate, immiscible thought patterns, irreconcilable and unconnected, such a view may be used as a cloak for some historical racist doctrine

If we accept the pluralistic view implied in the criticism of the ethnocentrist / progressivist views outlined above, we have to grapple with a further theoretical problem. Can there be more than one scientifically valid but distinct conceptual analytical framework for diagnosis and treatment of a single disease entity? Can there be more than one valid causal explanation of an event, forming the basis of the medical intervention as evinced by two different but presumably effective modes of interventions ?

Such a view is alien to the existing medical scientific thought, though not entirely so to physical sciences where multiple explanations of a physical phenomenon have been found to be acceptable but after a philosophical debate. An alternative to the plural view is an integrative view of all medical systems. Such a view argues that modern medical science has not replaced traditional medicine after carefully screening of traditional theories, practices. Ayurveda thus, for example, has just passed out of fashion as a result of forces other than those generated by internal developments.

Such a reevaluation forms the basis of integration of all valid theories / practices into the body of medical knowledge and would involve :

a) Interpreting a disease in modern terms and evaluating a traditonal drug like any other modern drug.

b) Diagnosing a disease using traditional conceptual framework and testing a drug clinically by the same method. This would not only-test, using modern evaluating techniques including the statistical ones, the efficacy of a drug but also the theoretical validity of the diagnostic principles involved.

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However, the critics of this view point to certain theoretical problems inherent in such a reevaluation.

(a) It presupposes the superiority of the testing techniques of the modern medicine over the ones used by traditional medicine, a presumption which, in itself, is questionable.

(b) This reduces traditional medical system, which is holistic, encompassing a healthy way of life and not just a therapeutic technique, into a technique within the terms set by a modern medical framework.

Finally the most fundamental theoretical problem, the question of traditional medicine throws up is regarding the definition of science itself. If science is defined (content wise) as a body of knowledge obtained by a systematic observation of events, phenomena, things and (method wise) as the process of knowing and explaining the dynamic interrelationship between events, phenomena and things in materialistic terms, based on such systematic observations, then the special status awarded to allopathy vanishes. There is nothing in this definition that precludes the possibility of referring back to the insights gained in the past or in other cultures in order to further the approximation to reality which it attempts to obtain. Organised traditional medical systems like Ayurveda, by this definition, can qualify as sciences proper, neither pseudo- nor proto- sciences.

Thus, at its most fundamental level, the problematic of traditional medicines is the problematic of the philosophy of science.

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science are made using units 'normalised' to an individual. That is, while assessing a person's height or the length of his or her limbs, the measurement is expressed in units of *anguli* the dimension of a finger of the concerned individual rather than an arbitrary standard external to the individual - the international metre. Such normalised units exist not only for measurement of length but also for volume and time. In *Yoga Chintamani*, for instance, a *maatra* of time has been defined as the time taken by a sleeping individual to complete one cycle of breathing - one inhalation and exhalation. Although measurement and quantification have their place in indigenous systems of medicine their importance is somewhat limited as compared to modern systems. In India it is not the geometry of Euclid but the *asthadhaayi* of Panini that is considered to be the supreme example of the construction of theory. Indian sciences are based on the understanding that numbers and symbols are essential to achieve scientific rigour rather than the technical use of natural language. Sanskrit, for instance has sufficed in highly abstract and technical topics like logic, mathematics and *Vedanta*. Recent research has indicated that this method of using natural language to achieve rigour has powerful applications in computer sciences as well.

The need for legitimising serious cross - cultural medical research

Such differences should come as no surprise to those medical professionals aware of the plurality of cultures and their varied scientific expressions. Difficulties in correlating principles, categories, concepts are only to be expected in any cross cultural endeavour. They have to be faced and resolved by serious comparative research workers. Schools for comparative medical research need to be established in the country. In these schools a creative dialogue must be initiated by the medical professionals, starting from the fundamental issues related to the epistemology and philosophy of science. A comparative framework needs to be constructed to serve as a bridge to cross from one side to the other. Only then will we be able to resolve the differences in the knowledge structures of the two systems. In such schools will the meeting ground for 'understanding' traditional medical sciences be found.

Glossary of terms

Although exact English equivalents are not possible, we give a brief explanation of the *sanskrit* terms not explained in the text, to help the lay reader understand.

1)	Shastras	-	Text based on principles and general and specific rules.
2)	Panchamaha-bhoota Sidhaanta	-	Principle of five states of nature. (Earth, water, fire, air, & sky.)
3)	Dravya Guna Shastra	-	Pharmacology - indigenous
4)	Ras	-	Taste
5)	Veerya	-	Potency
6)	Vipak	-	Metabolised taste
5)	Prabhav	-	Overall *in vivo* effect.
8)	Vaatha	-	Physiological function.
9)	Pittha	-	Physiological function.
10)	Kapha	-	Physiological function.
11)	Satwa Guna	-	Harmonising property.
12)	Yukthi	-	Method of solving a problem *in-situ* / using multi-variables.

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FOUNDATION FOR REVITALIZATION OF LOCAL HEALTH TRADITIONS.

The FRLHT has its history in the coming together of many individuals and organizations under the banner of the *Lok Swasthya Parampara Samwardhan Samiti.* The Foundation is expected to play a strategic role towards creating a supportive environment for the revitalization of the indigenous health culture of India. It brings out a quarterly bulletin which intends to forge information linkages as well as generate healthy interaction and dialogue with all those connected with the revitalization of traditional systems of medicine and related areas such as logic, mathematics, linguistics, plant sciences, etc.

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compared to Western medicine is because the former has not exploited the rapid discoveries of science and technology as effectively . It of course follows that such exploitation would also lead to its commercial exploitation. WHO recognizes the potential economic value of medicinal plants. Referring to research into African medicinal plants and herbs, Prof. Norman R. Farnsworth, Director of the WHO collaborative research programme said, *"Such research programmes can lead to industrial development in any country where discoveries are made"*. The question is, would such commercial exploitation through modern technology necessarily and always lead to curtailing pharmaceutical costs? Medicines may not necessarily be available at affordable prices to the general population. It would, perhaps, be more relevant and pragmatic to have traditional healers continue to prescribe herbal medicine while at the same time devising such policies and programmes as would ensure availability of medicinal herbs and plants to traditional healers.

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