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FAMILY PLANNING
An Alternative Strategy

N.H.Antia

The present Family Welfare programme has little to do with the welfare of the families to whom it is targetted. It is an imposition of the will of the rich on the poor, whose increasing numbers is looked upon not only as dilution of the gains of 'development' but also an eventual threat to their life style and very survival. This perception, seldom expressed openly, has been the determining factor in policy. making, funding and implementation of the programme at both the national as well as international level. This is revealed by the type of extensive propaganda and pressures, based on the perceptions and needs of the affluent classes and nations, having little impact on the poor who have entirely different needs, perceptions and thinking on this subject. Though seldom articulated, a large family is not only considered an economic asset by the poor but also the only security in old age or illness, besides being the only form of love and caring that is available to them in the inhospitable and uncaring world in which they have to survive or die. Many of the age old practices like the 'son complex' have very likely evolved on such a basis, even though they may not fit into contemporary circumstances.

Target Pressures : the backlash

Increasing consternation due to an almost uncontrollable increase in population since independence led to the use of overt force against the poor during the national Emergency. Having resulted in the overthrow of the Government, the pressure is now exerted in the form of, though not much less harsh, covert force -- not against the male who rebelled, but against the helpless woman. Not only half the Plan budget on Health, but even the entire public health services have been diverted to population control under the euphemism 'Family Welfare'. The chief reliance has been on female sterilization conducted through the 'camp' approach. Not having achieved the desired result, it has led to the increased advocacy of non-terminal methods such as Intra Uterine Device (IUD), condom and the oral pill. Since no political group, either in power or in the opposition, has the necessary courage to discuss population control after the Emergency debacle, the method has been to provide *ad lib* funds, which are readily available from both national as well as international sources, in order to exert extreme 'target' pressures through all available means, short of overt force. The incentive / disincentive measures are not only exerted on the people but also on all personnel in the public and, to an extent, in the private sector. The adverse effect this has had on the personnel and programmes in fields such as education and revenue, resulted in easing of these pressures on these agencies. Pressures were then accentuated on the health services and personnel, who now bear the major burden of this thorny cross thrust on their already reluctant shoulders.

Despite this despicable programme, which further harasses and terrorizes the helpless female, already exploited by traditional social customs and the country's economic policies, the population growth rate has hardly decreased, hovering near the factor of two for the past three decades. The increase in 'target' pressure has only resulted in an increase in the Couple Protection Rate without equivalent decrease in the Birth Rate, indicating a mere increase in false reporting. The plateauing of the graph during the past three decades, after an initial steep rise, only demonstrates that the methods which achieved initial gains can achieve no further decrease in the growth rate, though it may avert a certain number of births. This, by itself, is insufficient to control the rate of increase of our population, which now poses a threat not only to the upper classes but also to the economy and ecology of the entire country.

Distorted Commitments

And yet the response of the policy makers as well as of the bureaucracy is 'more of the same', using a variety of technological, administrative and managerial techniques as well as the introduction of new programmes like Maternal and Child Health and Universal Immunization to reduce maternal and child mortality. While laudable by themselves, none of these programmes have been able to achieve their desired results. This is because of the basic insincerity underlying these programmes, often initiated at the behest of international agencies. Their real intention is not the welfare of the people but as an aid to achieving the FP targets. This neither fools those who are asked to implement them nor the people whom they profess to cater to.

The FP 'target' pressures have so distracted and demoralized the health personnel and alienated them from the people, that they are unable to achieve their sole target objectives. This apart, it also prevents them from delivering those programmes such as immunization and curative services, which the people actually desire. It is not that the people are averse to Family Planning but they will do so only when it suits their own needs, not those of the

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government, international agencies or the elite. Many of the sterilizations, which are achieved only after an average of 3.8 births, would have been achieved without any need for motivation. More would be achieved if the programme was carried out more humanely and personal attention and caring than through the present 'camp' approach and where 'cases are bought and sold'. Family planning on the adivasi population, because they are readily amenable to pressures during drought, is immoral because they seldom show any natural increase in their numbers. It can, and often has, led to genocide of these communities. The problem of condoms in rural areas is their disposal and with that of IUD is the problem of utilizing a method where the vast majority of women already have chronic gynaecological problems. 'Norplants' and the possible availability of the injectable contraceptives raise serious questions of medical ethics and wide ranging moral implications of their widespread misuse by the elite and other groups who wield power over the vast majority of our people, as demonstrated by the present FP programme.

The Alternatives

It is abundantly clear that without the use of overt force (with bitter results) there is little hope of any further, significant progress in limiting the size of our population by utilizing the present methods. The future therefore lies in seeking the voluntary acceptance of non-terminal methods by the younger age group, both male as well as female. This can be achieved only if the antagonism and mistrust between the people and their health workers, (especially the Auxiliary Nurse Midwife, who is closest to them) is overcome and rapport reestablished. This cannot be achieved unless the present target approach of the FP programme is removed. It does not mean a total scrapping of this present method of accounting in the health services, which, unfortunately, seems to work only on the 'target' basis. Rather, the targets can be moved to better and more useful functional parameters such as accounting for individual maternal and child deaths from readily preventable and curable diseases like gastroenteritis, acute respiratory infections, tetanus and tuberculosis and of new cases of poliomyelitis, malaria, etc.

Simultaneously, measures will have to be instituted for bringing accountability of the Primary Health Centre and their staff to the people whom they are paid to serve and not permitting the provision of excuses and blame for their failure to a more distant authority. This can be achieved forthwith even without waiting for the Panchayati Raj. Such a shift of targets will automatically shift priority towards the programmes of MCH, immunization, health education and help re-establish the lost human relationship between the younger age group and their paramedical workers. Such request for priority medical help must inevitably lead to request for advice and help for family planning as and when they feel the need.

Another major change for re-establishing rapport must be the improvement of the curative aspect of the Basic Health Services, especially maternity and emergency services. This is essential in order to rehabilitate the lost image of the Primary Health Centre (PHC). The triad of Public Information on Health and Health Services, the Preventive aspects of health and Curative services cannot be achieved under the existing counter-productive FP approach. A Family Welfare programme in its true spirit must be integrated into the mainstream of the Health Service and the dichotomous and overbearing FP programme merged in its entirety at all levels from the Ministry of Health, to the PHC, into the general health services of the country. Only thus can the counter-productive effect of the present FP programme on population control as well as on Health Care be neutralized. The term Family Welfare is redundant, for health care cannot exist without care and welfare of the family. It is time this term is abolished. Good health care must be the approach to Family Welfare and not vice versa, as is the case at present.

Other Measures

Such changes will have to be associated simultaneously with several other measures which not only impinge on health and FP but have much wider social and economic implications of their own. Female education is probably the most significant of these measures. This will not only increase the status of the female but also in her economic activity which affects the age of marriage as well as the size of the family. It will also be a potent means for improving her own as well as her children's and family's health. It will ensure better nutrition with the available resources, better sanitation in the home and surroundings, higher rate of immunization and pre and ante-natal care, as well as better utilization of available health care services and facilities. There is no better example of this than Kerala, where the birth rate is 19.8 per thousand as compared to 30.5 per thousand in India as a whole.

While there is a need to increase the overall allocation to the Public Health Sector, much improvement can be achieved even today by better reallocation of existing health resources and expenditure between rural and urban areas of the country. There is an equal, if not a more urgent, need for reallocation and increase in inputs into education, with special emphasis on the female. These measures will not only affect the population growth but are essential for the welfare of the masses, besides being laudable in their own right and for the development of the nation as a whole.

The direct relationship of the limitation of family size to economic status is not only observed in affluent countries but is also observed in our own middle class which now accounts for about 10 to 15 percent of our population. Forty percent of our population growth is accounted by the four BIMARU states of Bihar, Madhya Pradesh, Rajasthan and U.P. which are the poorest states, with the lowest female literacy. This can be improved only through a major change of the nation's policy from the present polarized approach to a more egalitarian form of development.

No Short-Cuts

Four decades have provided sufficient evidence that there are no short-cuts to development or population control, certainly not within a democratic system. Gimmicks like social marketing and change in the name of the programme from Family Planning to Family Welfare fool no-one except those who look to the West for solutions to our entirely different problems. The decision for determining the family size is an intensely personal choice and cannot be dictated or enforced. Economic and social conditions must be created which enable and encourage the poor to control their family size. The present policy of population control for the sake of economic and social development is placing the cart before the horse. ■

ERRATA

Line 3, para 2, of the second column on page 1 (Alex George's article) in the last issue (FRCH Newsletter Vol.V, No.6, Nov.-Dec.91) should read "of India Act of 1919" instead of 1819, as printed. The error is regretted

Editor.

HEALTH CARE IN CHINA
A Model in Transition

Ravi Duggal, Sonya Gill

This is the 3rd article in the series, "Health Financing and Costs : Comparative Perspectives" (No.1 - Japan, No. 2 - Zambia).

China is the largest agrarian and poverty ridden country, with a past of colonial exploitation, which has achieved rapid improvement in the health status and social conditions of its people. In sharp contrast to the pattern of development characterized by large and increasing inequalities witnessed in India -- another vast, agrarian and post-colonial country -- the Chinese path of development emphasised the conscious, redistribution of resources from urban to rural areas and in favour of the poor workers and farmers on a big scale. The impact of this pattern of socio-economic development has probably been greatest for, and most visible in, the health sector. Roemer has summed up the acclaim for China's achievements in the health field --*"Nothing was more impressive than the central principle on which China's health service (like so many other sectors) was built : `serve the people. This meant many things, but in contrast to policies in most of the Western world, it meant that health care was not a commodity to be bought and sold in the market..... Health was not a matter for private profit".*

This country report briefly reviews the pre - 1980 system of universal provision of public health and primary care services that underlay the achievements in the health status and the direction of health systems of reforms after 1980.

Health Status

After the establishment of the Socialist State, the People's Republic of China, the period between 1950 - 1986 witnessed the doubling of life expectancy (from 35 years in 1949 to 69 years in 1986) and the rapid reduction in infant mortality (from the very high level of 250 per 1000 live births to 34/1000). In contrast, the average IMR for the developing countries is currently 92/1000 live births. Maternal mortality has declined to 44 per 100,000 live births as against the prevailing rate of 250 - 400 per 100,000 in India or 400/100,000 in Indonesia.

In 1949, poverty, malnutrition and a high incidence of infectious diseases such as typhoid, cholera, and tuberculosis were responsible for a death rate of 40 per 1000 population. By 1987, the mortality rate had declined to 7 per 1000 population and the disease pattern had begun to resemble that of developed countries. The leading causes of death today are cerebro - vascular diseases, heart diseases and malignant tumors, followed by respiratory diseases, rather than infectious diseases and malnutrition as in most poor countries. Despite one of the lowest per capita incomes for any poor country (US $ 310 in 1986), the availability of adequate food, education, housing and jobs, as well as public health campaigns and universal primary care have been at the core of the remarkable improvements in health conditions.

While the mortality profile has changed, the widespread morbidity due to infectious diseases such as dysentery, influenza, viral hepatitis, tuberculosis and schistosomiasis demand continued attention and resources for universal preventive and curative services. Chronic conditions related to old age among the growing number of people over the age of 60 and those arising out of occupational hazards and cigarette consumption, have also put pressure on health resources in the '80s and given new impetus to the development of traditional medicine.

Health Services: universalization of the public system

In 1949, the backward state of health infrastructure and services was reflected in the fact that there was one western allopathic doctor per 15,000 population, mostly concentrated in the few large cities along the coastline. The vast rural majority faced a dire shortage of doctors and medicine, except for those who had access to the traditional practitioners of a 2,500 years old system of Chinese medicine. The bulk of medical care was provided by the 276,000 traditional practitioners, approximately one per 2,015 population.

The health infrastructure expanded rapidly as the new health policy committed itself to providing universal coverage to the people. The existing fee-for-service system was converted into a semi-universal public system based on differing modes of financing of services. The first National Health Conference held in 1950 laid down the guidelines for development of the health system : Serve the workers, farmers and soldiers ; priority to be given to prevention; develop both western and traditional medicine; and unite health work with mass movements.

TABLE 1 : HEALTH SERVICES

Year	Physicians		Nurses	Barefoot Doctors	Beds
	Total	Allopaths			
	------per..... 100,000 ..... population-------				
1949	67	--	6	--	14
1960	90	12	26	--	106 ('65)
1985	131	57	59	121	213

Sources : Statistical Yearbook of China 1983, China : A Statistics Survey in 1985

In the early 1950's there was mass mobilisation and active participation of people and communities in improving environmental sanitation for the prevention of communicable diseases. The public medical services also expanded rapidly, so that as early as 1965 "every one of China's 2,000 or so counties had a fairly well-equipped and competently staffed general hospital. Most of these

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county hospitals have about 100 beds and larger ones have from 200 to 300 beds". Underlying this expansion was a policy framework that ensured that physicians and medical graduates were assigned to work in the public health institutions. However, the distribution of the rapidly expanding services tended to favour the urban areas, while the rural majority had much less access to health care. To meet the health needs of the vast, dispersed rural population, the insurance based cooperative medical system (CMS) was, from the mid-60's, universalized to cover the whole country.

The decentralized co-operative medical system was closely linked to the co-operative organization of agricultural production based on production teams (each having a 100 to 200 peasant population corresponding to one or more villages), and work brigades (averaging 16,000 people each). The brigades were directly responsible for providing health care to their members, and for constructing, equipping and managing the health stations. Both primary curative care (combining traditional and allopathic medicine) and preventive services (immunization, health education, family planning, communicable disease reporting) were provided by the "barefoot doctors" who were selected by the brigade members and given six months training in public health and primary care. These, and other part-time, para-medical workers, worked mostly in the brigade health station and also participated in agricultural production. Higher referral units, such as the commune health centres, manned by assistant medical practitioners and county hospitals provided the secondary-level support for the activities of the 'barefoot doctors '.

This 3-tier rural health services network made effective and technologically simple services available to even the poorest agricultural communities. Not only did it solve the problem of inadequate health and medical personnel in a relatively short time and provide a substitute delivery system to the expensive hospital-based care, it also developed an insurance system to cover primary care for the agricultural population. Rural primary health care was financed by an insurance fund created jointly through monthly payments by each peasant member of the brigade and the welfare budget of the commune derived from the proceeds and profits of its productive activities. This insurance fund paid for the brigade health station and cost of drugs used by barefoot doctors and paid a portion of the peasants' medical expenses at commune health centres and county hospitals. The barefoot doctors, like the peasants who worked on the land, were paid by the brigade according to the work-points they received each day.

Although a similar 3-tier, decentralized system based on red medical workers, street and neighbourhood health stations and district hospitals existed in the urban areas, the fact that most of the urban work-force was employed in government or state enterprises has given them access to the free medical care provided by employers through factory health stations or relatively better equipped urban hospitals and health centres. Thus, even in the 60s and 70s, the government and the enterprises fully funded the health insurance for their employees and for college students, while the rural population had to partly meet the cost of insurance premiums and some of the cost of higher level care. The Central government finances have mainly financed secondary and tertiary level care paying for capital in construction of hospitals and commune health centres, salaries for the staff and any deficits, such as unpaid bills.

The impressive improvements in health status since 1949 and the creation of, perhaps, the world's largest network of health care institutions and work-force, resulted in the advocacy of the 3-tier model of primary health care based on village health guides and para-medical health workers for the poorer countries, by the WHO. However, this model, transplanted to very different socio-economic and political settings, has remained non-functional and ineffective.

Health Financing and Delivery: current issues

The Chinese health system has undergone major changes, specifically in rural areas, since 1980. Some of the key changes and challenges are:

1) *Increased rural-urban inequalities in access to services and resources*: The general economic reforms of 1980 replaced collective agriculture with the incentive based household responsibility system, thereby raising productivity and rural per capita incomes. No organizational measures were however taken to save the system of health stations and barefoot doctor services based on co-operative finances and administration. Health services coverage declined from 90% of all villages in 1978 to just 25% in 1983-84. Since then co-operative insurance coverage has increased to about 50% of the villages. These are mainly the richer areas which can afford higher premiums and co-payments. The poorer areas bear the increased financial burden of a fee- for-service system. As Victor Sidel writes, *"Government workers still have insurance to cover health costs, but all others have to pay for care. Private health insurance is being introduced. Although health statistics are not available, it appears that these policies have reduced the government's ability to provide immunization and access to medical care, especially for people in poor areas. There are no statistics to evaluate changes in health conditions, but the infrastructure is clearly deteriorating, particularly in rural areas. New technologies are being introduced almost exclusively into urban areas, further reducing resources available to rural areas."*
2) *Cost escalation in hospital care*: Rising incomes have increased the demand for higher quality, hospital-based care and reduced the utilization of rural primary and preventive services. To raise additional resources under the new schemes of self responsibility of hospital management, charges have been raised and additional co-payments imposed on patients. The reforms in hospital insurance appear to have improved utilization and brought down waiting lists, as also created barriers to over-utilization and lack of proper referrals. However, these reforms have yet to become popular as they shift the financial burden to the patient.
3) *Encouragement to private practitioners*: Various experiments in financing methods have been initiated at the village and township levels to raise local resources and avoid investment by the state. To ensure the availability of services, an estimated 133,000 practitioners have been approved since 1980 to set up practice. Many have contracts with authorities to carry out immunization and operate the health stations. A large variety of contractual arrangements and reimbursement options are currently being tried out. However, all of them involve some combination of fee-for-service and subsidies.

With changes in the financing pattern, private expenditures have increased substantially. Direct private expenditure represented 27.5% of the total estimated health expenditures of Yuan 14,791 million in 1981. This, along with the premium paid by the individuals towards co-operative insurance, amount to nearly 32% of total health finances. The current move to replace free care for the urban employed with insurance will further increase the share of private expenditure.

Conclusion

These are only some of the issues facing China after 10 years of experimentation in health reforms. Prior to 1980, it had nearly achieved a system of universal basic health care coverage. At

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IN THE LAST FIVE YEARS.....

Usha Sethuraman

With this issue, FRCH Newsletter enters the sixth year of its publication. Below, we give a compiled list of articles that have been carried over the years, categorized subject-wise. Apart from these, the Newsletter has regularly carried information about books and reprint articles contained in our library and documentation unit. It has also carried bibliographies on selected subjects, book reviews and readers views, from time to time. Xeroxed reprints of any article(s) can be obtained at the cost of Re.1.00 per page plus postage. Please quote details regarding title and issue when sending requests for reprints.

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DELHI DECLARATION

On the safety of the vulnerable road users

An International Conference on Traffic Safety was held in New Delhi in January, 1991. This is the first time such a conference has been held in any developing country. The sponsoring associations and their participants passed the Delhi Declaration on road safety.

Road traffic crashes have become a major cause of ill health; each year at least 500,000 people are killed and millions are injured. The majority of those people are vulnerable road users (VRUs); pedestrians, bicyclists and motorized two wheeler riders. This worldwide epidemic of VRU injuries, disabilities and deaths can be controlled only by policies which change priorities in funding, remedial actions and research in favour of the VRUs, in recognition of the real world situation.

Improving the safety of the VRUs requires a political commitment at the highest level and a recognition by the community of the needs of the VRU. The safety of the majority of the users of the transport system must not be subordinated to economic interests, nor to the requirements of only one class of road users.

Specific Recommendations

Road and Vehicle Designs

Provision of bicycle lanes and pedestrian pathways separated from motorized traffic is one of the most effective methods of reducing VRU injuries.

Improving the urban environment by traffic calming techniques, pedestrianization and car-free zones, pioneered in Europe, have great applicability in less motorized countries if cultural and social factors are taken into account.

Traffic control methods should recognise the special needs and characteristics of the VRUs.

Motor vehicles should have turn indicators, brake lights and headlights which accommodate the specific needs of the VRUs.

Pedestrians

Motorists require special training as to the importance of low speeds for improving pedestrian safety. Children under 7-8 years should not be expected to cope with traffic and should be accompanied by adults.

Use of conspicuous clothing and retro-reflective devices should be encouraged especially for children and the elderly.

When pedestrian paths are not provided, pedestrians should be instructed to walk facing traffic.

Two Wheelers

Conspicuity is vital and all riders should wear appropriate clothing. Fluorescent and retro-reflective surfaces on both clothing and vehicles should be encouraged. Front and rear lighting on all two wheelers is essential. Daylight use of the lights should be encouraged, particularly on motorized two wheelers.

Correct bicycle size is important for adequate control by the rider. Bicycle manufacturers should provide greater choice in frame and wheel sizes.

Helmet use by all two wheeled riders should be made universal through education and regulation.

Alcohol

High blood alcohol levels in drivers and riders is a major cause of crashes involving VRUs. Alcohol testing after all crashes should be required by law. Programmes to reduce drinking and driving should be implemented with appropriate legal procedures including random breath testing techniques.

The consequences of medicines and other drugs, including alcohol, on all road users must be made clear. The use of drugs by long distance, commercial vehicle drivers needs to be controlled. Physicians and pharmacists should inform patients about the effects of prescribed medicines.

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POPULATION CONTROL AND WOMEN'S HEALTH.

Nagmani Rao

Case 1:

'A', who had an IUD inserted after her first delivery wanted to have it removed after a few months, due to excessive bleeding and discomfort. The ANM who had handled her case, rudely sent her away, saying 'A' was trying to spoil her record and making a fuss too soon. Finally 'A' bribed a nurse at the PHC to remove the IUD and to promise not to reveal this to the sub-centre ANM.

Case 2:

'N', a social worker, went to the PHC a few months after an IUD insertion (following a MTP), complaining of a dislodged Copper-T and suspected pregnancy. The attendant nurse removed the IUD, advised her to take EP-Forte to test for pregnancy and later come back for a renewed IUD insertion. Shocked, 'N' confronted her with the dangerous facts about EP drugs. The nurse responded sheepishly - "Oh ! you want this pregnancy do you? How do you know about EP drugs, are you a doctor.....?

Case 3:

'S', a dalit CHV, while at a meeting at the PHC, shared that a lot of women came with health complaints following sterilization and she didn't know what to tell them. The CMO humiliatingly censured her, saying that imagined problems should not serve as excuses for non-fulfillment of FP targets. The ANM, whom she turned to, in the hope that as a woman she would understand better, advised - "don't bother; tell the women that there is no connection (of pain) with 'operation' and, in any case, women should bear pain patiently !"

The above are illustrative of innumerable instances which hold up a mirror to the almost single minded obsession of policy makers and health personnel to carry out FP programmes at all costs. What is the rationale for such blind determination ? Is the assumption that population control serves as a panacea for all economic and social ills afflicting the country, based on sound principles ?

Countering Myths

The entire approach towards population control is based on certain myths. These include: a) the Malthus influenced view that a galloping population will spill-over to eat up the world's resources, cause economic drain, aggravate poverty and should therefore be urgently contained; b) the view that population control measures come as a boon for women since frequent pregnancies and childbirth are the major cause of women's ill-health.

The first argument above can be countered by the following facts:

-- While population increase in India has shown an 83% rise between 1951 and 1981, during the same period foodgrain production has shown a 135% increase.

-- The fears of the population of the Third World creating a crowded environment with associated ecological degradation is another myth propagated by the vested interests of the First World. The following figures disprove a proportionate correlation between population density and development.

Country	Persons/sq .km. (1981)
Japan	311
West Germany	246
England	228
India	200

-- Historical facts highlighting economic development of the (former colonising) First World countries have shown how the Third World countries served as a fertile ground for cheap labour and other natural resources and therefore high fertility in the latter was, in fact, an economic advantage (as opposed to the present cause for concern) for the former.

-- Countries such as Canada, at their highest fertility, had a Total Fertility Rate *(TFR - the average number of children per woman)* as 8, whereas the Indian TFR has never exceeded 6.

The premise of the relative safety of contraception vis-a-vis the greater dangers of child bearing is increasingly open to question on account of research results indicating morbidity and mortality risks associated with contraception. These are further elaborated in the following paragraphs.

The trend of targetting on women in FP efforts and contraceptive research has been gaining in prominence. The brief period of targetting men through vasectomies during the Emergency served to topple a government, which then seems to have reverted to targetting women with greater determination. IUD's, oral contraceptives, tubectomies have all been tried out with vigour, and when these had limited acceptance, a testing and promotional campaign for injectable contraceptives and implants has been embarked upon, disregarding the associated morbidity and mortality risks.

The theory that contraception reduces the burden of child bearing and maternal mortality and is therefore in the best interests of women's health also does not hold, on several grounds:

TABLE 1 : SELECTED GYNAECOLOGICAL DISEASES VERSUS PAST OR PRESENT USE OF FEMALE CONTRACEPTIVE METHODS. (N = 558)

Diagnostic groups	Contraceptive history present No.(%) (N=123)	absent No.(%) (N=435)
Menstrual Diseases	92 (74.8)	202 (46.4)
Sexual problems	16 (13.0)	28 (6.4)
Vaginal Infections	120 (97.6)	352 (80.9)
Cervical Disease	102 (82.9)	292 (67.1)
Pelvic Inflammatory Diseases	59 (49.0)	100(23.0)

(Source: High Prevalence of Gynaecological Diseases in Rural Indian Women, by R.A Bang and others (MFC Bulletin 159, Jan. 1990).

- Gynaecological disease have been found to be more frequent in women with contraceptive history. (Table 1)
- Innumerable studies (including a recent WHO sponsored study carried out by IIM, Bangalore in two districts in Karnataka) have indicated that terminal methods (tubectomies in particular) are promoted more forcefully through the target approach. The fact that

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women accept these only after achieving the desired family size (of four to five children) not only makes FP efforts a self-defeating exercise, they also hardly make a dent on the problem of maternal mortality, which is really a problem of inaccessible primary health care.

- The rate of morbidity arising directly from contraceptive use. (IUCD's, tubectomies, hormonal pills) has been substantial.

TABLE 2: COMPLICATIONS DUE TO CONTRACEPTION

Contraceptive method	Morbidity	Incidence	No. of acceptors in 80-81	No. of women who would have suffered ill health
IUCDs	Bleeding and pain	10-15/100 users	6,00,000	60,000 to 90,000
	PID	10/100 users	----"----	60,000
	Infertility	10/100 users	----"----	60,000
	Ectopic pregnancies	0.8 to 4% of method failure	----"----	240 - 1200
	Spontaneous	50% of method	----"----	15,000
	Perforation of uterus	1/2500 users	----"----	240
Tubectomy	Post op. menorrhagia	5.1%	1,550,000	79,050
	Pelvic infections	12.42 per 1000	----"----	19,251

Source: Incidence Rate (IR) for bleeding and pain, 'Contraceptive Technology, 1986-87', 13th Revised Edition, Irvington Publishers, p. 202, as cited in ref. 8.

- The legislation of abortion was considered a land mark in helping women attain reproductive control and prevent deaths due to quackery. Yet, physically, socially and financially MTP facilities still remain inaccessible to a majority of women. GOI data for MTP over a three year period (1978-1981) indicate that the highest percentage of MTP's were resorted to following contraceptive failure. While there may be more to these data than meets the eye, the fact that MTP is resorted to as a method for FP points to the lack of contraceptive education amongst the masses.

FP Vs Women's Health

The primary health programme makes a pretence of concern towards women's (and children's) health through the Maternal and Child Health (MCH) programme. However, as the name itself indicates, women are catered to primarily as mothers, the programme actually serving as an entry point to achieve FP targets. With the introduction of the concept of National Reproduction Rate Unity (NRR-1) the fate of the Family Welfare Programme and the associated MCH Programme is sealed. In fact, the first U.N. Advisory Mission stated as far back as 1966 that ANM's should be 'relieved from other responsibilities such as MCH and Nutrition so as to concentrate on FP efforts' because of 'the fear that the (FP) programme may be otherwise used in some states to expand the much needed and neglected maternal and child welfare services'. The fact that the health status of Indian women has shown no marked improvement over the last forty years despite 'improved' MCH programmes indicates that they hardly cater to the real health needs of women. The compressed MCH package and the slogan of NRR-1 further reinforce the policy of negligence towards women's health issues.

Other Health Issues

Viewing women primarily as mothers (or potential mothers) leaves a wide gamut of women's health problems out of the health policy and delivery systems. The interest in women begins and ends with FP services, with a few other half-hearted schemes added to the package. The integration of FP into the Primary Health Care services has been like the proverbial camel taking over the tent, thus adversely affecting the utilization of an important service by the masses of women. The ICSSR-ICMR document (1981) had succinctly commented that the health status of women had not shown any material change over the years, mainly due to the fact that women are nutritionally more 'at risk', yet utilize health services much less than men do.

Much of this is related to the social image of women (as self-sacrificing mothers who work long hours and eat less to sustain the family) and biases that view many of women's illness as psycho-somatic, whether these are menstruation related or arising out of sheer fatigue. The watering down of the MCH programme after it's enhanced focus on fertility control has also adversely affected its outreach.

While it is true that maternal mortality in India is rather high and the section comprising pregnant and lactating women would need special focus, there are other equally incapacitating (and potentially fatal) health issues such as anaemia, parasitic diseases, problems associated with long hours of back breaking work, gynaecological problems and yes, also violence. Neglecting these is doing injustice to the cause of women's health.

Contraception as Empowerment

The Conference marking the International Women's Year, 1975, declared "*the right of women to decide freely and responsibility on the means and spacing of their children and to have access to the information and means to enable them to exercise that right .....*". The situation for women in India is a far cry from the resolution. The targetting of women for population control has oppressed and harassed women - as health personnel, pressurized to achieve targets; as guinea pigs, for (often uninformed) contraceptive testing, as acceptors, as victims of a system where the choice on when and how many children to have and what contraceptive method to adopt is defined by the policy makers, health personnel, pharmaceuticals and family members who adhere to patriarchal norms.

It is in this context that one questions the research into and advocacy of newer contraceptive technologies. Why should it be that research aspires to develop contraceptives for women only? The persistence in testing and promotion of injectable contraceptives and hormonal implants seems to point to more pronounced efforts at taking away women's control over their own reproduction.

At the same time research into male contraceptives has hardly received any impetus. The fact remains that, at present, the 'ideal contraceptive' which is effective, safe, cheap and easily accessible and acceptable to all strata of society is simply non-existent.

While conceding the fact that contraception, if safe and effective, has the potential of empowering women, unless the approach

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POPULATION, POVERTY AND SOCIAL CHANGE
An Alternative Paradigm

Vasant P. Pethe

Population growth is one of the most critical issues of our times. Sharp differences of approach exist concerning the diagnosis of the twin problem of population and poverty in terms of its causes and the prescription in terms of policy interventions.

I have two propositions to make. My first proposition is that our perception of the population problem is based on the Western neo-Malthusian paradigm which is out of date and irrelevant to Indian conditions. This model regards the so-called over-population as the cause of poverty. By doing this, it has brought the analysis of poverty to the dead-end of population; My second proposition concerns my own approach. I have been proposing for the last many years an alternative paradigm, which is eclectic in nature. It begins with the argument that rapid population growth is not the cause but the effect of poverty. In fact, my central thesis is that the various socio-economic problems like unemployment, illiteracy, ill-health, etc. including the population problem, result ; (a) from poverty as their 'immediate' determinant, (b) from such evils as inequality, consumerism military expenditure, defective planning, etc. as their 'intermediate' determinants, and, (c) from out-moded non-egalitarian social structures and spiritual degradation as their 'ultimate' determinants These two propositions constitute the essence of my philosophy and line of thinking on social problems in general and the population problem in particular. While I call the Neo-Malthusian model as the "numbers game" paradigm, my paradigm may be styled as the "social transformation" paradigm.

The state of the Indian polity, economy and society has been in a bad shape indeed for a long time. On the demographic front, our population is growing unabated. Against this backdrop, the question arises as to how and why we have failed.

So far as the problem of population vis-a-vis poverty is concerned, we have unfortunately advocated very vigorously, what is known as, the neo-Malthusian approach in our population policy. This approach attributes poverty at the social level to population explosion and poverty at the individual household level to large number of children amongst the poor. To me, this paradigm is entirely obsolete, irrelevant, and to use strong words, even perverse. First, throughout human history, whatever the population size - big or small - the under-privileged have always remained poor - the slaves during slavery, surfs during feudalism and the vast majority of landless labourers, tribals and slum - dwellers under the present day capitalistic system. Secondly, empirically examine the economic developments in India since Independence. India of today having a population of about 85 crores is economically certainly richer and stronger, especially in terms of defence, infrastructure and scientific personnel, than India of 1951 when our population was as low as 36 crores. Thus, we find that both historical and empirical evidence proves neo-Malthusian thought to be totally erroneous.

My new paradigm begins with the initial proposition that population growth is not the cause, but rather the effect, of poverty. There are several reasons why the poor prefer to have a larger than a smaller number of children. One is that many of the children born to a poor man are likely to die in infancy. If population growth is not the cause of poverty the basic sources of the phenomenon of poverty will have to be sought somewhere else than mere population size or growth. Here, we arrive at the most central thesis of my paradigm. This I have already stated as proposition two at the beginning. I may restate it in a different way. The poverty for the masses results from the incapacity of our defective socio-economic system and inequitous international economic order to put into service modern science and technology for an optimal utilisation and distribution of this planet's vast resources for raising the living standards of the people.

To speak in some concrete terms, take for example, the crazy consumerism of the West (which is being aped by the emerging affluent classes in India). To convert this consumerism in population numbers, one can say that the population of the USA is not 25 crores but 2500 crores (30 times India's population). An American citizen consumes on an average energy resources 100 times the world average. Its population has therefore to be reckoned as 100 times of what the census shows.

Having delineated my basic approach, the natural question is what are the policy implications: three basic principles must underline the government policy. First, egalitarian social transformation must occupy the central stage and the major focus in all policies formulated to attain our over-all social progress. Secondly, we should not be crazy about the fulfillment of 'quantitative' targets. Rather, we should care more for the 'qualitative' transformation in human attitudes and behavior. Thirdly, there has been an explosion of expectations amongst the masses. However, in the context of limited and non-renewable resources, it is just impossible to satisfy completely all the expectations of all the people. Hence, it is imperative to give a proper direction to these expectations. This channelizing should be towards improvement in the quality of life, not towards vulgar, rat-race like ostentatious style of living (as is exhibited by the newly rich).

I am likely to be misunderstood, but I underestimate neither family planning nor the population problem. I am also not against Western people or culture. I am only against adoption of alien paradigms. I contend that if we want that the people should adopt family planning, it is necessary that we create conditions conducive to such motivation.

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BOOK REVIEW

Shubhra Krori

Your Health and the Indoor Environment: A complete guide to better health through control of the indoor atmosphere - *Randall E. Dunford,* Nu Dawn Publication, Dallas, Texas, 1991, pp. 270.

Environmental consciousness, stimulated by the growing threat of ecologically hazardous development processes, has been a growing phenomenon in the last few decades. This is specially true for the advanced, capitalist states like the U.S.A. The book under review 'would likely fit into the realm known as clinical ecology', a controversial area, one which suffers from a lack of precise clinical definition and scientific validation. However, the book draws attention to numerous issues and aspects which are easily overlooked as sources of toxicity and/or stress in the indoor environment.

The subject matter is organised in an understandable, lucid style, in sections and chapters which present each issue in systematic detail with an abundance of charts and diagrams. Part I sets the stage for the information contained in the subsequent section, by commenting on the fact that while the body is a wonderful self-perpetuating system, it has its limits in being able to combat pollutants. Part II goes into detailed identification of a wide range of substances in our indoor environment (from household artifacts to electromagnetic radiation and even air purifiers), their effects on health and ways by which these mal-effects can be controlled. The final section gives 'additional tidbits that should not go unrecognized' and looks optimistically towards a future where 'man will improve his environment because he must' and the hope that the reader 'will never again fail to see the importance of maintaining a healthy indoor environment'.

Besides the information contained in the chapters, detailed appendices and a glossary add to a better understanding of the information.

While, without doubt, the information is interesting and helpful in raising the awareness levels of readers regarding maintenance of a healthy indoor environment, the practical relevance of such a book to the conditions of the large masses, particularly to those living under conditions of poverty in Third World countries, is doubtful. The entire book is full of examples which bear testimony to this. To illustrate, the author cites the example of natural gas as being one of the greatest contributors of indoor pollution, on the assumption of its widespread application throughout the world. How many homes in India really use natural gas as a heating and fuel source ? In fact, in most rural households (70% of the population) open hearths (chullahs) using coal or wood are the traditional devices used. How many households have adequate ventilation (chimneys or, even windows) to let out the smoke ? Building awareness and finding alternatives for this section would be of far greater relevance in our context.

Shubhra Krori is based in Pune and is a researcher on the FRCH project studying the operational and social aspects of T.B. control.

THE U.N. CONNECTION

(abstracted from TOI, 14.5.91)

With a population of 853 million , India is the second most populous country in the world. At the current growth rate, adding some 19 million people annually, the population is expected to cross the 1 billion mark by the year 2000.

While releasing the State of the World Population Report, 1991, the United Nations Fund for Population Activities (UNFPA) has warned that such an increase will have very serious social, economic and environmental consequences, undermining the progress made in development and further affecting the livelihood of the 322 million people who already live below the poverty level.....To help the Indian government achieve its population and development objectives, the UNFPA has promised $90 million assistance over a five year period starting in January this year. The proposed programme has been designed to complement the country's revised strategy for National Family Welfare and the Development Plan Document for the Eighth Five Year Plan. A UN 'Programme Review and Strategy Development mission' (PRSD) visited India for that specific purpose last September. The population goal of India is to achieve a net reproduction rate of one by the turn of the century and zero population growth by the year 2050. Short-term targets set in the Eighth Five Year Plan include increasing contraceptive use from 43.3% to 53% by 1995; reducing crude birth rate from 30.5% to 26.7% in five years; reducing crude death rate from 10.2 per thousand to 9.3; infant mortality from 91 per thousand live births to 80 per thousand live births. This is expected to drop the population growth rate from 2.03% to 1.76% in five years....In collaboration with Hindustan Latex, the UNFPA would help set up a plant in Trivandrum for manufacture of IUDS. The IIT in Delhi would be setting up a cell to monitor the quality of the IUDs manufactured.

Since women's literacy development help to control population growth, the UNFPA's programmes revolve around women. In Madras, through the Working Women's Forum there is a proposal to create a revolving fund to help women set up income-generating projects.

But now there is a greater effort worldwide to draw men into the population programme. In India, where the terminal method of family planning is still prevalent, for some years now the emphasis is on tubectomy. To make vasectomy more acceptable to men, now a 'non-scalpel vasectomy' is being advocated. Voluntary organisations are being encouraged to manufacture as well as to do social marketing of condoms.....

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sincerely seeks to enhance women's self - determination and health through a process of informed and free choice, the exercise becomes self - defeating and adds to the burden of their oppression.

Studies of the impact of FP programmes on the fertility decline in 94 Third World countries (between 1960-70) were estimated around 3 to 20 percent. Social and economic factors accounted for the rest. A policy which aims at enhancing women's health should take such realities into account and stop being singularly obsessed with the ideal of optimum target achievement in family planning. The priorities must be women's health and empowerment; not state and social control over their fertility.

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present the different local governments, entrusted with providing care under the reforms, are experimenting with a number of health insurance and market mechanisms. There is no existing model of a viable health insurance for an agrarian society and, to that extent, China's experiments will be watched with interest. It is hoped that, in the process, the system will remain accountable to the needs of the poorer sections, the backward regions and basic health care.

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FREE ABSTRACTING

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Frch NEWSLETTER

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FROM THE EDITOR'S DESK

A visit to an unusual pre-primary school, Ankur Balmandir, in Pune, provided the impetus for this special issue. Here was a school where one saw a very "normal" and healthy mixing of handicapped children (called "special children") and other children. The nature of handicap varied, from hearing impairment to mental handicaps. Yet, over four years of its existence, the school has provided a positive insight into the potential for integration of handicapped persons into mainstream society.

Yes, the focus of this issue is on integration, on awareness and, on understanding. The handicapped are also capable - they are "handicapable". They have their special needs and if society takes a collective responsibility to meet these needs, the enrichment would be mutual.

What is the general attitude towards the handicapped? People seem to see in them only that which is wrong or different (spelt abnormal) and not that which is right and normal. Innumerable handicapped persons experience the trauma of rejection, ridicule, pity, over-protection -- everything to reduce their self-esteem. What they look for is acceptance, encouragement and opportunities. A good life for them means acceptance by family members, social peers and vocational and recreational outlets.

While surveys of the disabled by the National Sample Survey for the Disabled does not seem to take into account every kind of disability, researches by some voluntary agencies indicate over fifty million disabled in India. Research has also established a definite correlation between poverty and disabilities, with the lower socio-economic groups having a larger concentration of disabled children than the affluent sections. Facilities for education of the handicapped are woefully inadequate, covering a bare one percent of the fifty million. Till 1988, there were just over a hundred Special Education Centres for the 4 million blind, seventy special schools for 15 million deaf and hearing impaired persons, less than a hundred schools for twenty million children having mental handicaps and just a handful of institutions for the orthopaedically handicapped. (*Alur et al, 1988*)

There is still no clear-cut government policy in India, backed by appropriate legislation, for the benefit of the handicapped. The education and rehabilitation of the disabled comes under the purview of the Department of Social Welfare, already operating under severe budgetary constraints and catering to a wide section covering destitutes, juvenile delinquents, etc. While the government puts forth an impressive list of concessions (in fields like education, training, employment, economic assistance, housing, etc.) these are hardly adequate or accessible to the large number in need.

The recommendations of the Kothari Commission on Education (1964-66) for development of educational facilities with regard to the disabled, turned out to be an exercise in vain, (as with numerous such well-meaning commissions) in the absence of strong political will. The accent therefore is on the voluntary sector, which, despite dedication and motivation, is beset with innumerable constraints.

The government apart, society in general also exhibits ignorance and lack of concern for the issues of the handicapped. The masses, living on the brink of poverty, have other immediate survival concerns and therefore cannot even think in terms of meeting the special needs of the disabled. Ignorance, superstition and a fatalistic attitude blocks any constructive collective effort to provide the handicapped with opportunities for self-development. Amongst the more privileged classes, who may have the time and resources to avail of special facilities, the tendency to over-protect the disabled is strong. The general attitude therefore is one of seclusion, non-integration. ***The handicapped suffer alienation not so much because they are disabled but because society encages them in their isolation.***

This is where the importance of integration centres comes in. It benefits both ways ,-- **a)** in enhancing the sensitivity, awareness and a sense of acceptance (on the part of "normal" persons) with regard to handicapped friend and, **b)** in helping the handicapped to face up to the rigours of a normal life and thus gain in self-confidence.

The process paves the way for the handicapped themselves taking initiative to organise rehabilitation of their own kind.

The articles in this issue do not cover all categories of handicaps, but only the more prevalent viz. - the orthopaedically handicapped, the deaf, the blind and the mentally handicapped. They seek to share experiences and enhance public awareness with a unanimous vision of an integrated world for the handicapped. ■

FOR PRIVATE CIRCULATION ONLY

INTEGRATING THE ORTHOPAEDICALLY HANDICAPPED
the challenges

Arnie Antia

The relationship between society and the wide spectrum of its citizens is an interesting yet complicated subject. The question under discussion is, how individuals are able to contribute in a positive manner to the environment and the state in which they live. Each person has a role to play and it is the part played by the orthopaedically handicapped which we are considering here.

Causes of Physical Handicaps

The causes resulting in physical handicaps are numerous and their incidence overwhelmingly high. An unhygienic living environment, inadequate health services and poor socio-economic conditions in which many of our children live, largely account for their being handicapped. Other prenatal factors include genetic and chromosomal anomalies and other hereditary congenital defects. Muscular dystrophies cause progressive weakness and wasting of the muscles which cause gross crippling. These ultimately lead to a bed-ridden existence before a premature death. Spina Bifida (a congenital defect of the spine) may cause paralysis of the lower limbs and the loss of control over urination and defecation. Arthrogryposis is another congenital abnormality, where the muscles of various joints shrink and bend, producing loss of functions. Other prenatal factors such as drugs, illness, malnutrition, etc., which play a damaging role, take place in the first trimester of pregnancy and result in various physical deformities such as absence of limbs or deformed limbs.

Injury and infection are important post-natal or acquired factors causing orthopaedic handicaps. Trauma during delivery is a common cause of cerebral palsy and may be accompanied by mental retardation. Head injuries later in life may also cause brain damage. Injuries to other parts of the body may result in deformities or require amputation and the loss of a limb. However the diseases most commonly responsible for orthopaedic deformities are poliomyelitis, encephalitis, meningitis, tuberculosis and hemiplegia.

Educating the Crippled

When the handicap is mild and mobility not grossly impaired the child can attend a regular school. However with a severe disability, a Special School for their all-round development, during their most formative period of growth, is essential. If this is not provided an opportunity is lost, that cannot be made up for at a later stage. Whereas, disabled children would be frustrated by their inability to compete with "normal" children in a regular school, in a Special School they are able to have close association with other children with similar difficulties. This helps them gain confidence, gives them a sense of security and encourages them to make progress despite their disability. Attending school is the first step in the process of meaningful integration into society. It is here that they (and their parents) realize their potential and thus build on the possiblities of a hopeful future.

The Society for the Education of the Crippled (SEC) was established in 1960 with such concerns in mind. It aims to educate handicapped children and adults by providing them with the opportunity to be productive and responsible members of society. It also seeks to enhance public awareness on the issues of the physically handicapped. A significant feature about the SEC school units is that they cater entirely to the lower socio-economic sections: a class most often deprived in terms of capability for and access to special facilities such as these.

The following table gives information regarding the disabilities of the children attending the SEC School Units in Bombay and Talegaon.

NATURE OF DISABILITY	S.E.C. DAY SCHOOL UNITS, BOMBAY	RURAL PROJECT: SEC CENTRE FOR INDEPENDENT LIVING, TALEGAON
Poliomyelitis	192	39
Cerebral Palsy	30	7
Hemiplegia	23	--
Muscular Dystrophy	16	--
Congenital Deformities	9	4
Spinal Anomalies	7	2
Bone Deformities	5	--
Amputation	8	1
Post Measles Alexia	1	--
	291	53

Parents usually seek admission for their children into Special School after having spent a vast sum of money and considerable effort in trying to cure their child's disability. They include whatever means have been available to them, both medical and religious, but having little positive impact. It is a comfort for them to eventually realise that there are several other children who have similar difficulties as their child. For the well-being of these children it is essential that their particular handicap be understood and their abilities and limitations be accepted by their parents and that they be treated on par with the other siblings in the family. This is not easy, as many parents are inclined to be emotionally involved and may develop a sense of guilt. They tend to be over-protective and prevent the children from managing their own daily requirements or they may reject such children, considering them as liabilities.

Besides other considerations, emphasis is placed on academic education at school, whereby the children are required to follow the same curriculum as approved by the Department of Education, Bombay Municipal Corporation. However, here, teachers ensure that each child receives individual care and attention for developing his/her own abilities. This is achieved by having small class groups and providing those with scholastic and adjustment difficulties with additional inputs.

The author is the President, Society for the Education of the Crippled (Child and Adult), Bombay.

Integration into a regular school generally takes place when students complete std.IV and are academically on par with the others in their class.

Creating Facilities: Enhancing Mobility

Since the children are unable to use public transport, school buses are an essential requirement. To minimise the distances children have to travel, day school units are located in central Bombay and the eastern and western suburbs. At the rural unit at Talegaon in Maval Taluka it has been found necessary to have a semi-residential unit, so that handicapped children living in the surrounding villages can attend school during the week and return to their homes for the weekend and holidays. In this way they keep in constant touch with their family and community.

To ensure mobility, appliances need to be used by most children. These need constant repair and maintenance. Conventional calipers are cumbersome, very heavy, require leather boots and are often rejected. A research project to make light - weight, easy-to-manage appliances is underway. This should help each child achieve a maximum degree of functional independence at an early stage. Therapists help with mobility training, give exercise and instruct parents on how to conduct activities to prevent contractures and deformities. Swimming is an excellent exercise for strengthening and maintaining the muscles of handicapped children. This is an essential weekly activity for the children attending the day school units and at the rural centre. General medical services with doctors conducting routine check-ups for the children and providing advice for their parents, contributes to the children's physical well-being. Besides this, fruit, milk and a hot meal has proved to be of value in sustaining the general health of the children.

The Process of Integration

In preparation for successful integration into regular schools, children need to develop self reliance as well as social and emotional growth. Children with a handicap are often not exposed to recreational activities in their home environment. It is therefore essential that maximum exposure be provided, with extra-curricular activities as part of the school program. These include outings for the very young and camps extending from a weekend to ten days for the older students. Annual days to be celebrated include sports, which provide an opportunity for all children to participate and compete in an event appropriate to their age and disability. The Prize Distribution Day is also an important event, when the current children and ex-students perform with confidence, to be witnessed by an appreciative audience including parents, proud of their children's abilities and talents in drama and dancing. Other activities include indoor and outdoor games, art and music.

Much of the success in rehabilitation depends on the positive acceptance by the children and their families of their own condition. Social workers provide counselling, make home visits and maintain community contacts. In our rural project they conduct surveys in the villages to identify the handicapped, arrange for assessment camps and hold meetings with the Sarpanch, along with the parents. They also provide vocational counselling and assistance for improving the occupational skills of disabled youth.

Parents' participation and involvement in their children's overall development helps them know of their child's progress and to recognise his/her abilities. With the teacher they can successfully draw out the best in their own children. However parents have varied requirements of their own, which need to be met. An "awareness" programme of monthly meetings related to their everyday life has a positive contribution to make. Topics covered include health requirements, vacation activities, legal aid, housing, employment opportunities and field visits to the B.M.C., Airport and Nehru Centre. Dialogues with personnel from agencies such as the Indian Cancer Society, Mobile Creche, Yoga Institute, and viewing audio-visuals, open up areas of interest outside their daily routine and thus enrich their lives.

Preparedness for Regular School

The process of integration into a regular school and mainstream society starts as soon as the child enters the special school. To be considered for admission into a regular school, children not only need to achieve adequate competence in academic subjects, but also be able to cope physically with architectural barriers and toilet facilities which are not modified for their convenience. Besides, they also need to be psychologically ready to cope with being one of 50 in a class, and emotionally prepared to face a new environment and new challenges.

Successful placement of handicapped children into a suitable normal school requires much effort and planning . This is done through group meetings by the integration team. The social workers locate a suitable school which is accessible, has transport facilities and if possible, a class for the child on the ground floor. On being accepted by the Principal, the parents and their child are introduced to their prospective school. Psychological and emotional readiness is created through camps and meetings with integrated ex-students. Nevertheless, the students entry into a regular school is often demanding and may prove a traumatic experience, if not handled with sensitivity.

The challenge of integrating severely handicapped children into regular school does not end with the children leaving their special school. Follow-up and supportive services are essential to facilitate adjustment to society and to prevent them dropping out of school. Ex-students take part in regular Sunday Sessions where they meet their friends and have discussions which cover topics like smoking and alcoholism. They participate in activities like street plays, community singing, music sessions, picnics and visits to different industries. These meetings also provide opportunities for socialising, recreation, structured and unstructured learning sessions.

Counselling is available for school matters, career selection, employment and issues related to adjustment in life. Thus they are able to solve problems related to their studies and other difficulties. Many ex-students apply for assistance. Educational aid, Mobility grants and Merit Scholarships are sanctioned each year. Eventually successful integration results in finding suitable and gainful employment and accepting the fact that it is the individual's mental attitude, perseverance and hard work that counts.

Building Public Awareness

Public Awareness Programmes are helpful in bringing about greater understanding of the disabled. They can be undertaken through workshops, integrated programmes, the press and other media publicity. It is a sad reflection of our society that funds are more easily obtained while projecting a "pitiable" condition rather than a happy situation. This attitude is most damaging and prevents the handicapped from feeling like "persons" and erodes their self-respect. It takes a greater effort to provide for the true requirements of the handicapped, as felt by them, rather than to dole out what the giver gains satisfaction from giving.

The effort, time and thought spent on integrating the handicapped into mainstream society can only be successful when they are accepted by society as people with the same rights and obligations as any other citizen. Finally, it is the attitude of society which determines, to a large extent, the successful integration of a handicapped person ■

HEARING IMPAIRMENT
The Invisible Handicap

Yeshashree Gurjar

"My child is 4 years old but still does not utter a word". It is typically with complaints like this that most parents of Hearing Impaired (HI) children approach doctors. Very rarely do they realise that their child is unable to speak because s/he has a hearing impairment or is a 'deaf' child. Most people label their children 'deaf and dumb' or 'deaf and mute'. Contrary to the belief that deaf people are also dumb or mute, these children are born with normal vocal apparatus. Parents are surprised when they are told that their child cannot speak because s/he cannot hear what is being spoken by people around. Language has aptly been described as the finest form of imitation and what one cannot hear one cannot imitate. Thus the process of language acquisition, which normal children acquire with ease, remains stagnant in deaf children. Hearing impaired children have to be taught to understand and speak the language of their community. This procedure is long and labourious, but can definitely make these children vocal enough not to be labelled 'dumb' or 'mute'.

Initial Identification Difficult

Hearing Impairment has been described as the invisible handicap mainly due to the difficulty in identifying it. In fact , it is never easy to identify a H.I. person from a normal hearing person in a crowd, since persons with this difficulty do not have any external signs of having a handicap. It is only through their unintelligible speech that they are identified. This handicap thus goes unnoticed in the early years and is often detected at about 2 years of age or later. A H.I. child can be identified much before this since a normal child responds to sounds, especially loud sounds, by the time s/he is two months old.

Since the effects of hearing impairment are seen on the language development of the child, if the rehabilitation process is started early, s/he can be helped to achieve near-normal, if not normal, vocal capacity. A normal hearing child begins the language learning process right from birth, hence it is never too early to start teaching language to a deaf child.

Varying Degrees

Hearing Impairment, like any other disability, has varying degrees of severity and no person can be classified as 'totally deaf' or what is known as, 'stone deaf'. The degree of hearing loss present in a child determines the extent to which his language abilities can develop without intervention. The following chart gives various degrees of Hearing Loss as measured in decibels (dB). These are meant to be guidelines and are not rigid parameters.

Degree	Loss in dB (range)
Normal	0 - 20
Mild	25 - 40
Moderate	45 - 60
Severe	65 - 80
Profound	85 and above

Needless to say that language of children with severe to profound loss is affected the most. Some children might not be Hearing Impaired at birth but might become so due to illness or accident. If this happens after they have acquired some amount of language ability, their rehabilitation procedure becomes slightly easier, but if rehabilitation measures are not immediate, regression in existing language abilities can occur.

Importance of Early Identification

It is imperative that a H.I. child has a proper hearing aid. In a sense they are the ears s/he does not have. These hearing aids are prescribed by an audiologist and are available in various powers. A hearing aid picked up at random cannot suit any child. It has to be brought keeping in mind his hearing loss.

A H.I. child must begin his/her language training as early as possible with a special teacher or a language therapist. Research has proved that children who begin training in the first three years of their lives show better academic achievement ,since language forms the basis of any curriculum. Sometimes a hearing impairment is overlooked at an early age because it is not severe enough to affect responses to sound during infancy. The problem arises when the child starts going to school and is unable to cope with academics and keep pace with peers. The child is labelled as 'dull', 'inattentive' etc. The H.I. which has always been there is the actual cause.

In India, especially in rural areas, there are very few children who are identified when the effect of this disability manifests itself. Sometimes the lack of speech and language is also overlooked with the hope that the child might start talking late. This view is encouraged by well meaning relatives, neighbours and friends.

We are also faced with the problem of children becoming deaf in their childhood due to constant and untreated ear infections. Illiteracy and ignorance about ear hygiene leads the parents to taking these problems very lightly, little realising that it can lead to permanant damage to the ear. This type of hearing loss can be prevented with public awareness about ear care. To cite a few examples :

- Any ear discharge should be referred to a specialist for examination and treatment .
- Ears should never be cleaned by any sharp or wide edged instruments (ie. hairpins, toothpicks, safety-pins, small sticks, etc.)

The author has studied linguistics and has specialised in education for the hearing impaired, for her B.Ed. studies. Her doctoral research has been to study the language development of hearing impaired children. At present she is co-ordinating the forum, "Action for the Rights of the Child", in Pune.

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SPECIAL EDUCATION

The term 'special education' refers to all special provisions made enabling or allowing disabled children to get education. Special education requires services of experts, adapted equipments, and specially trained teachers.

Special education would include all the disabled i.e. the blind, the deaf, the spastics, the polio affected and the mentally retarded.

In the developed countries and even in some of the developing countries, 'special education' is the responsibility of the Ministry of Education. In India, it still comes under Ministry of Welfare, which is wrong, as disabled children sitting for public examinations do not need welfare or custodial care but technical experts and modified equipment and environment.

Source : "A Critical Review of Services for the Disabled in India with Special Reference to Education", Mithu Alur et al. Research Dept., Spastics Society of India, Bombay, 1988.

- Children suffering from constant coughs and colds should have a routine check-up after each period of illness to monitor ear blocks or damage. Such a check-up can be carried out even by a qualified general practitioner.
- The practice of putting oil inside the ear creates condition favouring fungal infections and should therefore be discouraged.
- The ears of infants and younger children prone to ear infections should be protected by not allowing any water to enter the ears, particularly while bathing.
- When a child (sometimes or always) does not respond to calls, parents often dismiss it as his/her "moodiness". However if this is a recurrent phenomenon it should immediately call for examination for possible onset of deafness.

Limited Facilities

Even if a child is identified early, there are very few schools in India which offer pre-school programmes for deaf infants. Most schools only take in children at the age of four and above.

According to the 1981 census there were about 3 million H.I. people in India. These figures do not take into account children below 3 years of age. Most of the population is concentrated in rural areas. In contrast to this there are only 365 special schools for deaf children and these are mostly in urban areas. The facilities available for H.I. people in India are very few, considering the enormity of the problem.

Most experts in the field agree that a special school environment is best suited for a H.I. child, especially in the initial years of his life. However setting up new schools in every rural area is not possible in a country like India where the problem far exceeds the resources available.

Integration : The IEP

The Integrated Education Programme (IEP), a government sponsored programme, aims to provide the H.I. child with equal educational opportunities, that is, a right to seek admission and study in schools meant for normal children. Integrating the H.I. child ensures educational opportunities to the child living in remote areas with no special school facility. The child can socialise with his hearing counterparts and hence feels a part of the mainstream. Though the IEP has a lot of advantages it has yet to be successfully implemented in areas where its need is the greatest. This is partly due to ignorance about this programme and partly due to teachers in normal schools, parents and school administrators being apprehensive about the H.I. child's ability to cope with the normal school environment and course work.

The successful implementation of IEP in about six schools in Pune has proved beyond doubt that not only do H.I. children cope but they excel in certain areas of study. The IEP makes provision for a resource teacher for H.I. children for additional inputs. Although exact statistics are not available, the dropout rate in these programmes is very low and most children pass their 10th standard examination with atleast a second class.

Other Aspects of Rehabilitation

The problems of rehabilitation do not end by providing them with equal educational opportunities. Rehabilitation aims at making H.I. people a part of the society without the stigma of the word 'handicapped' being attached to them. Unfortunately they are sometimes denied college admissions and equal job opportunities, not because they do not have requisite qualifications, but because people are skeptical about their intellectual and physical capabilities. This results in a lot of frustration in the minds of young H.I. persons, who, despite remarkable capabilities, are uncertain about their future.

H.I. persons strive all their lives to see that their disability does not handicap them in any way. Yet they are faced with the grim reality of having to constantly convince people around that they can do anything that others do -- except hear.

THE U.N. CONVENTION ON THE RIGHTS OF THE CHILD. -- ARTICLE 23.

1. States Parties recognize that a mentally or physically disabled child should enjoy a full and decent life, in conditions which ensure dignity, promote self-reliance, and facilitate the child's active participation in the community.

2. States Parties recognize the right of the disabled child to special care and shall encourage and ensure the extension, subject to available resources, to the eligible child and those responsible for his or her care, of assistance for which application is made and which is appropriate to the child's condition and to the circumstances of the parents or other caring for the child.

3. Recognizing the special needs of a disabled child, assistance extended in accordance with paragraph 2 shall be provided free of charge, whenever possible, taking into account the financial resources of the parents or others caring for the child, and shall be designed to ensure that the disabled child has effective access to and receives education, training, health care services, rehabilitation services, preparation for employment and recreation opportunities in a manner conducive to the child's achieving the fullest possible social integration and individual development, including his or her cultural and spiritual development.

4. States Parties shall promote in the spirit of international co-operation the exchange of appropriate information in the field of preventive health care and of medical, psychological and functional treatment of disabled children, including dissemination of and access to information concerning methods of rehabilitation education and vocational services, with the aim of enabling States Parties to improve their capabilities and skills and to widen their experience in these areas. In this regard, particular account shall be taken of the needs of developing countries.

Source: UNICEF, Nov. 1989.

SETTING SIGHTS HIGH

K. Ramakrishna

Dhritharashtra, the legitimate heir to the throne of Hastinapur, was denied his rightful due, only on the pretext that he was born blind, the result being ambitions nipped at the bud, frustrations carried through life, hatred of the very near and dear ones, finally culminating in a fratricidal war, the like of which history has seldom seen. The blind man may have proved himself incapable of managing the affairs of the mighty empire, but what is regretted is that his incapacity was taken for granted. The negative traits that this character so vividly displayed, more towards the latter part of his life, may well be attributed to denied opportunities than inherent human frailty.

There are yet others like Surdas, Swami Virajananda, *(whose disciple was the well known social reformer, Swami Dayanand Saraswati)*, Louis Braille, John Milton and Helen Keller who have shown outstanding ability to conquer disabilities.

Welfare of the Blind

नाक्षरं मंत्र रहितं
न मूलं अनौषधम् ।
अयोग्यः पुरुषः नास्ति
योजकः तत्र दुर्लभः ॥

(There cannot be a syllable which finds no place in a word, no plant without medicinal properties, no human being without abilities, however, what is rare is a good planner who harnesses the qualities in people and brings the best out of them)

The government, as also the voluntary agencies, have mobilised men, money and materials to promote the socio-economic rehabilitation of the visually handicapped in India. Blind welfare has been in existence for over a century now. Over this period the approach has evolved from one of relief to rehabilitation, which is evident from a variety of programmes and projects currently undertaken by the government and the voluntary sector.

The past few decades have witnessed appreciable work in the areas of prevention and cure of blindness, and education, training and employment of the blind. The activities include eye camps, cornea transplants, cataract operations, production and distribution of Braille and recorded literature, scholarships, special schools for the blind and integrated educational programmes, vocational training centres, self employment and placement services, etc. National Association for the Blind, (NAB), is the main organisation carrying out these functions. The whole effort is directed towards a single objective -- the economic resettlement of the blind. When this objective is not achieved, the entire gamut of services becomes somewhat redundant. Years of well directed work have certainly yielded desired results facilitating blind persons to be gainfully employed as lecturers, solicitors, teachers, social workers, stenographers, telephone operators, factory workers etc. We also have a large number of blind persons who are self-employed through vending stalls, public call offices or in small business activities. Not only have they thus blended with the productive labour force in this country, but some have achieved heights in their respective professions, -- Dr. R.T.Vyas of the National Association for the Blind who pioneered the Blind Welfare Movement, the late Dr. Wadegaonkar, ex-principal of Government Law College, Bombay, Deepak Motiwala, Solicitor, Ravindra Jain, renowned lyricist and music director, Dr. Kalyanraman, an officer in the Economic Research Department of RBI, to name a few. It is heartening to see that the younger generation is not far behind; -- Raman who specialised in Computer Science from IIT Powai and is presently pursuing doctoral studies in the U.S.A., Sam Taraporewala, lecturer in Sociology in St. Xavier's College Bombay, and many others.

Succeeding Against Odds

Notwithstanding persons who have excelled in different walks of life and scores of other individuals pursuing lucrative and respectable occupations, there are instances of even well-informed persons expressing apprehensions about the abilities of blind persons who have a sound academic track record. I wish to share some personal experiences which reflect this. I was initially denied permission to avail the services of a writer during the entrance exam to the post graduate degree course in management studies, by the authorities of a reputed management institute in Bombay. The authorities seemed to be convinced that let alone going through the course, a visually disabled person would never be able to tackle the quantitative analytical problems of which the entrance test comprised of. My interest was humoured as over-enthusiasm. It required considerable persuasive effort on my part to convince them to give me a chance, which they condescended to. If I may be excused for sounding a little immodest, I cleared the entrance test, joined another institute and completed the entire course, standing second.

In sharp contrast, when I recently took the GMAT examination conducted by the Education Testing Service of U.S.A., upon my request, the authorities not only permitted me to avail the services of a reader but also allotted extra time, if required. The question paper was set in large print braille, as also audio cassette, though none of these were requested for. This aptly brings out the fact that blind persons are well capable of competing with others, when given the necessary infrastructural support and a positive approach from society showing confidence in their abilities. Such challenges apart, the government, the voluntary agencies, educational institutions and people at large have played a determinant role in shaping my academic and professional career.

Congenital cataract at birth and subsequent deterioration of vision, compelled me to discontinue my school education for five years. Ms. Rahmad Fazelbhoy, a social worker attached to NAB, paid home visits and convinced my parents, the school authorities, and me that I

The author, a post graduate in Economics as well as Management Studies, is presently the Deputy Manager, Project Finance Department, IDBI, Bombay.

More Disabled in Rural Areas

There are more handicapped persons in rural Maharashtra than in urban areas and those with locomotor disablity top the list of disabled persons, according to a survey. Statistics compiled by the National Sample Survey Organisation after a survey of disabled persons during July - Dec. 1991, indicated that the estimated proportion of such persons in the state was 15.74 per 1000 population. Of these 17.17 per thousand were in rural areas while 13.42 were in urban centres.

Source :Indian Express. March 20th 1992.

could continue my education. She assured us of infrastructural support. I completed my graduation in Economics and Statistics from St. Xavier's College, Bombay, with the support given by the college and friends with whom I could establish a relationship of 'mutual benefit'.

After completing post-graduation I joined a friend in his electronics business, primarily as in-charge of the marketing and finance functions. Though initially the customers had apprehensions in dealing with me, my professional approach in delivering quality products on time, my effective communicative skills coupled with perseverance, removed all such doubts in their minds, over time.

Management education is characterised by heavy course load, pressure on time management, data crunching and heavy numerical analysis. The faculty in these institutes, largely consisting of professionals from the industry, had reservations about my ability to cope with such a programme and even if successfully completed, whether I would be able to get placed in the industry. It is however largely, sheer hard work and goal orientation, aided by the very positive approach of my co-students, and the encouragement from the faculty, that I out-performed all expectations and earned recognition . There was some initial resistance in my getting a placement in the industry. I received offers from a few private sector companies; however the amount of options available to me were much more limited as compared to my co-students. The Central Government, at this stage, and on a request from me, forwarded my bio-data to many public sector units who interviewed me and offered me placement commensurate with my qualification. I joined Industrial Development Bank of India as an Officer. The nature of my job here is appraisal of industrial projects. Appraisal techniques are subject to continuous upgradation and are increasingly more computer oriented. My success on the job is due to my ability to continuously adapt to the job requirements. The support on the job given by the organisation in the form of PC availability linked to speech synthesizer and a full-time assistant has contributed much to my productivity. The approach of my seniors and colleagues has been one of co-operation rather than sympathy.

In an endeavour to continuously evolve professionally, I have associated myself with teaching in some of the leading management institutes in the area of finance. I did not restrict my achievements to professional success only. I am also a performing artist in vocal music, rendering devotional songs in many languages, in several parts of the country.

Need for a Changed Focus

The ultimate welfare for the blind may be ensured only through a well-planned and co-ordinated approach by all the interested parties. Government and voluntary agencies should place more accent on spreading the services to the rural sector and funding community based rehabilitation programmes. It will be desirable to educate, train and rehabilitate the blind in the general environment, thus integrating them into society, rather than subjecting them to a special environment in the form of special schools, sheltered workshops etc. which, unfortunately, isolate them and make them apprehensive in interaction.

Economic rehabilitation of the blind will become increasingly difficult if we do not change the methods of imparting education and vocational training. We may have to view this activity of economic rehabilitation in the background of general unemployment, resulting in severe competition and changing job requirements due to increased mechanization, automation, and computerisation, both in production and service sectors. This calls for a transition in our vocational training. More emphasis should be placed on our exploring newer avenues for self-employment, as also re-orienting educational methods to include training in the areas of computers, electronics and communication skills.

Society can play a much more constructive role in the rehabilitation of the blind rather than merely providing funds. There is need to engender awareness in the society that collective welfare can be optimised by complementing strengths and combatting weaknesses through appropriate technologies and facilities. This awareness should translate itself into the needs of all segments of society, impaired or otherwise, and creation of appropriate facilities to fulfill these needs, not out of a sense of sympathy, but in the spirit of service. We, as a society, must recognise that disabilities can be of various kinds and dimensions, physical, mental, social, so on and so forth. We can collectively optimise only by being sensitive to each others' distinct needs and pursue steps by providing appropriate support systems to fulfil these needs in a spirit of co-operation . This approach of society could play a crucial role in the transition from dependence to self-reliance, darkness to light, mediocrity to excellence.

In the current competitive environment, the blind cannot depend solely on external help, but rather, have to rely on initiative and self help. They have to equip themselves to be equally efficient, perhaps more, as compared to the sighted, and have to rely more on merit rather than reservation in the competitive job market. He has to make a conscious effort to come out of their shells of isolation and integrate themselves with the mainstream. In keeping with the trend of self help, organizations for the blind are giving way to organisations by and of the blind. To name a few, Blind Men's Association, National Federation of the Blind, Blind Graduates, Forum of India, National Sports Club of the Blind, and a few industrial Co-operative Societies.

The success of these efforts will assert the fact that, where there is a will, there is a way.

RALEGAN SHINDI : ek sakhol abhyas

(Marathi)

by D. Panmand and R. Awasthi

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From Isolation to Integration
THE MENTALLY HANDICAPPED

Nagmani Rao

The mentally handicapped, perhaps, are the most deprived section amongst all the handicapped. While the generally popular attitude towards the handicapped is not a positive one, in the case of the mentally handicapped this is even more pronounced. It is no cause for wonder then that family members often choose to tuck the fact of a mentally handicapped person within the family away from public glare. While the intent may be to protect, this attitude amounts to further punishing a person already deprived on account of a disability. Institutional care (if accessible) may offer opportunities for training upto a point. But the seclusion in institutions will neither take care of meeting all needs, nor will it gear the person to face up to mainstream life. The question raised is, do we advocate institutional care for the mentally handicapped for their betterment, or is to protect ourselves from taking a more responsible and sensitive role in their real development ?

Social Stigma and the Family

The author, several years ago, had occasion to be associated with a residential centre for the mentally handicapped, in Madhya Pradesh. This was a premier institution, offering excellent care and facilities from a dedicated staff. The Head of the institution once painfully remarked, *"Most of the children here are from well-to-do (professional or big business class) families who don't have the time or patience to cope with the situation of these special children. Somewhere, there are also elements of shame and guilt. We however stipulate that the children spend at least their long holidays with their families. Since the children come from as far away as Delhi and Bombay, it is not possible for us to have the parents' on-going participation in their ward's rehabilitation. However, we do keep them regularly informed through detailed reports and correspondence and give them elaborate guidelines when the children go home for holidays. Yet, in most cases, the parents find it difficult to manage and when the children return we are dismayed to see that our year's labour has almost been washed away in just two months and we have to begin again ! "*

The experience related above sharply brings to the fore the limits of exclusive institutional care and makes a strong case for family and social responsibility in the rehabilitation of the handicapped. It also emphasises the need for integrated efforts between professionals and concerned lay persons to ensure the ultimate well-being of the handicapped.

But then, the example cited refers to an experience 15 years ago. There are signs that today, situations and attitudes are changing -- if not radically, at least perceptibly enough to indicate hope. The contents of this article are drawn from the experiences of parents of mentally handicapped children; their reactions, their struggles, their hopes. The names of the parents and children have been deliberately changed to protect the identities of those who shared their thoughts and feelings so openly against a committment of confidentiality. The parents and others interviewed come from educated, upper-middle class backgrounds. They, therefore do not represent a generalised experience. Yet, even amongst these privileged classes, not everybody makes an all out effort to get over the trauma of having a mentally handicapped child and to seek opportunities for his/her integration.

Amit's mother, Vaishali, was so disillusioned that her first child was mentally handicapped that she was least concerned about the way he dressed or looked when he went to the play school. Madhuri Deshpande, who runs an integrated play school for normal and special children, questioned Vaishali on this and got the reply -- *" Why bother? Who knows how long he'll live ? This is just a time-pass ....."* She had to use a combination of sternness and persuasiveness to help Vaishali come out of her apathy regarding Amit.

Experiments at Integration

In fact, Madhuri, has several anecdotes to reveal the process of transformation of attitudes of parents having mentally handicapped children. A post-graduate in Child Development, Madhuri's inspiration for an integrated play school for pre-primary children came from her own experience with Ameeta, a case of Down's syndrome, and the daughter of a friend. The child was unable to adjust in any of the regular nursery schools. Around the same time (Jan. 1988) Madhuri started a small play group at home, with 4-5 children, including her son, Anoop. Ameeta joined this group. Over the years she found remarkable progress in Ameeta and also noticed the positive impact of a normal, healthy friendship between Anoop, Ameeta and the other children. This encouraged the idea of expanding on the experience. Since then, there has been no looking back.

The parents who have sent their children to this school also express great satisfaction, although, as admitted both ways, it has been no cake-walk. The parents of the handicapped children are often quite broken down, more so when they have gone through a series of (misguided) experiences, as happened with Sonali's or Rahul's parents. Sonali was not born with any apparent handicap. The second of two daughters, the first signs of a problem were noticed when she did not communicate verbally till two years of age, despite there being no hearing impairment. When she was a little over two years, in the absence of full time home care support and both with full-time jobs, her parents had to put her in a creche. They had faced no problem with their elder daughter, who was six years older. But Sonali felt totally traumatised; she stopped eating and sleeping and exhibited other signs of emotional insecurity. The resulting severe dehydration compelled hospitalisation and the beginning of a series of long term treatments, not always rational. Subsequently her non-adjustment in a regular nursery school in a big institution brought her to this play school, where, with special attention to her and guidance to the parents, she now shows definite signs of progress, in speech, as well as peer group interaction.

The author looks after the publications work at FRCH.

Rahul was a case of delayed delivery, a breech case, who created initial panic because he did not breathe immediately. Considering that he had exceptionally tall parents, at 18 inches he did seem small. Yet, the doctors certified him as a normal baby. The first signs of a problem began when he had severe convulsions at about 6 months of age. Various tests revealed a diagnosis of "febrile convulsions" which recurred frequently till he was nearly two years old. During this duration he had had 20 convulsions. When he was six months old, his mother, Romi, closely monitoring his development, felt and expressed that he was showing signs of delayed milestones. But others (family members) dismissed these thoughts and preferred to adopt a "wait and watch" policy, although various treatment regimens for the convulsions continued. The persistence of Romi however, led them to a senior paediatric neurosurgeon, through whom an I.Q. test was carried out when Rahul was 2 years old. His mental age was revealed to be 14 months and he was recommended for occupational, speech and physio therapies. He is now four years old, happily adjusted in his play school, shows signs of a good memory and spontaneous expressions of emotions. In the past 2 years he has also not suffered a single convulsions attack, despite high fever. All these signs make the parents hope that perhaps he is a border-line case. As Romi says, *" a normal person uses only one-tenth of his potential and still functions well; then, with the scale of advancement in medical knowledge and a good deal of effort to create a stimulating environment for my handicapped child, I believe his normal functioning, to a very large extent, is possible."*

Shashank, now 26, was also a breech case. Asphyxiation and a delayed supply of oxygen following birth damaged a part of his brain. But he has managed to complete high school, (he went to a normal school till the ninth standard and was tutored at home for the public examinations), has picked up several other skills such as music, bicycling and so on and is able to share a few responsibilities with his parents. A large measure of his progress can be credited to the attitude of his parents and grand-parents, as well as the special efforts made, specially by his mother Sulabha , who was closely involved in each detail of his treatment and rehabilitation, which began since he was two years old. Sulabha and Vikram also consciously decided to delay their second child, to enable a longer period of attention towards Shashank.

Bringing up a child is no easy task. When the child is handicapped, the difficulties are further multiplied. How do parents of mentally handicapped children cope ? What are the support structures they can fall back on ? How does one integrate normal siblings in the process of rehabilitation of a handicapped child ? What are the hurdles ? Given existing conditions how could the process of rehabilitation be further facilitated ? The parents interviewed came out with a wealth of insights on these matters.

The Focus on Mothers

In most cases the mother seems to take on the greater responsibility in the rehabilitation of the handicapped child, though, in many cases, the father and other family members do take on a supportive role. At least three of the mothers interviewed expressed an initial feeling of deep guilt on the discovery of a handicapped child. They wondered if their strenuous schedule during pregnancy, or other factors caused by unwitting negligence could have caused the handicap. In Asmita's case, this was reinforced by her in-laws who were apparently misled by their family doctor into believing that she was to blame for her son, Sumit's retarded growth, because she had not rested enough during pregnancy. Sumit, the older of two children, was born a full-term but underweight baby and although he was kept in isolation for two and a half months and seemed stiff-limbed, there was no immediate indication of a major handicap. As the handicap became obvious, Asmita, who held a graduate diploma in fine-arts, submerged all her interests to taking care of her son who is now over seven years. It also involved a good amount of persuasion on her part to convince her husband, Vineet, that a second, normal child was possible and necessary. Their daughter, Sheetal, is now a two-year old.

Another striking aspect in our conversations was the varying degrees of isolation experienced by many of the mothers. Many of them and more so the professionally trained women, while apparently coping in a rather stoic manner, definitely felt that if alternative structures did exist and if there was greater sharing of responsibility by their husbands, they could have pursued other creative pre-occupations. Some of them, like Shamlee, are biding their time till the handicapped child becomes sufficiently trained, such that dependence on the mother is not so total.

Siblings and Others

All, except one couple interviewed, had at least one other child (older or younger) who is not handicapped. Tackling the delicate issue of the relationship between normal and special siblings has posed its own challenges. Sonali's parents were, in fact, the only ones to claim that this was the least of their problems. Perhaps the fact that the older daughter, Meenal, was a good six years older and therefore relatively independent when the special child demanded attention was an advantage. And, as the parents candidly admitted, *"Sonali is a good looking child and both of us worked together closely to involve Meenal in giving Sonali the special attention she needed. Meenal's friends accepting a "different" little sister went a long way in her accepting responsibility for the little one "*. For others, it has not been easy. Shamlee's younger child, Anjali (3 years) has been handicapped since birth. Her elder son, Ajay (5 years), is unaware of his sister's handicap. The explanation, "she is small" seems to satisfy him. Yet Shamlee wonders anxiously what the situation will be like as the children grow older and comparisons are drawn. Asmita felt particularly emotional while talking about Sheetal, who, she feels, is being denied a normal childhood because she is being inculcated with a sense of responsibility towards her older brother. Parents shared their feelings of hurt when normal siblings (specially in their adolescence) exhibited embarrassment or resentment and impatience towards their handicapped brother/sister. They felt responsible to explain the differences and enhance the sensitivity of their normal siblings. This, they felt, is crucial in the wider social integration of their handicapped child.

In the process of wider integration, apart from family members outside the nuclear family unit, are the circle of friends, neighbours and eventually, those the child comes face to face with in school. As Romi said, *"to a large extent, society's reactions are tempered by the way the family members relate to a handicapped child. The more normal and open our behaviour, the more accepting are the reactions of friends and neighbours "*.

Inadequate Facilities

At the same time all parents expressed unanimous dismay at the dearth of "rational and human" professional guidance in dealing with a handicapped child. Facilities are few and inaccessible to most people, more so for those living in small towns or rural areas. Even in the cities, the distances and the costs involved make most facilities beyond the reach of those families who need them the most - i.e. the toiling classes. Many parents were also critical about the almost mechanical, clinical

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AIDAN - VHAI MEET

Members of the All India Drug Action Network (AIDAN) and the Voluntary Health Association of India (VHAI) met in New Delhi, on 27th-28th of February '92, to discuss the forthcoming 'New Drug Policy'. Audrey Fernandes, FRCH researcher presently involved in the study on *'Use and Cost of Drugs and Pharmaceuticals in Government Health Care Centres'*, attended the meet. Below are some of the major issues put forth by the members.

Hopes were first belied in 1988 when the then New Drug Policy, turned out to be only a price control for some essential drugs. This resulted in a decline in production of those drugs under price-control.

The Indian Drug Industry while whining about the unfair and unfriendly environment has expanded from 1643 units in 1952 to about 20,000 units today, and has similarly grown in sales from Rs 34.68 crores to about 4000 crores **(Anil Pilgaonkar)**,. The drugs they manufacture have no real links with giving rational therapeutics at reasonable rates **(Dr. Wishwas Rane)**. Yet, they have been lobbying for a change in the 1988 policy, reports of which have been trickling in. The consequences on the anvil are :

1. Slashing down of the number of drugs under price control,
2. An across the board increase in mark-up (profits);
3. Increase in returns allowed for bulk drug manufacturers;
4. Freedom to companies to automatically revise formulations and prices without prior Government approval *upto 70% of CPI (Cost Price Index) increase*;
5. Allowing Foreign Equity Participation upto 51%, automatically, with a case by case study for higher foreign equity component;
6. Exemption of all formulations from licensing (except I.V. Fluids);
7. Ratio Parameters for Bulk Drug to Formulation production abolished.

(Dr. Amit Sengupta)

Profit making being the sole aim, besides irrational combinations and formulations, some firms have been trying to pass old allopathic products as Ayurvedic products, to bypass excise duty. Again, though it is well known that self generated alcohol in Ayurveda cannot exceed 11-12%, recent Sura tragedy has brought into focus, 'Ayurveda' products with 70% alcohol base. **(Dr. Unnikrishnan)**.

On the other hand, the Government's pre-occupation with family planning, has meant using uninformed Indian women as guinea pigs for testing of contraceptives. Not only is the method of research unethical, the clandestine testing of Norplant and Neten has cast doubts about the safety of the drug itself **(Dr. Sathyamala)**.

One of the main features of the Dunkel Draft Proposals involving Intellectual Property Rights, demands a change in the model Indian Patents Act, 1970. Accepting these would mean succumbing to the chauvinistic economic interests of the developed nations. It would also mean a 30-fold increase in today's drug prices. The implications for agriculture, scientific research, Indian industry and the economy are far worse. It would virtually amount to surrendering economic and political sovereignty. This discussion was facilitated by **Mira Shiva, Dinesh Abrol**, and **Narendra Mehrotra**.

The Hathi Committee Report in 1977, decried the role of the foreign sector because of its reluctance to produce bulk drugs and its non-performance in producing essential drugs. Their interest was in producing non-essential drugs with low technological inputs. Yet, this is precisely what liberalisation is inviting.

The government now totally belies the rights of more than half the country's population, for whom public sector health facilities are the only feasible means to health, by attempting to introduce service 'at cost'. This would reduce actual welfare expenditure (as is seen in the present budget) and introduce a drug policy which would only lead to price rise and in no way increase the accessibility of essential and life saving drugs. Is the Government of the people, by the people, keen to work against the people ?

The meet ended with a call to oppose the Dunkel Draft Text and as part of the proposed campaign, called on all concerned citizens to send postcards to the Prime Minister, conveying dissent about the same.

contd. from page 9

approach in professional institutions. They feel that while institutions have a role to play, in terms of giving specialised guidance and therapy, total segregation in such institutions isolates the handicapped and blocks their integration in society. The general public also remains isolated from, and therefore insensitive to, the issues of the handicapped.

Some parents also expressed that if neighbourhood facilities for recreational opportunities were organised and multiplied, it would help in inter-mixing between handicapped and other children. It could also pave the way for a forum where parents of handicapped children could meet, share experiences and put their minds and resources together to advance the rehabilitation process of handicapped children.

For all of them, living and taking each day as it comes, utilising one's time and creativity for the best possible development for their special child is the most pragmatic way of coping with the situation. Their attitude is summed-up in the motto, ***"Do your best, step-by step. The future can be faced, as and when ".***

THE NEED FOR FULL INTEGRATION

It must be remembered that opportunities for a close, loving relationship are only one aspect of leading a full, accepted and participating life in the community.

The more that can be done to bring about greater integration and participation of disabled persons in the life of the community, the more everyone will learn to look beyond a disability and see the person. When it happens, it opens up many new possibilities.

Source: Disabled Village Children, David Werner, *The Hesperian Foundation, 2nd edition, 1988. Chp. 52, pg.494.*

SEGREGATION
the other side of the coin

When parental concern about a handicapped child goes beyond the confines of one's own home, the effort can help transform the lives of many handicapped children. This forms the history of Vidya Jyoti School for slow learners. Dr. Poornima Pandit and Ms. Rita Makhija, both parents of slow learners and Fr. Alfred Barretto, former Principal of Vidya Bhavan School, Pune, discussed the problems and decided to put their collective ideas into action. The germination of the idea for such a school came from the experience that regular educational institutions are compelled to instill a competitive curriculum and slow learners cannot cope with this, particularly as they advance to higher levels.

Started in Pune in 1986, Vidya Jyoti is perhaps the first such institution in Maharashtra. Dr. Pandit, who is also a Paediatrician and Family Physician and Founder President of this school, pointed out, "*Slow learners are certainly not mentally retarded. They are children having below average intelligence (I.Q. range 70)85) and suffer from repeated failures in school because the sheer crowd and course load does not allow for individualised attention to those who need them. Repeated failures also frustrates these children and reduces their self esteem. What is needed is an institution that allows them to study at their own pace.*"

Vidya Jyoti, as a special centre, keeps the teacher-student ratio at an optimum of 1:10. Innovative methods of teaching and an adaptive curriculum, with varying proportions of academic and vocational courses (to keep with the levels of progress of each child, irrespective of age) help each student "attain a level of self reliance" and become "a useful member of society".

While, on the one hand one talks about integration, what is the role such institutions can play ? Dr. Pandit, whose own daughter (now 17 years) came into this school after being in a regular school till the sixth standard, admits,

"*My daughter certainly benefitted from her initial experiences in regular schools. But today regular schools are increasingly rigid in their policy of not accepting handicapped children. Hence, while a process of segregation (and therefore non-integration) is not desirable, social attitudes make these efforts inevitable* ".

And so, it comes to pass, that while initally Vidya Jyoti admitted older children finding difficulties in regular schools as they went to higher classes, today children are taken in from the primary school level itself.

STATEWISE DISTRIBUTION OF VARIOUS AGENCIES/INSTITUTIONS FOR THE HANDICAPPED IN INDIA -- 1986

STATE / UNION TER.	MENTALLY RETARDED	ORTHO-PAEDICALLY	VISUAL HANDICAP	DEAF MUTE	TOTAL
Andhra Pradesh	12	10	16	10	48
Assam	--	--	2	2	4
Bihar	1	2	9	7	19
Gujarat	20	4	25	28	77
Haryana	--	4	2	2	8
Himachal Pradesh	1	--	--	--	1
Jammu & Kashmir	--	1	1	2	4
Karnataka	17	6	9	12	44
Kerala	10	7	11	17	45
Madhya Pradesh	3	7	10	17	37
Maharashtra	43	18	30	53	144
Orissa	--	--	2	2	4
Punjab	2	4	5	11	22
Rajasthan	2	5	10	3	20
Tamil Nadu	18	17	19	34	88
Uttar Pradesh	5	4	9	29	47
West Bengal	7	1	13	27	48
Delhi	20	8	10	11	49
Goa	1	1	--	--	2
Chandigarh	--	1	1	--	2
Pondicherry	--	2	2	2	6
Sikkim	--	--	1	--	1
	162	102	187	269	720*

**Includes institutions run by the Govt., either Central/State or Local Muncipal Administrations, which is approximately 10% of the total. Therefore only 72 are run by Govt. and 648 by voluntary organisations (underestimated in any case). Source . "A Critical Review of Services for the Disabled in India with Special Reference to Education", Mithu Alur et al, Dept. of Research, Spastics Society of India, Bombay, 1988.*

STATEWISE RURAL/URBAN DISTRIBUTION OF DISABLED POPULATION

STATE	RURAL	URBAN	ALL (RURAL +URBAN)
India	11,586,635	2,683,416	14,270,051*
Andhra Pradesh	1,229,732	274,841	1,504,573
Assam	147,655	13,777	161,432
Bihar	1,370,235	139,733	1,509,968
Gujarat	411,266	140,159	511,385
Haryana	246,826	74,043	320,869
Himachal Pradesh	86,512	4,085	90,597
Jammu & Kashmir	85,868	10,224	96,092
Karnataka	623,812	177,949	801,761
Kerala	420,434	96,747	517,181
Madhya Pradesh	688,806	138,942	827,748
Maharashtra	807,189	311,248	1,118,437
Manipur	9,814	2,041	11,855
Meghalaya	18,313	1,541	19,854
Nagaland	--	--	478
Orissa	609,391	53,587	662,978
Punjab	360,033	88,331	448,364
Rajastan	650,554	140,416	790,970
Tamil Nadu	946,582	397,174	1,243,756
Tripura	39,737	4,158	43,895
Uttar Pradesh	2,074,504	352,693	2,427,197
West Bengal	814,715	169,514	984,229
U.T. (all)	44,697	91,735	136,432

***Note:* Computed using data from National Sample Survey prevalence rates and 1981 population Census of India.**

Source. Krishnaswamy S. The Demography of the Disabled and the Handicapped in India, The Indian Journal of Social Work, Vol.XLVIII, 1.April 87., as cited in Mithu Alur et al. Spastics Society of India Bombay

** According to this estimate there are 14 million handicapped in India. However, a survey done by the Spastics Society estimates a population size of 50 million who are handicapped in India.*

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BOOKS IN BRIEF

Usha Sethuraman

Programmes and Concessions for the Disabled Persons, *GOI, Ministry of Social Welfare*, New Delhi, pp.70.

This document lists programmes and concessions provided for the disabled under various heads - Education and Training, Employment, Economic Assistance, Medical and Health, Welfare and Rehabilitation, Housing and Travel and Communications - by the different agencies, at various levels. These agencies are, for example, 'public sector banks' for economic assistance, 'Welfare and rehabilitation institutions' for medical and health, etc. Every agency lists out each scheme with rules concerning eligibility, duration, etc.

There is also a section on measures undertaken by the Defence Ministry for the rehabilitation of the war disabled and the dependents of those killed in action. There are ten annexxures listing notifications issued by the ministry of Home Affairs like 'Grant of priority to the physically handicapped persons', 'Award of scholarships for the physically handicapped' etc. Ten more annexures list notifications like 'Income tax concessions', 'Grant of conveyance allowance to blind and orthopaedically handicapped' and so on.

Disability Prevention : the global challenge, *Sir John Wilson (Ed.)* Oxford University Press, Oxford 1983, pp. 107.

Towards the close of the International Year of the Disabled an international group was convened by the British Department of Health and Social Security, at Leeds Castle. It was a group of scientists, doctors, health administrators and politicians, who met to consider practical measures to prevent disablement. This book contains papers presented at the seminar.

While examining the principle causes of the problem, some papers discuss factors like vaccines, prenatal neglect, malnutrition and mental handicap, as important in the development of disabilities. Acute conditions like blindness, deafness, injury and occupational accidents form another set of causes. Chronic conditions like leprosy, tuberculosis, stroke and hypertension, coronary heart disease and old age are dealt with as the third set of causes. The book, through detailed examination, shows that most of the world's disabilities are preventable and that many of them are curable.

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ESIS AND WORKERS' HEALTH
need for action

Vijay Kanhere

The Employees State Insurance Scheme (ESIS) was started in 1956 with the idea of providing comprehensive health care to workers in the organised sector. Taking a part contribution from employees as well as employers and subsidised by state governments, this scheme is supposed to cater to treatment of illness as well as occupational disabilities and accidents involving workers and their families. In reality this is not so.

"*When you are suffering with `stomach upset', ESI hospital gives you same tablets which they will give for 'flu' or for 'sore throat'. Generally they have two-three types of tablets, one or two types of syrups; with this kind of medicine they claim to treat any type of disease*", says a worker from a textile mill in Kanpur.

ESIC : Financial Position

The ESIC (Employees State Insurance Corporation) needs to improve its functioning. Many committees have given suggestions for improvement but they are not being implemented. ESIC cannot complain about lack of funds for not improving its services. Figures in the adjacent box establish this fact. Part of these reserves are earmarked for particular purposes. ESIC still has large non-earmarked funds at its disposal. These reserves are invested in nationalised banks (Rs. 933 crores) and with the Central Government (Rs 184 crores).

Total Reserves of ESIC (in crores)	
31-3-89	31-3-8
1119.10	944.42

These funds are just deposited and are idle. They are generated because ESIC does not spend sufficient money on the necessary services. Apart from these reserves, its arrears from employers stood at 116 crore rupees in 1989.

Comparison with money spent on benefits from employees shows how little is actually spent on benefits. If it is assumed that ESIC spends Rs. 100 for employees' benefits, then its own figures show that Rs. 40 to Rs. 50 are with the employers as arrears and its reserves are more than four-fold and are rising at a faster rate than the expenses on benefits.

For every Rs.100 spent on Benefits	87-88	88-89
Arrears from employers	Rs. 43	Rs.50
Total Reserves of ESIC	Rs. 438	Rs. 483

Yet ESIC is still trying to reduce expenses on benefits. After reserving money for construction fund and contingencies, (an amount around 20 crores) it had net excess income over expenditure.

Is this a body established as a profit making corporation? We do not say it should go in a loss. Without going in loss it can spend more money on hospitals, by making the doctors permanent, employing more doctors and paramedical staff, obtain better drugs and equipments. For every 100 rupees spent on benefits, its net excess income was around Rs. 54. Add this to the arrears from employers and you have good resources to use in a much better way than is being done today.

"*ESIS is insuring the employers not the workers*", said one legal activist from Delhi. He explained: "*Employers can keep the workplace unsafe; if number of accidents are more, the ESIC takes care of the injured workers. Employers can keep the work-place as unhealthy as they want; if workers get affected due to diseases, ESIC is there to treat the workers*". This is very true. The employers can get away even by not paying contributions by employees, cut from wages, to ESIC . ESIC is very soft towards employers. It coolly states that arrears from employers are 116 crore rupees. Employees suffer, as benefits stop if ESIC does not get money from employers. " *The panel doctor is not interested in proper treatment. So we go to other private doctors, pay from our own pockets. The ESI doctor is useful for certificates*", said a worker. ESIS needs to become a scheme for employees in its true sense and all its resources need to be directed towards this goal.

Broad Areas of Complaints

1) Panel doctors and doctors in hospitals are not interested in patients.
2) Supply of medicines is irregular. Medicines need to be bought by workers and reimbursement takes undue time.

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3) Staff in ESIC offices and hospitals do not treat workers humanely. Workers contribute to ESIC, but the atmosphere is such as to make the workers feel that some favour is being done to them. "*We contribute; ESIC runs on our funds, but we have no control over it*", said a worker.

4) There is a shortage of medical shops supplying ESIC prescribed drugs. At places such as Anand (Gujarat), workers have to travel long distances to reach the medical shop attached to ESIC. Otherwise workers spend from their own pockets.

5) Necessary forms are not available with ESIC offices.

6) Diagnostic instruments are not available with ESIC doctors and hospitals.

7) Medical boards decide percentage of disability of injured workers. But medical boards do not meet frequently. "*They are more concerned in reducing percentage of disability and compensation paid to us* ", said workers in an asbestos factory.

8) The most notable complaint is lack of hospitals. ESIC has set itself a norm of 4 beds per one thousand insured persons. The shortage was around 2000 beds in 1988. This norm of 4 beds for one thousand persons itself falls short of the need. Hospitalisation is needed for :

i) Accidental injuries resulting in temporary disablement.

ii) Accidental injuries resulting in permanent, partial or total disablement.

iii) Employees affected by occupational diseases.

iv) Employees and family members needing hospitalisation for causes not directly related with employment.

ESIC records themselves show that injuries resulting in permanent disability were 23,414 in 1987-88 and 23,196 in 1988-89. It turns out that, in concerned employments, injuries resulting in permanent disability were 3.8 per thousand employees. Accidents resulting in permanent disability are serious accidents; their proportion is nearly 4 per thousand. These require hospitalisation. Hospital beds are needed for others as well, as noted above. ESIC has thus set itself a norm which is not satisfactory. The Review Committee Reports need to be taken seriously by ESIC and employees' representatives in ESIC.

Causes of Problems

A. Staffing

One report had pointed out the following things:-

1) Medical officers are drawn from general health cadre of the state governments and reluctantly join the scheme. They are therefore uninterested. Service conditions of doctors also need to be improved. Many doctors remain temporary for many years. One MARD (Maharashtra Association of Residential Doctors) activist said, "*lot of corruption is involved in getting a good posting, becoming permanent and for promotions of doctors. A doctor who is at the mercy of corrupt superiors won't be interested in patients or in rational medical practice*".

2) At all levels, there is under-staffing. The Review Committee had also said that there is a shortage of drugs, drugs may be sub-standard, there is a shortage of ambulances.

B. Linkage with the State Governments

ESI Scheme is tied with the state governments. ESIC and state governments share expenses on benefits in the ratio seven is to one (7:1). That is, ESIC spends around 87.5 percent and state governments around 12.5 percent. If, in any state, the expenditure rises above the national average, then ESIC claims these amounts from the state governments. In 1987-88 ESIC received around 2 crore in this manner. Secondly, there are ceilings decided by ESIC. Expenditure upto the ceiling is shared as given above. Expenditure above the ceiling is borne by the state governments. In 1988 ESIC increased ceilings and they are as follows:

Full medical care per insured person	**Rs. 190**
Expanded medical care per insured family	**Rs. 085**
Restricted medical care per insured family	**Rs. 070**
Expenses on drugs per insured family	**Rs. 070**

Building hospitals and running them is costly. This increases the contribution by the state government. For example, suppose Rs. 5 crore are to be spent to build a hospital in a particular year, in that year expenses will go above the national average and the state government will have to contribute heavily. It is in the interest of the state governments that the above expense is spread out over as many years as possible, such that, for every year their contribution is within limits. Because of these constraints, hospitals are built slowly by Government departments. Built hospitals are not commissioned fast so as to delay and spread over costs of running hospitals. As a result workers are denied proper medical care.

The contribution by the state governments is just 12.5%. We saw earlier that the net excess of income over expenditure of ESIC was around Rs. 54 for every Rs. 100 spent on benefits. We estimated contribution by state governments as one seventh of ESIC expenditure on benefits and extra contribution was added to it. (i.e. contribution for crossing ceilings).

	87-88 (in crores)	**88-89** (in crores)
Contribution by State Govts.	32.77	36.40
Arrears from employers	92.84	116.64
Net excess	117.80	124.05

(of income over expenditure, of ESIC)

These figures are self-explanatory. Even if ESIC bears all the expenditure on benefits, it will still be left with net excess over income of around 85 crore rupees per year.

Tying up with the state governments increases red-tapism. All proposals go through two channels — ESIC and the respective state government. The ties with state governments need to be restructured. ESIC can fix a definite amount for each state to be contributed by the concerned government. Then ESIC can run its schemes as it wants. Ties with state government have now become a dead weight. The idea of national average expenditure is a disincentive for state governments to develop new hospitals, plan new schemes. Even if ESIC plans anything, the threat of increased contribution will compel state governments to slow down the development. The union representatives on the apex body of ESIC need to go into the question of ties with state governments and give a proposal for fixed contribution (linked with price index) from state governments and should free ESIC to give better services.

C. Medical Boards

Medical Boards are constituted to decide percentage of disability of injured workers. The injury may be due to accidents at work-place, or during the course of employment, or, due to occupational diseases. The pension/compensation paid to workers depends on the percentage of disability. The medical boards are constituted by doctors who may

not be residing in one city. Meetings of Medical Boards become less frequent due to lack of time on the part of specialists, the problem of bringing them at one place and the expenses involved. An injured worker has to wait for months before the Medical Board calls him for checkups. A worker affected due to asbestosis said, "*The doctor saw my X-ray. There was not enough light in the room. He said 23% disability. KEM doctors told us correctly that we are affected due to asbestosis. The percentage (of disability) given by KEM was higher than the one given by the Medical Board* ". The procedure to challenge percentage given by Medical Boards is lengthy and tedious. Workers affected due to silicosis (in Baroda) had to battle in courts to get proper compensation from ESIC. A worker already affected by disease, or due to accidental injury, has to wait and also has to face humiliation. This is inhuman.

Medical Boards should meet six times a year, in each district, or more frequently. A worker should not be forced to wait for more than 2 months to get the opinion of the Medical Board. Medical Boards should record reasons of deciding on a particular percentage of disability. The criteria for this must be put forward clearly.

Procedures to challenge Medical Board decisions should be simple and fast. We saw that the number of workers involved in accidents, resulting in permanent disabilities, was around 23 thousand every year. This shows the necessity of fast, proper functioning of Medical Boards.

D. Lack of Attention to Occupational Health and Safety

Doctors in ESIS seem to be unaware of the branch of medicine concerning Occupational Health. This is shocking, because ESIS is meant for industrial workers also.Thousands of textile workers are affected due to byssinosis - a disabling disease caused by cotton dust. Similarly silica dust, coal dust, asbestos fibres take the toll of human life. There are many carcinogenic substances used abundantly in Indian industries - asbestos, benzene, chromium, nickel, vinyl chloride, auramine and many others may cause cancer to exposed workers. Lung diseases, skin diseases, nervous system disorders may also be occupational diseases. The Factories Act (1948) has given a list of occupational diseases which are to be notified to factory inspectors. Do ESI doctors notify factory inspectors when they treat a worker affected by occupational dermatitis (or any such occupational diseases)? Most are unaware of their duty under the Factories Act. They are also not trained to diagnose occupational diseases. They do not have enough equipment needed for proper diagnosis. Secondly, ESI Act has Schedule III which lists occupational diseases for which employees can claim compensation from ESIC. ESIC has neither informed the workers and the doctors about Schedule III, nor the workers about how they may know if they are affected by any occupational disease in Schedule III. It has not acted responsibly in this important area.

What Needs to be Done

ESIC needs to be made to do the following things :-

A. Recovery from Employers

1) There are more than 900 employers in India who owe ESIC more than Rs. 1 lakh each. Total dues, we have seen, stand at 116 crore rupees.
2) When worker's/employees' contribution is cut from wages but not paid to ESIC by the employer, this should be treated as a criminal breach of trust and ESIC should not stop at recovery of fines or writing off dues as bad debts.
3) It is heard that there is a lot of corruption involved in procedures of inspection, recovery of dues from employers etc. Stringent procedures must be evolved to overcome this.
4) At one end ESIC denies beds, hospitals, diagnostic equipment, drugs to poor workers and allows employers to keep dues at the other end. Action by ESIC is needed on this front also to establish its bonafides. Only pressure by unions, workers/employees will ensure improvement. If there is enough pressure, well-intentioned representatives of people, doctors, officials will help in improving ESIC.

B. Work on Occupational Health

1) Trained doctors in Occupational Health Institutes such as NIOH Ahmedabad, CLI Bombay, ITRC Lucknow, may help ESIC in organising the training of their own doctors.
2) Develop Occupational Health and Safety Centres all over India - at least one in each district, more in industrial cities such as Bombay. These centres should be well equipped and have specialists and should cater to the employees of ESIC hospitals as well.
3) All panel doctors, doctors in ESIS hospitals, should start recording occupation of employees. This should include nature of work, exposure to high noise levels, heat, chemicals (particulars) and necessary information for diagnosis of occupational diseases.
4) A Superintendent of an ESIS hospital said *"We should treat employees even after retirement. Proper medical records should be preserved until expiry of an insured person. Proper forms for medical records need to be prepared* ". His suggestion needs to be implemented. In case of cancer due to asbestos, it may affect a worker many years after exposure. Many diseases have long, latent periods. This makes us emphasize the need for proper medical records.
5) Section 69 of ESI Act gives a right to ESIC to recover excessive sickness benefit given to employees due to unsanitary working conditions or unsanitary residential facility provided by the employer. Has ESIC used this section against any employer ?
6) In case of higher rates of accidents, ESIC should inform the Factory Inspectorate to check up unsafe working conditions. The inspectors of ESIC should inspect work-places and should not stop at just inspecting records.
7) Compensation Rates - The disability rate should be linked to the index. Suppose a worker is awarded Rs. 15 per day as disability benefit -- this amount should change every year, depending upon the average price index of that year. The prices are rising and disability compensation for loss of earning capacity should be linked with the price index.
8) Procedure for collection of disability benefit, dependents' benefit, must be made easy.
9) Sickness benefit, other benefit rates amounts for drugs, need to be linked with price index and revised every year. They should not depend on arbitrary desire of ESIC heads. The present rates need to be raised and ESIC does have the necessary finances to do so.

C. Simplification of Procedures and Information Dissemination

i] ESIC should produce booklets in regional languages. These booklets should explain :-

a) Procedures involved in getting benefits.
b) All the benefits available to employees. This should include information about compensation in case of occupational diseases (Schedule III).
c) All the proformas of forms required by ESIC.
d) Grievance procedure -- where, and how to complain, etc.

contd. on page 8

OBJECTIVITY, HEALTH AND POLICY

Amartya Sen

Health is perhaps the most crucial aspect of human well-being. "Health transition" refers to the transformation of a society with high morbidity and mortality rates, into one in which people standardly live long, disease-free lives. Health transition has to be a central feature of significant social progress. Many countries have achieved such a health transition, and the list includes poor as well as rich countries. India, despite some considerable achievements, is still quite far away from such a health transition. It is in this context that the issue of objectivity of health assessment assumes crucial importance. The need for objectivity in health assessment is significant in two distinct exercises: (i) in crucially appraising the **health status** of the people, and

(ii) in scrutinizing **policy issues** in promoting good health.

The demands of objectivity are quite exacting in both the exercises. Consider the first problem - that of objectivity in appraising health status. This appraisal can run into problems with the subjectivity of perceptions. The difficulty is not related only to individual variations, such as hypochondria, on the one hand, and health bravado, on the other. There are systematic social variations as well. For example, the state of Kerala has had great achievements in longevity (the average Keralite life expectancy at birth appears to be now over 70 years), but that state also reports the highest incidence of self-perceived illness in the country. The lowest reports of morbidity come, oddly enough, from states with the lowest life expectancy levels (i.e.,Bihar, Uttar Pradesh).

Self - perception and Health

These contrasts may appear to be puzzling, and there have been some attempts to explain how a high incidence of illness may go hand in hand with low mortality. But is the picture of reported morbidity rates (i.e., high in Kerala, low in Bihar) a good reflection of the objective situation in different parts of India? In making inter-personal or inter-regional comparisons, is self perception of health a good indicator of one's actual health status?

There are good reasons to think that it is not. A more literate population tends to have a greater understanding of illness, whereas an illiterate and ignorant population may have little appreciation of its health predicament. Also, greater availability of health services and medical facilities, which make it easier for people to seek medical attention, may reduce death rates (and improve health conditions), but, at the same time, it also increases the perception and understanding of illness. Non-availability and non-use of health facilities can go with non-recognition of morbidity. Thus, a greater subjective perception of suffering from illness may be a concomitant feature - and a necessary condition - of achieving better health and low death rates. Perception of morbidity is a precondition of its solution.

This interpretation of the picture of reported morbidity rates in India is corroborated by a study by Lincoln Chen and Christopher Murray, who apply similar criteria of self-perceived morbidity to the U.S. population. In disease by disease comparison, they find that while Kerala has much higher morbidity rates than the rest of India, the US population has even higher rates for the same illnesses. If we go by self-reported morbidity, we would have to conclude that the USA is the least healthy in this comparison, followed by Kerala, then the rest of India, with the states most backward in education and public health services - such as Bihar and Uttar Pradesh - enjoying the highest levels of health !

We clearly do need a different approach. But what? It is a mistake (as argued already) to take the relative rates of self-perceived morbidity as reflections of actual rates of illness and ill health, but it would also be a mistake to ignore the information on self-perceived morbidity rates as worthless and irrelevant. For example, it is not irrelevant to the persistence of high mortality rates in Bihar and Uttar Pradesh, that there is such a deficiency of self-perceived morbidity there. The educational, medical and social backwardness of these states links the low levels of reported morbidity rates to the high levels of actual mortality rates. The biased positional view of the truth is important to understand the truth and its persistence. In my Storrs lectures at the Yale Law School (*on "Objectivity", given in September 1990*), I have tried to discuss the precise role of "positional" observation in objective assessment. (*The lectures will be published later - supplemented by some empirical studies- but some of the main themes are discussed in my paper "Objectivity and Position : Assessment of Health and Well-being," Working Paper No. 1, Harvard Centre for Population and Development Studies.*)

Gender Inequality and Perception

To illustrate the same issue with a different example, nowhere is the importance of positional views as crucial as it is in understanding gender inequality. The questionnaire method of obtaining the views of rural women on their own perception of gender inequality has often failed to find any strong recognition of disparity or inequality. This has sometimes been interpreted as a proof of the absence of any "real" gender inequality in rural India. It has even led to the suggestion that raising the question of gender inequality in this setting amounts to planting an alien notion in an illegitimate way into the classical harmony of Indian rural living. And yet, in terms of various directly observed criteria of mortality rates, literacy rates, nutrition-related diseases, use of hospital and medical services, etc., women emerge as being systematically underprivileged vis-a-vis men in rural India.

If the analysis I am trying to present is correct, then the perception of harmony and the absence of a perceived sense of gender inequality are quite central to understanding the nature and persistence of gender inequality in rural India. These perceptual features contribute to the casual influences sustaining the inferior position of women, rather than contradicting the existence of gender inequality. The positional view - distorted as it is - is far from irrelevant. We have to see it as an important

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part of the objective picture of women's deprivation - a crucial casual influence that has to be reckoned with to understand the durability of that deprivation.

Objectivity of health assessment is a complex task. It requires the rejection of subjectivism, but it also demands that serious attention be paid to positional perspectives - limited and distorted as they are. Observational generalizations that would amount to crude subjectivism if they were seen as reflections of the simple truth (e g., low reported morbidity rates in Bihar or Uttar Pradesh, the absence of perceived gender inequalities in much of rural India) are, in fact, important parts of the objective truth seen as crucial **casual** influences (i.e., in the continuation of generally high mortality rates and of gender disparities). Objectivity has many dimensions and the objectivity of health assessment is no exception.

Positional Views and Social Philosophy

The question we are discussing here links with many classical issues in social and political philosophy. For example, the systematic distortions present in "positional views" can be seen as undermining the reach of utilitarian philosophy, at least some versions of it. The fundamental information on which utilitarian evaluation relies is the psychological self-perception of each person's well-being - various utilitarian building blocks such as "pleasure", "desire", "satisfaction", all share this feature. While these psychological features have importance of their own, they are quite limited as guides to individual well-being in objective social assessment. The illiterate villagers in Bihar and Uttar Pradesh may be "happier" with their health conditions than are the probing Keralites fussing about their health, but are they really better off for that reason? Happiness, however fragile or misguided, should not, of course, be scoffed at altogether, but nor should it be taken as a terrifically good indicator of a person's overall well-being. Utilitarian calculations stand in some danger of concentrating or rather limited - and often somewhat superficial achievements, ignoring deeper and more fundamental aspects of one's health, well-being and the capability to live fulfilling lives.

These issues also link with other classical problems in social philosophy, such as Adam Smith's investigation of deprivation and necessities, John Stuart Mill's discussions of women's subjugation, and, of course, the large area of social research opened up by Karl Marx's analysis of "false consciousness" (a concept that draws particularly on the positional distortions from the perspectives of deprived groups).

Policy Divisions and Objective Assessment

I turn now, briefly, to the second issue - that of objectivity in assessing alternative policies. This is a particularly important question at this time in India, since the traditional governmental policies are now undergoing major reforms. It is clear that official policies will tend to be much more "pro-market" now than they have been in the past. These changes have divided the professional economists and political commentators into different camps. The divisions, to a great extent, have followed traditional dichotomies (e.g., "left" versus "right", "pro-business" versus "pro-government"). This is, obviously, not the occasion to discuss these general social divisions and their important political role. But the need for objective assessment of the cause-effect relations on health and well-being cannot be over-emphasized. There are essentially two different ways in which health conditions improve for the more deprived section of the population. First, economic growth and employment in gainful activities can bring the means of health care and nutrition within the reach of the deprived groups. Second, public support of food consumption, community health, medical care, basic education, etc., can transform general health conditions. To some extent, these two processes working, respectively, through economic growth and through public support, can work independently of each other. Indeed, some countries (such as China, Sri Lanka, Cuba, Jamaica, Costa Rica) have achieved remarkable improvements in health conditions even without much economic growth, and despite the fact that they have remained quite poor in terms of gross national product (GNP) per head. However, there is evidence also, that, given other things, economic growth and the consequent rise of per capita GNP can contribute significantly to health achievements, especially when the growth process takes an employment-oriented participatory form.

Growth Mediation Versus Unaimed Opulence

But the two distinct processes - based respectively on economic growth and public support - can also supplement each other very substantially, as Jean Dreze and I found in our joint study, assessing comparative international experiences (*Hunger and Public Action, Oxford University Press, 1989*). Countries such as South Korea, Hong Kong, Singapore and Kuwait have not only achieved fast economic growth (yielding high average incomes), but have also ploughed back substantial parts of the resources generated by economic growth into public provisioning of health, education and social security. These countries have brought about major transformations of health conditions in a way that has not happened in, say, Brazil or Oman, which have experienced comparably fast economic growth without the generated resources being particularly used for improving public health, or public education, or social security. The "unaimed opulence" of Brazil or Oman contrasts quite sharply with the "growth-mediated process" of health improvement in Hong Kong or South Korea. What differentiates the two categories of experiences is not really the vigour of markets, or the contribution of private economic enterprise in generating economic growth - they share these features (though there has been much more state planning of industrial direction in South Korea than in Brazil). But the Brazilian neglect of public support of health, education and social welfare contrasts sharply with the emphasis placed on it in Hong Kong, Singapore or South Korea, and these latter countries have reaped as they have sown. The debates on "pro-market" versus "pro-government" policies may have to be redefined to take note of empirical regularities, particularly those that emerge irresistibly from trying to understand and assess comparative international experiences. The central issue is not one of "supporting" the market mechanism or "opposing" it, nor of being either "pro-government" or "anti-government". The real challenges are much more complex than that.

Positional Views and Integration

In this short presentation I have tried to discuss two rather distinct aspects of the need for objectivity in assessing health status and policy. First, as far as health conditions are concerned, self-perception proves to be a rather unreliable guide to the prevalence of illness and ill health, but, at the same time, provides important clues to the persistence of these deprivations. The positional views - distorted as they often are - have a crucial role to play in the continuation of prevailing inequalities. Objectivity has much to do with understanding both the relevance and the limitations of positional perspectives, and the need to construct a more integrated picture.

Second, on the question of policy assessment, it is important to go beyond simple "pro" and "anti" attitudes about the respective roles of markets and of government actions. Empirical studies of international experiences suggest that the causal influences on health transition have to be understood in less fragmented, more integrated terms. Objectivity can offer rich rewards in this vital field - as in others.

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THE DUNKEL PROPOSALS AND INDIAN INTERESTS

Audrey Fernandes

The Indian media have focussed many articles on the negotiations under Super 301, GATT (General Agreement for Trade and Tariff), DDT (Dunkel Draft Text). All these have many serious implications to health status, drug availability and use and the concept of essential drugs. Especially, the frontal attack being made on the Indian Patent Act (IPA) 1970, if relented to, would turn the clock back, and make essential drugs out of reach for the common person and perhaps, not available at all. Some of the important features of these negotiations are presented below.

Special 301 and GATT

The US has, under its Omnibus Trade and Competitiveness Act of 1988, a special, Super 301 clause. It is under this clause that the US argues that, unless India offers 'adequate' protection in the area of intellectual property rights it would impose sanctions against its exports to our country. Access to the US market is used as a leverage against erring countries so as to be able to enter their markets. The clause empowers the US President to employ coercion to attain greater compliance from its trading partners. This includes compelling changes in their respective trade and investment policies. During May 1990, the US began investigations against India for its 'unfair trade practices'. Later, action was deferred. The breathing space India got was aimed at bringing stronger pressure at the GATT negotiations at Brussels, in December, 1990. This was an extension of the Uruguay round, launched in September 1986. At Brussels, an impression was created that governments, including India, were destroying multinationalism in trade. The warning of a choice between a collapse of the system and triggering of a depression was made. Germany, and the US, in particular, accused India of blocking progress in the negotiations, particularly because of the latter's stand on Intellectual Property Rights. Why was this so? In the earlier seven rounds of GATT negotiations, international trade was sought to be liberalised mainly through cuts in tariffs and selective lowering of non-tariff barriers. But now, for the first time in the Uruguay round, the reorganisation of the international economy was being sought, through proposals covering trade, investment and technology. Multinationals are being favoured and the Third World would be required to change the regulations regarding foreign investment and intellectual property rights. Three new themes proposed by the US were introduced.

1) Trade related investment measures (TRIMS)
2) Trade related intellectual property (TRIPS)
3) Trade in services (GATS)

The failure of the EEC and the US to reach an agreement on Agriculture at Brussels, resulted in the talks being suspended. Now, Arthur Dunkel, Director General of GATT, has introduced what is known as the Dunkel Draft text (DDT) which seeks to break the impasse at Brussels and widen the scope of GATT. It includes seven broad areas : (1) Market Access (2) Agriculture (3) Textiles (4) GATT rules including TRIMS (5) TRIPS (6) Trade in Services (7) Institutional matters.

The Indian Patent Act

What is it, in the Indian context, that the US and other developed countries find so objectionable about our Patent Law? Briefly, the Indian Patent Act (IPA), 1970, came into being after a long debate on Industrial Policy and the recommendations of the Tekchand Committee 1948 and the Ayyangar Committee 1957. Both Committees suggested that :

(1) A Patent should not be granted to enable patentees to enjoy a monopoly to export the patented product to exploit the poorer nation; rather patents should help the development of industries and protect them from aggression of foreign capital.

(2) Patents should be granted to encourage inventions and to put them into operation in India on a commercial scale.

(3) India should not become a member of the Paris Convention. (The Paris Convention on Patents which dates back to 1883, was established to restrict industrialisation of former colonies.) As a result, an act which served as a model to developing countries came into being. The important features of the IPA, 1970, were :

(i) National interests held priority over patentee interests.
(ii) Product patenting was not allowed in chemicals, drugs and pharmaceutical products.
(iii) Only process patenting was allowed, permitting the manufacture of the product through any different processing. In pharma--ceuticals it was lower than for other inventions, five years from the date of grant, or seven years from the date of application for patent, whichever was shorter. This allowed for research and development in drugs and pharmaceuticals, suiting Indian conditions.
(iv) Compulsory licensing for process patenting in medicine after the expiry of the three years from the date of granting the patent, meant that the government could revoke the patent if it found that it had not met the requirements of the public, or was available at unreasonable prices. Such licensing ensured that the patentee worked the patent in the country.
(v) The patentee was not allowed to import the patented product at his/her own price.
(vi) The burden of proof of violation of the patent was on the patentee.

This had a positive impact on the drug and pharmaceutical Industry, where, from 1975 onwards, the production of bulk drugs increased 5 times, the production of formulations 6 times, the rise in exports of drugs pharmaceuticals 10.5 times. The time-lag for introduction of new drugs, which was 10-15 years before the IPA 1970, now got reduced to

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4 to 6 years, and the production of 100 bulk drugs was introduced with indigenous technology.

DDT, TRIPS and TRIMS

Interestingly the Dunkel proposals seek a reversal of the above salient features. Where, even today, multinationals control about 78% of the drug production in India, the private sector 16% and the public sector only 6%, most life-saving and essential bulk drugs are produced in the public sector and small scale units. A reversal of the IPA would mean a worsening of the present situation, where already 80% of the over 60,000 formulations sold in the country, are, according to WHO, non-essential and irrational.

Again, the Indian Patent Law does not allow the patenting of living organisms, as in the American Patent Law (which we would be required to accept under TRIPS). Bio-technology is set to be the technology of days to come. It governs the manufacture of products derived from living organisms, like foodstuffs, vaccines, medicines and even certain categories of chemicals which are manufactured by fermentation technology based on micro-organisms.

Acceptance of TRIPS would mean overturning of conventions which regard genetic resources as the common heritage of humanity. These resources, now available in limitless quantities, would restrict the full use of biological potential only to what is patentable, and will erect barriers to entry in certain branches of production. Monopolies thus created would be detrimental to the poor and needy of the Third World. It will become increasingly expensive for the Third World to build local technological capability, the thrust of research will change, human needs would take a back seat and research for profit to multinational corporations will determine priority.

The fact is that, most plant genetic resources have been concentrated in areas of genetic diversity located in tropical and semi-tropical areas. Also, germ-plasm collected from the Third World is the result of sustained efforts of farmers who have carefully selected and observed varieties for generations together. (Bolivian farmers were first to create disease resistant potatoes, and rice, as we know it, was created by farmers in India). Under TRIPS these would become the monopoly of multinational corporations.

The DDT also introduces new proposals under TRIPS. Firstly, it takes away the sovereign right of developing countries to exclude certain subject matters from patentability for national interests. It treats import of the patent to be working of the patent in the country. Obligations on patent-holders, such as compulsory licensing for non-working of the patent, are to be completely abolished. Instead, the burden of proof is on the defendant, in case of violation of intellectual property rights. This would, in practice, mean an almost non-existent check of such violations. Next, the draft rejects any kind of special and differential treatment for developing countries in view of their low level of technological development. Instead, it provides for a time bound mechanism for allowing governments to bring their national laws into conformity with the proposed TRIPS draft.

The bilateral Super 301 has led to objections to India's 'unfair' trading regulations regarding foreign investment covering :

(a) 40% ceiling on foreign ownership of Indian companies
(b) the phased manufacturing programme, which requires that at least 25% of the value of production should consist of local inputs within 5 years
(c) requirement to export a certain percentage of production if foreign ownership exceeds 40%
(d) exclusion of foreign companies from the Indian insurance market.

Under TRIMS too, industrialised countries such as US, EEC, Japan, have identified 14 such measures. They cite a number of regulatory performance requirements which have 'distorting and inhibiting' effects on trade. These requirements, introduced by Third World countries in accordance with their development needs and priorities, include requirements for local manufacturing, technology transfer and local equity. Through these they have tried to make sure that net outflows by way of profit remittances or payments for goods and services etc. do not cause strains on the balance of payment; also that the business practices of the multinationals are kept under control and their adverse effects on economies are reduced.

Alongside, DDT proposals under TRIMS would also knock our agricultural economy askew. It would prevent any practical price support to farmers, whether to promote self-reliance, or food security, or to promote export. In developing countries, input subsidies would be allowed only to very restricted groups of farmers. The Public Distribution System would be limited only to nutrition as a criteria. The freedom the government now enjoys to protect farmers from imports of agricultural commodities by introducing safe-guards such as non-tariff barriers etc. will be taken away.

Liberalisation : the GATS way

Under GATT negotiations many issues regarding increasing participation of Third World countries in world trade and expansion of their service exports are subject to application of the provisions of agreements relating to progressive liberalisation, market access and commercial establishment or presence. Whereas issues like the 'definition of services', 'definition of commercial presence' or 'the application of the most favoured nation principle' remain unresolved. While discussions have covered the content of proposed annexes for tele-communications, construction, professional services, financial services and labour mobility, there is no general obligation imposed on the need to provide access to foreign service enterprises or for granting them national treatment, i.e. same treatment as to national enterprises. These are subject to negotiations on a request and offer basis. The sectors where India has made an offer include engineering services, computer related services, research and development, hospital services, and the construction of road and bridges. Since the agreement on services deals not merely with trade in services between countries, but also affects 'domestic services', it goes against national interest. Any attempt at supporting any service sector in the interest of the public would be seen as interfering with the agreement of liberalisation of trade in services. The DDT fails to take note of the distortions that would be caused in, for example, health care or education. For instance, if health care is opened to foreign commercial interest, would it take care of basic health services or public health services? Chances are they will not. To imagine that justice could be obtained if disputes arise when the interests of our people clash with the commercial interest of powerful transnational corporations is a delusion. With GATT as a super - national body, the Third World is being forced to open out sectors which were kept for national enterprises. Therefore globalisation and liberalisation of trade in services cannot be looked at without the existing social context.

Finding our own alternatives

The whole thrust to globalisation and the supremity of multinational companies does countries like India, no good. We see this from past experience. Before the introduction of the IPA in 1970, multinationals with patents only imported drugs into the country, at 5-6 times the cost.

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Due to unavoidable circumstances, the fourth country profile in the series, "***Health Financing & Costs: comparative perspectives***" could not be carried in this issue.

The profile of Brazil will now appear in the July-Aug issue of the Newsletter. Inconvenience to readers is regretted. - Ed.

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Their stress then, and even now, continues to be largely irrational combinations. At present too, foreign drug manufacturers sell drugs in India, which are banned in their own countries, also charge exorbitant prices for life saving combinations patented by them and marketed through high power advertising campaigns. What the situation will be like, if the DDT proposals are accepted, perhaps, cannot be imagined. If we are to reject the GATT and DDT proposals, the fear is that the developed countries will use their economic strength to throttle us. On the other hand, if we relent, we will be co-opted into a system which will benefit only the rich and powerful. It is perhaps time to question what this "development", "globalisation", "liberalisation" and the sole aim of "industrialisation", at all costs are all about. India is a country which launched a large resistance movement to drive away the British, who plundered the land for self-interests. Will it allow the same kind of robbery, though at a very magnified scale, to occur again? Or will we find our own alternatives to "development", to benefit the large majority of our citizens ? It is, perhaps, time we did.

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ii] Industrialists are now having facilities of one window clearances. Employees should get one window clearance of their dues from ESIC. They should not be made to run around to get forms, to queue up at various offices and windows. Simple procedures in consultation with employees need to be developed.

iii] Local committees should publish reports of their meetings. Local committees need to have some powers. Employees need to have avenues to reach decision making bodies and disciplinary bodies and get errant officials and lengthy procedures straightened.

There are employees' representatives (union representatives) on ESIC bodies at national as well as local levels. Still, workers' complaints are not heard. The unions need to take more active interest in ESIC affairs. Now the wage limit has gone to Rs. 3000 per month, so more employees are coming under ESIC. The need to pay more attention to make ESIC a more vibrant and effective agency to provide health care for the working class has therefore now become all the more imperative.

Associations of Doctors, health activists, such as industrial hygienists, need to work to develop criteria for deciding disabilities and also to improve ESIC functioning.

FREE ABSTRACTING

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BRAZIL
A Profile in Contradictions

Shirish Kavadi

This is the 4th article in the series, "Health Financing and Costs: comparative perspectives". (No.1- Japan, No.2- Zambia, No.3- China.)

The Brazilian health system combines in itself features of both the developed and developing countries. The two dominant features of the health system are public funding and private production of services. One of the most developed of the developing countries, Brazil spends as much on health (4% of the GDP in 1981) as the industrialized developed nations, facilitating far greater availability of health care resources than exist in most of the developing world. Health care is Brazil's largest social security programme, receiving in 1982, 90% of the total health budget.

Yet, about one-third of the population lacks regular access to basic health care, resulting in high morbidity and mortality rates amongst the poorer communities. The enormous expansion of curative medicine in the social security system on account of government policies has resulted in excessive costs, unnecessary surgery, overly sophisticated care and all the distortions of modern, hospital-oriented medicine.

This then represents the paradox in Brazilian health care system. The Brazilian policy-makers are thus, on the one hand, faced with the task of containing rapidly increasing medical costs and on the other, reducing the disparity in the quality and quantity of health care available to different sections of the population, owing to chronic under-funding of the public health sector.

Health Status

Brazil, in 1985, had a population of 134.6 million. Health indicators have shown a reasonable improvement over the years (see Table 1). However, there are regional variations. For example, the infant mortality rate in 1990 was 68/1000 nationally, but in the north-east region it was 200/1000.

The author was formerly co-researcher in a WHO sponsored FRCH study, from which the above article has been drawn. At present he is involved in the study, "Health Expenditure and Investment in a District".

TABLE 1: HEALTH STATUS.

Year	Crude Birth Rate	Crude Death Rate	Infant Mortality Rate	Child Death Rate	Life Expectancy
1	2	3	4	5	6
1970	35.0	10.3	98.6	12.5	58.9
1985	29.0	8.0	67.0	5.0	64.5

Sources: World Tables, Vol 2, 1983, and World Development Reports, 1987, 1989.

Brazil has a disease pattern that is a combination of communicable diseases common in developing countries and illnesses afflicting the developed world. Nutritional deficiencies affected half the population. In 1975, 46.8% of the children in the age group of 0-5 suffered from some degree of malnutrition. Brazil, in the 1980's, was said to be a 'sick country', with Chagas' disease, tuberculosis, malaria, and tetanus taking very high tolls.

Doctors in Brazil have neglected preventive services in favour of curative services. Various measures undertaken by the government, such as mass immunizations, mobile vaccination teams, mobilization of national health teams and national publicity campaigns, failed to effectively curb or eliminate the most common communicable diseases, except for short periods. It is significant, however, that incidence of poliomyelitis fell from 2.1 per 1,00,000 persons between 1975-1980 to 0.1 per 1,00,000 persons since 1981.

Slow population growth over the years and increased life expectancy has led to the aging of the existing population, which has, in turn, contributed to the growing rate of chronic and degenerative diseases. Mental disorders are common and deaths due to accidents and violence are increasing in frequency.

Organisation of the Health Sector

Administrative and Legislative Framework: Brazil is a federation with a three-tier governmental structure. Formulation of

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health policy and its implementation is the responsibility of governments at all the three levels. Planning at the national and state levels is confined to developing standards in disease control programmes and staffing of hospitals. Consequently, the more basic concerns of an equitable health system have received little attention.

Health Care Development: The first attempt at national organization of health and welfare by the Brazilian government in 1887, was guided by considerations of controlling epidemics which threatened the urban population. Growing industrialization prompted increased governmental intervention in the social sector in the form of various welfare measures. Improvement in the health of the working class was essential for increasing industrial production.

However no coherent policies were ever formulated and the social security system that evolved was essentially discriminatory in nature. Social security was first introduced in 1923 to cover railway employees but gradually expanded its coverage to include the organised working sector, such as maritime and dock labour and other politically powerful groups. However, it left out the marginal urban groups and the poor rural masses. In 1971 this drawback was somewhat corrected when social security was extended to rural workers under the programme of assistance for rural workers.

World War II gave further impetus to public health endeavors. These were a part of the war effort undertaken with US cooperation. The focus was on rural health programmes, especially malaria control, and training of public health personnel. US cooperation came to an end in 1960.

From 1964-1984, Brazil was under a military regime. This government too had no well-defined health policy. Committed to a modernization programme, it pursued economic and social policies which subserved public health needs to curative medicine. With the emphasis on hospital based technology and specialist-oriented, curative medical care, preventive and promotive health care were neglected, to the detriment of the health of urban and rural poor.

A new civilian administration took office in March, 1985. As a part of the various steps undertaken to address the problems faced by the people, the government outlined a new health sector strategy. This strategy focussed on integrated health services delivery; financial control; expansion of state municipal services; and finally, increasing efficiency of the delivery structure through decentralization and de-emphasizing specialized and professionalized health care.

Health Care System: services and resources

Brazil has a pluralistic health system wherein health care is delivered through both public and private sectors. Facilities in the form of polyclinics, health centres and posts run by the national and state governments and municipal bodies provide ambulatory and primary medical care to about 20% of the population, mainly the poor and the children.

This section of the population also receives primary health services from non-government organisations. Although there were about 6000 groups spread throughout the country in 1990, the importance of voluntary bodies in recent years has generally been declining.

Industry-run network of '*consultarios*' and polyclinics in the main cities provide medical care to the employees and their dependents. Private profit-seeking groups, similar to health maintenance organisations (HMO) in the United States, have prospered in areas like Sao Paulo, where the governmental health infra-structure is weak and inadequate. In addition, privately owned hospitals and private practitioners with their own clinics cover the health care needs of the economically well-off sections of the population. This covers about 20% of the population, either on a fee-for-service basis or through contractual arrangements with social security agencies.

However, in recent years, private medical practice is becoming a peripheral activity. Only 7.5% of the total number of physicians are purely private practitioners. The rest are primarily salaried employees dependent on the State. Of these, 45% are reported to have private practices, though on a small scale, spending less than 12 hours a week attending to private patients.

Seven autonomous social security institutions operate their own facilities. They also have contractual arrangements with private health providers. The social security agencies cover medical care for different categories of private and public employees in urban and rural areas. The largest of these is the National Institute for Medical Assistance and Social Insurance (INAMPS). In 1980, INAMPS hospital network consisted of 41 hospitals, all with out-patient units. It also had 487 health centres, which constituted the bulk of its own ambulatory care resources.

The Government of Brazil made every attempt to increase health care resources over the last three decades, but this has not necessarily resulted in the extension of health care coverage. Since the 1960s the number of persons trained in medicine has increased five-fold (Table 2). The doctor to population ratio is considered high. The number of para-medical staff has also gone up, but the ratio of nurses to population remained below the standard set by the Ministries of Health of the Americas.

TABLE 2 : HEALTH RESOURCES

Year	Beds	Physician (per 100,000 population)	Dentists	Nurses
1970	370	48	2	6
1985	410*	143	12	19

Source : U.N. Statistical Yearbook for Latin America and The Caribbean, 1988.
**Figures are for 1984*

Yet most public hospitals in the late 1980s faced a serious shortage of staff. Brazil faced no real shortage of physicians, and had many under-employed and unemployed physicians. The non-availability of doctors to large sections of the population was due to geographical maldis-tribution. The geographical distribution of doctors tended to follow the level of economic development of a region and the location pattern of medical schools and hospitals. Out of 76 medical schools the majority existed in the Rio de Janeiro - Sao Paulo belt, which falls in the economically developed and high income Southeast region. This region had 65.6 percent of the physicians against 16.3 percent situated in the northeast. Of the total doctors in the state of Rio de Janeiro in 1980, 78.56 percent were reportedly in the capital alone. Adding neighboring municipalities, the concentration in the Rio metropolitan area reached 89.6 percent.

The inadequate supply of health staff, along with under-funding, mismanagement and shortage of supplies affected the working of the public hospitals. In 1987, some 1500 of the 3500 public hospital beds in Rio de Janeiro were taken out of service. This created the 'deadly problem' of overcrowding in the public sector hospitals throughout Brazil. However space is always available in private institutions. Out of

the total hospital beds, 75% (1990) were in the private sector. However, since government social insurance for the poor pays around 60 to 70 percent less than private insurance programmes, the private hospitals show little interest in treating this section of the population. The Brazilian bed to population ratio (Table 2) is better than the Latin American average of 2.5/1000 but is lower than the WHO standard of 5/1000.

Financing of Health Care

There are both public and private sources of health financing in Brazil. The private sources include individual households for personal health care (16.5%), employers' schemes (6.3%), private insurance (2.9%), trade unions (2.1%) and voluntary agencies (0.7%). It has already been pointed out that most of the medical care delivery is organised through the private sector but financed dominantly by public sector agencies. 72% of overall health expenditure in 1982 came from public funds. Public sources include the Federal government (primarily Ministry of Health), state and municipal governments. In 1982 the contribution of each of these in the total public health budget was 6.8%, 20.4% and 7.3% respectively.

This inverse relationship between private provision of medical care and public funding has been responsible for various distortions in the system. The culprit is largely seen to be the social security services. Says James Horn, "Social Security policies and expenditures have been the major factor increasing the privatization of medicine and the expansion of a ' medico-industrial complex' whose growth threatens to increase the gap between those covered by sophisticated technologies and those lacking even basic services".

Around 37% of the total health sector funds came from the INAMPS, the social security agency for medical care. This was the single largest source of finance. Some 80% of the total Federal government funds went into the social security system.

The INAMPS subsidizes services partially funded by the government, the employers' schemes and trade unions. Government agencies have increasingly turned to this institution as a source of financial help, on account of a chronic shortage of funds.

Unable to meet the demand for increasing coverage through its own resources, the INAMPS progressively turned to the private sector. A very large proportion of its funds were allocated to the purchase of medical care from private providers. In 1981, 71% of the INAMPS budget was spent on paying private providers for medical services and, as such, the thrust of this institution was towards curative care. (The rest of the funds went to INAMPS health units for services provided - mainly to out-patients - and to federal, state and municipal hospitals and health centres).

The INAMPS reliance on private practitioners, hospitals and medical enterprises nourished a lucrative private sector. Doctors and hospitals determined need and duration of hospitalization, surgery, tests and treatment. The reason is found in the mode of payment made under the scheme to private providers through their contractual arrangement with the institution. The INAMPS reimbursed a doctor a low flat fee for office calls, and a schedule of fees per unit of service, for tests and procedures. For example, in 1984 the consultation fee was even less than $ 1 (Cr$ 2100) per office call. This low remuneration for office calls encouraged physicians to order more tests on hospitalizations in order to enhance the amount of their own payment. Given the deficiencies of public hospitals, the private hospitals gained. In 1982, INAMPS thus financed about half of the out-patient care, two thirds of the laboratory tests, X-rays, specialized treatments and 90% of the hospital care provided by the private sector.

Excessive surgery has also been a common phenomenon. In 1980, one third of the deliveries compensated by INAMPS were caesarean. The caesarean rate in Brazil is perhaps the highest in the world and higher than normally accepted. There were 400,000 surgical deliveries in 1981.

Another distortion in Brazil's health care system is the highly technological orientation of medical services. In 1981 INAMPS paid Cr$ 22 billion or 6% of its budget to just 10,000 patients who had received kidney dialysis, coronary bypass surgery, or intensive care. It has been pointed out that these patients cost more than the Cr$ 19 billion spent the same year on all public health services and disease control for a target population of 40 million people. Most of the specialised services have thus been directed at a small elite population.

The expansion of social security medical care and increased privatization of services caused a relative reduction and progressive marginalization of the public health budget. Thus, the share of the Ministry of Health in the federal budget went down from 5.87% in 1960 to 1.31% in 1980. Besides, it was the public health sector which was most affected during the economic crisis of the 1970s and early 1980s. The government health sector had to curb most of its capital expenditure.

But not so the INAMPS. Robert Woodward points out that during this period of recession and international debt problems, Brazil was able to effectively maintain the funding of its health services. The real gain however, was of the INAMPS. By 1982, INAMPS medical budget was eight times higher than that of the Ministry of Health.

Is Social Insurance the Answer ?

The government made attempts at reforming the system. For example, in 1988, the government launched the National Programme of Basic Health Services (PREVSAUDE) which unfortunately died a quiet and early death. No amount of reorganisation and reorientation of the health services appear to have rectified the distortions and drawbacks of the Brazilian health system. Part of the problem lay in the overall socio-economic policies which ignored and neglected the impact these would have on health conditions and health care delivery.

The Brazilian case is a good example of how the mere existence of social insurance and large government funding do not necessarily lead to good and universal health care. The availability of funds and resources alone do not determine the quality of health care. But, the priorities and concerns of the government, as reflected in its policies, do. Policies should foremost reflect concern for proper management and equitable distribution of resources. Commitment to equity in health care arises out of a commitment to justice and fairness in the social and economic sphere. The true test of a government's political will lies in its ability to go beyond mere rhetoric to an uncompromised exercise of its commitment to the common good.

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SPREADING INFORMATION
Some Preliminary Results

Vasudha Joshi

In the literature on development one discerns a tendency to first look towards structural factors in terms of lack of resources, followed by social network, and then, individual/psychological explanations (such as presence or absence of innovativeness or fatalism) for identifying obstacles to development. There is also an inclination to attach prime importance to structural factors in the Third World setting and to discuss the social network and individual problems primarily in the context of the First World. The issue of access to information has accordingly been discussed more in the First World context.

The Perspective

To identify information as a factor that inhibits development is to assume that current behavior is poorly adapted to the prevailing environment. People do not know, so they do not act optimally. People do not know because information, which they can understand and act upon, has not reached them. Ensuring access to information should hence serve as the first step towards conscientising the poor and the underprivileged. This is an issue which has become very relevant to the Third World societies today.

This perspective forms a useful backdrop for evaluating the effectiveness of the various development and poverty removal programmes that have been launched in the country since the late '60s. The problem of 'leakage', which is acknowledged to bedevil all of them alike, may primarily be due to the lack of information among the potential beneficiaries about their entitlements and the modalities of these programmes.

Dissemination of information regarding these programmes has mostly taken place, so far, through the government machinery. Bureaucracies are not known for sensitivity to the problems of the disadvantaged. The secretive fashion of bureaucratic functioning results in mystification, while vested interests bring about systematic disinformation. This prevents community participation, which is essential for the effective implementation of these programmes and also for creating accountability in the implementing machinery.

The Project

FRCH decided to undertake a Public Information Project with the objective of gaining first-hand understanding of the effects of making information about government and other programes, facilities etc. available to the rural poor. Printed leaflets, in Marathi, regarding the Integrated Rural Development Programme (IRDP), Employment Guarantee Scheme (EGS) and the government health services were distributed in twenty villages in Pune and Ahmednagar districts. Different methods of communication were made use of to judge their relative effectiveness. To ensure credibility and acceptability, the pamphlets were circulated with the signatures of Padma Bhushan Shri Anna Hazare, the famous leader of Ralegan Siddhi, and Dr. R.C. Awasthi of FRCH. Hazare's association with this project was considered specially significant as the success of the Ralegan Siddhi experiment stemmed from the same basic premise of becoming aware of one's rights first and then asserting them collectively.

IRDP is the top-most development programme started by the government in 1980. It enables the poor to obtain, through bank loans, productive assets for generating a continuous flow of income in future. EGS is a well-known wage employment programme of Maharashtra State. It guarantees employment to the rural poor and has been in operation since 1974. Government health services provide facilities, in the form of health centres and health staff, for improving individual and community health.

IRDP and EGS entitle the poor to immediate monetary benefits while health services are designed for a more long-term impact. In the rural areas health is not a priority with people but illness is, specially when it interferes with their wage earning capacity. Even then, our experience is that no more than 4% to 8% of the illness cases come to the public health services. This is due to the poor opinion people universally have about their functioning. A more positive response to IRDP, EGS pamphlets was hence expected by us. Giving information about health services was thought to be more of an awareness-building exercise.

Implementation

Results from a pilot study that was first undertaken in 1990 in Purandar taluka (Pune district) were very encouraging. The study showed that people appreciated the information so much that they were willing to pay for it. Gram Panchayat officials unscupulously collected money for giving the pamphlets to them. Villagers also applied for IRDP loans in such large numbers that the officials could not cope with the work-load and advised us to go easy.

Apart from indicating a good deal of enthusiasm and receptivity among the villagers, the pilot study also threw light on the myriad difficulties they faced when they decided to act on the information and to get benefits to which they were entitled. A full-fledged project was then undertaken to give a better understanding of these difficulties and their impact on the villagers' behavior.

In this expanded study covering selected areas in Ahemdnagar and Pune districts, it was decided to distribute detailed printed pamphlets among the villagers. Pamphlets were prepared on the basis of information obtained in the concerned government offices. Rough drafts were shown to the officials for comments and correction. The emphasis was on simplicity and specificity. Specimen application/ request forms were included in the IRDP and EGS pamphlets.

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Field workers visited the villages several times and decided about the appropriate method of information dissemination. They went back to the villages after a gap of a month or two, to check the progress and observe the villagers' response.

Communication Methods and Impact

1) House to house distribution, so that pamphlets would reach the villagers without getting 'lost' in transit, and also to enable them to get their doubts clarified immediately.

2) Gram Sevak or Gram Panchayat attendant : Wherever they were found to take interest and initiative in the development programme they were requested to pass on the pamphlets to the villagers.

3) By post : In small villages the pamphlets were merely posted to each beneficiary to see the effectiveness of impersonal modes of communication.

4) Group meetings followed by pamphlet distribution : It was thought that discussions in the meetings would make the villagers receptive to the information in the pamphlets. Help from local youth clubs, Mahila Mandals was also taken for this purpose.

5) Posters, notice boards, wall writings : These were used to highlight selective information about the programmes. Posters and notice boards were placed at strategic points in the villages, including the ration shop, hotel, community hall *(chavdi)*, etc.

6) Through contact with school teachers, students of 8th and 9th standards were addressed on the government health services. Pamphlets were then distributed and the students were requested to read them out to their parents and elders in the family.

Distribution through post was quite effective in reaching the information to the villages. However group meetings followed by discussions had the greatest impact in initiating people to act. This underscores the importance of interpersonal media in introducing change. Distribution through gram panchayat functionaries was probably the least effective method, as in most of the cases, they were reluctant to pass on the information.

In a couple of villages however, newly elected sarpanches, in their initial enthusiasm, showed some interest in the project.

Progress and Findings

The villagers unanimously opined that the pamphlets contained comprehensive, useful information that was hitherto not available. They knew about all the three programmes but were uninformed about some vital operational details which prevented them from taking full advantage of them.

For example, many did not know whether their names were included in the list of households below poverty line, in order to avail of the benefits of IRDP. It was also generally not known that under IRDP one was entitled to a second or third "dose" of loan, provided the subsidy limit of Rs. 4000 had not been crossed by previous loans. As for EGS, most of them did not know that they could demand work as a matter of right and that the government was obliged to give them work. The application forms in the pamphlet were therefore highly appreciated. Information about where and for what reason complaints could be lodged was appreciated particularly in the case of health services.

The EGS pamphlets were particularly welcome as most of the villages were reeling under severe drought and the people badly needed employment. In Parner taluka, many villagers filled in the application forms but were skeptical about the possibility of really getting work. The Tehsildar, who was contacted for submitting the application forms, cynically maintained that people who applied for work rarely turned up regularly, once it started. He hence advised the field workers to make efforts to ensure regular attendance at work-sites. In spite of the large number of application forms and also letters written to the concerned officials, this year no work was started in the twenty villages till mid-May, by which time the worst was somehow over.

People also applied in large numbers for loans under IRDP. They had to contact the Gram Sevak or Talathi for this purpose and encountered many difficulties in doing so. In many villages the Gram Sevaks were mostly unavailable, as their visits were highly irregular. So, in Purandar taluka, complaints were made to the Sarpanch and through him the Gram Sevak was asked to be regular. In one village where the information was sent by post, prospective beneficiaries pressurised the Sarpanch and accompanied him to the Panchayat Samiti office to get a Gram Sevak appointed for the village, in order to process their loan applications. Being forced to visit these functionaries again and again for follow-up and paying "on-money" were the other obstacles mentioned by the villagers.

Some Gram Sevaks were openly dismayed by the increased work-load following the spate of applications. Bank officers, and in one case, even the Block Development Officer, advised the villagers to make fewer applications so that they could cope with the processing work.

There was a noticeable lack of enthusiasm among the villagers about the pamphlet on public health services. They, on the whole, preferred information that promised some monetary benefit to them. Inquiries with health visitors and attendants revealed that almost nobody came to them after reading the pamphlets. This also reflects the mood of disenchantment and cynicism that the villagers widely share about public health services.

The government nurse in one village in Purandar taluka requested the field worker not to distribute the pamphlets in the sub-centre village where she was posted, as she feared that the villagers would insist on her staying in the sub-centre village - a proposition highly inconvenient to her. At the same time, in another village, the CHV, after reading the pamphlet, successfully pressurised the government doctor to pay a monthly visit to the sub-centre. In one village, a written complaint was filed with the District Health Officer for holding Immunization Camps regularly in their hamlets. In another, the health services pamphlet was distributed among women at an Immunization Camp. They sat together and jointly read it out. In a subsequent camp, when the PHC functionaries tried to take money for the drugs supplied, these women refused to pay, saying that public health services were supposed to be free.

Potential for Action

All the villagers were well aware of the importance of information. They also understood that information would not reach them easily.

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FRCH PUBLICATION

STATE HEALTH EXPENDITURE: A Database
All India and the States (1951-1985)

Authors: Ravi Duggal, Sunil Nandraj, Sahana Shetty.

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BOOK REVIEW

Maya Parchure

Ideas about Illness : an intellectual and political history of medical sociology - *Uta Gerhardt*, Macmillan Education Ltd., London, 1989, pp. 425.

The emergence of modern medicine and our growing obsession with health, higher life expectancy, etc., are simultaneous events. Our personal suffering invariably finds expression in medical discourse, to get qualified as illness, which consequently acquires a social dimension. Medical sociology becomes privileged in theorising the idea of illness. Sociologists are engaged in locating the origins of illness in the doctor-patient dialogue or in social welfare politics, rather than in the immediate experience of pain. Medicine, with its claims to political neutrality and self-righteousness, becomes the first rate institution of social control, which clandestinely expands to other areas hitherto defined by religious or legal discourses. Uta Gerhardt traces the changing configurations of 'illness', generated and monopolized by medicine, through the range of sociological traditions. The tremendous documentary work brings out the evolution of sociological thought in relation to medical science and medical practice.

Illness as Social Role and Motivated Deviance

Truly speaking, health, rather than illness, plays a decisive role in the 'structural-functionalist paradigm'. Health indicates the basic condition for participating in the competitive world. Harmony, equality and democracy are symbolized alike, by the health-quality shared by the majority citizens. Illness is regarded as a minor, accidental phenomenon. Corrective interventions of medicine, propagating individual's social conformity, are considered only as secondary defenses.

The view that both the body and the society are organic in nature and that the doctor-patient relationship is an exact replica of the social system in minature, leaves a simpler task for the sociologists. They legitimize doctors, who in turn favour interests of the capitalists. Doctors' obligations to follow the highest possible standards of technical and scientific competence interfere with their loyalty to patients' welfare. The idea of a patient in this context includes an adult male worker in an organized sector, who has benefits of earned sick leave, insurance policies etc. In a reciprocal but hierarchial relationship between the doctor and the patient, illness is supposed to be generated from patient's anticipatory consent or from his unconscious motivation. Cure means annihilation of patients' disease consciousness, so that the patient resumes a role in a competitive society.

In this approach, illness becomes sociologically relevant only if the ill people enter into a sick-role. Anti-semitism in a fascist society does not qualify as an illness. The book argues that sociology serves the function of re-establishing the boundaries between healthy and sick, between normal and deviant. Structural-functionalist medical sociology was engaged in understanding Nazi prejudices as a disease. It has been criticized for sympathizing with the fascists, by way of medicalising the act of mass-murders.

Illness as Professional Construction

With the symbolic-interactionism, the hierarchies between the patients and the doctors, between the oppressed and the oppressors, become unclear. Uta Gerhardt remarks that interactionists relentlessly take sides with the oppressed classes to resist processes of exclusion in the society, and consequently fail to discuss the problem of social pathology altogether. Sociology, rather, becomes an 'ally of the welfare state', pushing the deviant into the mainstream. It takes a political stance on the side of patients, who succumb to the professional politics of medical and welfare service agencies, to acquire 'illness' and 'disability' labels. A person with a poor vision, when pronounced as blind by the ophthalmologist, suffers no longer from medical but social-psychological problems of adjusting to the new identity. For the harmfulness of such diagnosis, patients' right to challenge or negotiate the diagnosis and course of treatment becomes all important. The book argues that negotiability of diagnosis does not make medical knowledge a lesser truth.

Illness as Intersubjectively Constructed Reality

The doctor's responsibility for the patient's well-being explains the former's apparent dominance in medical encounter. Since illness becomes obvious only when help is sought, it seems no further appeals can be made. Even suicide is a matter of interpretation of the dead person's presumed behaviour. The sociologist, a stranger to the world of clinical reasoning, is obliged to assume perspective of a patient.

A phenomenologist cannot distinguish between a sick person and a criminal. The amount of responsibility attributed to the behaviour of the victim/convict (medical or judical) and available freedom are debated at length. The author suggests that criminology shoud be re-established outside the scope of medical sociology.

Illness as failure of resources and ideological construction

Medicine, as an instrument of social reform, has been expanding into areas of life beyond curative purposes (plastic surgery) and taboo areas (alcoholism, pregnancy) etc. Through unequal distribution of services it also serves an exclusionary function. It discourages people to enter into a sick role and encourages them to maintain work or family responsibilities, regardless of their personal sufferings. State interventions concerning health are said to serve the bourgeois' purposes.

Despite the virtually epidemic advancement in medicine, a vast amount of illness remains untreated. This has motivated the sociologists to focus on health rather than on medicine. After all professional terrorism of doctors and of sociologists, and the mundane patient politics, the sociological thought has come across a lay conception of treatment. Self-help movement, deprofessionalisation and demedicalisation of health care are the results.

Illness, now, refers indirectly to social inequality, exploitation etc. and directly to pollution, toxic wastes, unsafe goods and dangerous

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The reviewer above is involved in the FRCH study, "Health Expenditure and Investment in a District".

LIBRARY AUTOMATION
Its In-house applications

Usha Sethuraman

Library automation is no more a new concept. Libraries have been using computers to carry out different functions like accessioning, cataloguing, issuing and various aspects of documentation, to mention a few. Every library is a growing organism where innovation leads to change. It is not only the size which indicates growth, but also the documentation techniques and extent of dissemination. Our library and documentation unit has introduced changes and always adapted to them.

This article shares our experiences in introducing the method of continuous cataloguing using CDS/ISIS in the Library and Documentation unit at FRCH. Here we describe only the advantages and preliminary techniques for such automation. Subsequent articles would share other aspects concerning use of CDS/ISIS in libraries.

The Advantages of Automation

We started the creation of a database in 1989 using CDS/ISIS. Since then we have been learning this software package and have now introduced it for cataloguing also. There are various reasons for changing from a manual system to an automated system. The labour-intensive original cataloguing is eliminated. It reduces the chances of error or inconsistency and thereby produces standardized records. Of course, last, but not the least, it saves time and costs and takes care of staffing constraints. Using library automation enhances the in-house applications by improving library services and management. For example, it is a time consuming activity to prepare a bibliography from the manual system, as the librarian has to copy all the references over again from the catalogue cards. On the other hand, in a computerised system, the details of all entries which are on record are made only once and different outputs like an accession register, a bibliography, a catalogue card, a search, etc., can be printed out from such a master record.

Planning, Orientation and Adaptation

At the pre-planning stage of automating the cataloguing routine of the library, the assessing of the existing system is important. The fields like author, title, subject and the part statement are written over and again in the accession register, in a minimum of three catalogue cards : in the worksheet to enter in the database, in the book card, and finally in readers' issue books. Acclimatising and evaluating the library staff is an equally important aspect. New machinery requires fresh orientation. The staff should posses the capability of grasping the new technology and adapt to the resultant changes in their routine work.

At the planning stage the major task is to create the database. A field definition table (FDT) is where the fields are defined and a tag is assigned to each field. The nature of the field - numeric, alpha-numeric or alphabetical -is defined, along with the length of the field. The FDT should be created keeping in mind the indexing fields and the added entries.

The next step is to create the field select table(FST). In this table selected fields are assigned indexing techniques which will enable sorting and retrieval of records accordingly. The work-sheets and different formats are prepared to suit different outputs. For example, there is one format defined to print author cards. There are also subject cards and title cards prepared for both books and reprints. To take care of added entries the concerned field is sorted in the print work-sheet and printed through the author format. The print menu of the ISIS programme provides a worksheet and by choosing it with the combination of formats earlier defined, these cards are printed. The lines per page should number 18 so that the information fits into the 5" x 3" card. To edit before printing the catalogue cards, the output can be read through the DOS editor and changes can be carried out. We run the save file through a 'C' programme to eliminate the page break put by the ISIS programme.

While printing author cards, the author field is sorted alphabetically, followed by the titles. The subject cards and the title cards are similarly sorted. The task of filing thus becomes very easy, since the print-out is already sorted according to the filing order. User orientation is a very important factor because this will help optimise efficient use of an automated library system. This kind of library automation looks forward to networking, remote access and maximum utility.

The author is in charge of the Library and Documentation Unit at FRCH.

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Readers would be aware that FRCH operates on limited, time-bound grants. Therefore, to help make this newsletter a self-sustaining, long-term venture we request you to share in the production and postage costs.

Those of you who have made no contribution for more than a year, please fill the attached 'Friend of FRCH' form and send it to us, along with your contribution. If, however, you have made a contribution in the recent past, please pass on the form to others who may be interested in sharing information on health related issues.

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LIBRARY NEWS

Books

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services, rather than to individual's presumed behavior or confession. The dividing line between pathology and normality finally breaks down in a society where practically everyone is sick owing to the degenerated living conditions. The celebrated 'healing' powers of medicine then boil down to a 'cure' dogma.

At this point Uta Gerhardt warns the medical sociologists against the temptation of seeing themselves as better healers than medicine itself. She asserts that medical sociology should never attempt to overcome or replace medical practice. The author is doing exactly what she thinks sociologists should do; that is to keep the disciplinary boundaries of society or those of social sciences intact. The conventional history of medical sociology anticipates a drastic change in its scenario. The future focus would be 'the imminent world-wide epidemic of behavior-induced incurable diseases'.

The bibliography included in this scholarly work is very resourceful. It gives exhaustive references useful for research in critical theory, sociology, psychoanalysis, pathology and medical sociology.

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One villager quipped, " being informed is as good as holding power. So why should one who has information part with it? "

The villagers were quick in seizing the opportunities that information opened before them. Even in those cases where they decided not to make use of these opportunities, their behavior appeared to be rational. For instance, a villager did not want to file an application under IRDP as he felt that he would actually be better off without a loan, considering the cost of the time that would be required to chase the application.

It would appear that village communities do recognise information as an important resource. Just like other resources it is something to be acquired and guarded. Therefore persons with some authority are not willing to share their information with others.

Information is the first step towards the objective of empowering the disadvantaged. Information is necessary, but may not be sufficient for activating them. The structural barriers around the underprivileged are so strong that a substantial breakthrough may require collective action with a firm ideological direction and leadership. In spite of this over-riding limitation the positive implications and potential of taking the first step of information dissemination were judged to be significant in themselves. The pamphlets planned for the near future include those concerning Panchayati raj system and laws related to women.

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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CHILD LABOUR IN INDIA
Promises to Keep

Ingrid Mendonca

The Constitution of India, through various articles such as Article 45, Article 24, Article 39F, as well as the National Policy of Children, pledges a commitment to the welfare and protection of children against exploitation and harm. At the international level India has ratified 6 of the ILO conventions concerning the employment of children and young persons and is now in the process of ratifying the U.N. Convention on the Rights of the Child. One of the main obstacles to this process is that the U.N. Convention specifies that the minimum age for a child to start work is 18. Yet, the reality starkly belies these pledges. Many promises are yet to be kept ....

In India, many children start work at a very young age. Even children of a pre-primary school age can be seen working in cottage industries. Children sometimes work to pay debts incurred by their families, even those related to marriage of other children. While parents gain from children's employment, at home or outside, it remains unclear how much worse off the family would be if these children were in school. Children are universally recognised as the most important asset of any nation.

In developing countries like ours the problem of child labour in both urban and rural areas is principally one of poverty and unemployment, themselves a result of unequal distribution of land and production assets and low levels of development. Nearly half of India's population subsists below poverty line. The distribution of land is most iniquitous and economic compulsions weigh heavily on the consciousness of poor parents. They would thus not mind colluding with their children's employers in violating the law and putting their children under risks of inhuman exploitation.

Child Labour Laws : an overview

There has been a long history of legislation in order to regulate the employment of child labour. The Child Labour Regulation and Prohibition Act, 1986, is often criticised because the government of India has legalised child labour. The Act also places the responsibility of education and recreation on the owner, which is equivalent to asking the thief to guard the house. This enactment has to be seen as a culmination of the legislations relating to the employment of children since the pre-independence days. Many legislations since the 1930's banned the employment of children in certain industries. But these were neither enforced nor was any regulation laid down regarding the working conditions and wages of children in the industries where their employment was not prohibited. The 1986 Act bans the employment of children (those below 14 years) in specified 'hazardous' occupations and processes. Significantly, only a few industries where children are employed in a large way are notified under the Act as 'hazardous'. This Act further tries to regulate conditions of work of children and lays down enhanced penalties for their employment in violation of the provisions of the Act. It lays down a procedure to decide modifications to the Schedule of 'banned industries'. This Act also tries to arrive at a uniformity in the definition of 'child' in the related legislations.

The Employment of Children Act, 1938, already prohibited the employment of children in certain occupations which are considered hazardous and injurious to health. Prior to this, the Children (pledging of labour) Act, 1933, prohibited a parent or a guardian from making an agreement to pledge the labour of a child. The Factories Act, 1948, prohibits the employment of children below the age of 14 in factories and lays down certain conditions for the employment of children between 15 and 18 years. The Contract Regulation and Prohibition Act, 1970, lays down the permissible age for contract labour as 18 and above. Bidi and Cigar Workers (conditions of employment) Act, 1966, prohibits the employment of children in any industrial premises. The Act is however silent on the employment of children at their own houses. At the same time the Minimum Wages Act, 1948 provides that the minimum wages applicable to adolescents is three-fourth of the adult pay and to children two-thirds of it. These rates are decided by the State Governments and the above stipulations are applicable to Maharashtra only. The Bombay Shops and Establishments Act of 1948 prohibits children below the age of 12 years in any of those establishments covered under the Act - eg. hotels,'dhabas', juice bars. Employment of children in motor-transport undertaking is banned, by the Motor Transport Workers Act, 1961. Then there is the Apprentices Act of

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1961 which stipulates that a person shall not be qualified for being engaged as an apprentice in any designated trade unless he has completed 14 years of age. Employment of children has thus been a topic of concern in various labour welfare Acts. Yet, millions of children continue to work in extremely oppressive conditions.

Extent and Forms of Child Labour

India's 1981 Census Report shows that 13.6 million children were in employment. But the National Sample Survey of 1983 shows that the number of children in employment had increased to 17.6 million. As against these official figures, independent research organisations like Operations Research Group, Baroda and the Balai Data Bank of Manila claim that, the number of working children is 44 million and 100 million respectively. India has the largest number of child labour in the world.

TABLE 1
STATES WITH THE LARGEST NUMBER OF CHILD LABOURERS : (1981 CENSUS)

Name of the State	Figures in 000s
Andhra Pradesh	1754
Madhya Pradesh	1372
Maharashtra	1263
Uttar Pradesh	1246
Karnataka	966
Bihar	893
Tamilnadu	871
Rajasthan	589

Source: The Lawyers, Aug. 1988. p.13.

Though poverty is definitely the major cause of child labour, other countries like Bangladesh, Pakistan, Sri Lanka, Afghanistan, also having a similar socio-economic background, do not have such a large percentage of child workers. In India too the extended school system in high literacy states like Kerala, has helped to control, if not eradicate, the extent of child labour. The child work participation rate in Kerala was 1.9 percent as against the all India figure of 7.1 percent in the year 1981. The National Council of Educational Research and Training reported in a 1975 Survey that 82 percent of all children who entered primary school in Kerala completed the fifth grade as compared with 26 percent for India.

Despite this, neither the Indian State nor the parents seem committed to children's education. Part of the reason for this is that education does not provide the skills or assurance for employment and a better future. Employers preference for child workers as they constitute a cheap, productive and obedient labour force without the demands of adult unions is also another cause for the persistence of child labour.

Child Labour Intensive Industries

While large numbers of children ar employed in specific industries, the agricultural sector stands out as the biggest single employer of child labour in India. There are several other specific industries where child labour is prevalent.

TABLE 2
AREAS WHERE CHILD LABOUR IS MOST INTENSE

Sr. No.	Name of the Project Area	Name of the Industry	Estimated No. of child workers
1.	Sivakasi	Match & Fireworks	40-50,000
2.	Jaipur	Gem polishing	15,000
3.	Mirzapur	Carpet	50-60,000
4.	Ferozabad	Glass	4500
5.	Markapur	Slate	2000
6.	Moradabad	Brass	7500
7.	Mandsaur	Slate	500
8.	Aligarh	Lock	500

Source : Report of The Task Force on the Implementation of the 1986 Act, Constituted by The Central Advisory Board on Child Labour, Dec. 1989.

It is significant to note that while in the carpet industry, lock making industry and tanning, more boys are employed, more girls are found in the match factories. The bidi industry is another employer of a large number of children, mostly girls. Many of these girls work from their houses and share the family labour. Silk weaving is another major employer of children in South India. The furnaces used by the glass industry in Firozabad generate a heat between 700 degrees and 800 degrees centigrade in the pot variety. Children work around these furnaces and even carry balls of blazing glass and burning loams of glass stuck onto iron rods. Cottage industries like wood carving are no exception for employing children. In the agricultural sector children are found working as part of family labour and also as wage labour. Even instances of bonded child labour are often reported from different states. Brick kilns, stone crushers are other sectors where children are employed, in the rural areas. And in the urban centres children are found employed in market places as headload workers, helpers, vendors, etc. Rag picking and other odd jobs like shoe shining, cleaning of cars, scooters, vending of newspapers are other jobs which children do.

TABLE 3
PARTICIPATION OF CHILDREN IN THE WORK-FORCE BY SEX

	Total pop. (5-14 yrs)	Main Workers	Main & Marginal Workers	Child Work Participation Rate % Main	Marginal
RURAL (Total)				5.8	11.3
Males	72993	6681	7339	4.9	21.3
Females	66671	3506	5211	8.9	9.6
URBAN (Total)				2.1	5.0
Males	20446	732	757	1.8	5.9
Females	18942	246	281	4.6	4.6

Source : Report and tables based on 5 per cent Sample Data, Series 1, India, Part II, Special, Census of India, 1981, New Delhi, Registrar General and Census Commissioner, 1983.
***Note** : Figures in thousands.*

Many of these jobs are gender specific, with different ramifications for girls and boys. While boys largely work in hotels and tea stalls, girls constitute 70 percent of child workers in the weaving industry and 63 percent in the match making industry. Other major areas in which girl child labourers out-number boys are agriculture, rag picking, bidi-

making and construction sites. Cultural protection of girls, however, restricts their mobility, thus limiting their choice of work. This makes them vulnerable to underpayment, as compared to boys, for the same kind of work. While age-wise, girls enter the work-force earlier than boys, there is gross under-enumeration as the former's vast contribution to domestic labour is rarely accounted for.

Occupational Health Hazards

Occupational hazards may originate in the poor working environment or the vulnerability of children.

TABLE 4
HEALTH HAZARDS IN CHILD LABOUR INTENSIVE INDUSTRIES

S.No.	Occupation	Type of health hazard
1.	Bidi Industry	Chronic bronchitis & tuberculosis
2.	Glass Industry	Asthma, bronchitis, tuberculosis, eye defects
3.	Handloom Industry	Asthma, tuberculosis
4.	Zari & Embroidery	Eye defects
5.	Gem cutting and Diamond cutting	Eye defects
6.	Construction	Stunts the growth of the child
7.	Rag Picking	Tetanus and skin diseases.
8.	Pottery	Asthma, bronchitis, tuberculosis.
9.	Stone Quarries Slate Quarries	Silicosis

Source : Dingwaney et al., Children of Darkness, p13.

From the description above, it is obvious that works which are hazardous to any worker are certainly much more hazardous to vulnerable children.

Vishwapriya Iyengar, in her study on the match industry at Sivakasi writes that, "children mixing chemicals in the boiler get lungsful of toxic fumes, suffer high degrees of intense heat and run the risk of being badly injured in fire accidents. Children who stamp frames on the metal sheets also suffer heat, toxic fumes and excessive strain on the arms and shoulders which have to remove and place the heavy frames with great rapidity. Delay of a second can cause the entire frame to go up in roaring flames, causing instant death."

The Status Report on Child Labour, prepared by the National Institute of Occupational Health (NIOH), Ahmedabad, has this to say regarding the glass industry -- "In this industry there is a serious risk of physical injury, burn hazards, and exposure to silica containing dust." According to an NIOH study report there was a prevalence of 4.76% silicosis cases among 84 child workers studied in the batch house of a glass sheet factory.

The above are only a few illustrations amongst many. Sometimes the effect of risks exposed to are seen only much later and take a heavy toll on the child. Many succumb, while others suffer from a variety of diseases. Yet, hardly any attention is paid to the issue of occupational diseases.

Positions Concerning Child Labour

There are different positions regarding child labour. Banning of child labour and enforcement of free and compulsory education is proposed by Myron Weiner to be an approach to the problem in 'The Child and the State in India'. However many groups argue that banning of child labour is not practical, nor is it going to solve the problem. They predict that, children who are actually working will then be thrown out of their jobs with no other viable alternative. The socio-economic situation of their families will deteriorate because the earnings of the children, though meagre, are an important economic support to the families.

It appears however, that more than the need of the children, is the need of the industries which cause the employment of the children. Considering their meagre earnings, no substantial change occurs in the socio-economic status of the family if children are taken out of employment. On the contrary, the only significant change would be a fall in the profit margin of certain industries. Also, because the children are employed, adults remain unemployed. According to Dingwaney and others, there exists a link between child labour and adult unemployment. The all India average of unemployed persons is 9.21 million and that of child labour is 12.55 million. Similarly there also exists a link between child labour and people below poverty line.

Children cannot be allowed to wait for structural adjustments in the industry and the socio-economic milieu, nor can child labour be legislated away. Children need to be assisted to protect their own interests, by banning child labour or by ameliorating the conditions of the working child. The final goal of eradication of child labour has to be the focus of even rehabilitation and regulation programmes for working children. The process of development has to be designed to overcome unemployment and destitution. As child labour is embedded in poverty and unequal distribution, it is only through a sustained increase in standards of living that it will be abolished. Meanwhile, children are still working in extremely oppressive conditions, following the dictum 'all work and no play'. The promises of protecting the Rights of the Child made to her/him remain to be kept, yet.

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Convention on the Rights of the Child. Article 32.

States parties recognize the right of the child to be protected from economic exploitation and performing any work that is likely to be hazardous or to interfere with the child's education or to be harmful to the child's health or physical, mental, spiritual, moral or social development.

Source: The State of the World's Children, 1991, UNICEF, OUP 1991.

STREET SURVIVORS

Poornima Chikarmane

FREEDOM, IS BEING ABLE TO TAKE THE NEXT TRAIN TO SOMEWHERE : ENTERTAINMENT, IS THE PREMIER SHOW AT ALANKAR : WORK, IS DOING ANYTHING THAT WILL PUT MONEY IN THEIR POCKETS : JOY, IS GIGGLING AT DISNEY CARTOONS SHOWN ON THE PLATFORM TELEVISION : FEAR IS THE POLICEMAN FROWNING IN THEIR DIRECTION : TRAGEDY, IS BEING CONFINED IN THE REMAND HOME : FRIENDSHIP, IS SHARING FOOD WITH EACH OTHER : CARING, IS BUYING CROCIN FOR A SICK FRIEND ..... HUMILIATION, IS BEING SHOOED AWAY BY THE LIKES OF US.

THE TRANSIENT SHADOWS

The above encapsulates the life of what are called 'the Children of the Street'.

The Phenomenon

Street children are a growing phenomenon in most countries of the world. In countries of the developing world such as Brazil, the Phillipines, Pakistan, Bangladesh and India, an interplay of complex structural factors account for the increasing numbers.

Various theories have been propounded to explain the existence of street children. Unprecedented industrialisation and urbanisation have led to widespread migration from rural to urban areas.

The layman's perception of migration in terms of the lure of the city's glamour has little substance. The role of the 'pull factor' is limited and proves inadequate for explaining the phenomenon. Recent studies on employment trends have shown increasing rates of underemployment among poor urban dwellers. Consequently, galloping inflation pushes children and women to seek low skilled, low wage employment.

Economic reasons apart, large numbers of children take to the streets on account of family disintegration and violence. They feel ill-equipped to cope with desertion or harassment and the street provides the only means of escape.The problem of street children cannot be explained merely in socio-cultural terms either. It is neither aimlessness nor delinquency but primarily existential in nature. For the street child, the street is, above all, a means of survival.

Determining the exclusivity of street children has proven difficult. Yet, it is acknowledged that they are a distinct group with specific distinguishing features and special needs. For operational purposes, UNICEF has attempted to classify them on the basis of the nature of shelter and extent of family contact.

Children of the street, live and work on the street. They have families with whom they maintain irregular contact. They seek shelter, food and companionship on the street.

Abandoned children are part of the above group; but these have severed all ties with their biological families and are therefore the most vulnerable. Children on the street are those who spend long hours working on the street but return to their families every night. These, who are primarily working children, comprise the largest group.

Extent and Living Conditions

It is estimated that there are between 50,000 and 1,00,000 street children in every metropolitan city. In Bombay alone there are said to be over a lakh of them. Global estimates by UNICEF about six years ago placed the figure at 6 million, most of them in the countries of the South.

Street children are, more than anything else, little labourers, part of the mass of the unorganised informal sector which supports the urban economy. They are seen at railway stations, bus stands, in public parks, engaged in polishing shoes, sweeping, petty vending and rag picking. Their work is invisible, underpaid and unrecognised.

Situational analyses of street children in six major Indian cities were commissioned by UNICEF. They revealed significant aspects of the life styles of the children. The average age ranged between 8 to 16 years. Boys outnumbered girls, probably because the street life is more harsh on girls. About three-fourths of the street children in Bombay city were found to be working; over half of them were self-employed. Thirty eight percent of them earned less than Rs. 400 per month. Most working street children reported a 10-12 hour working day.

Contrary to popular belief, the UNICEF studies also revealed that most street children (74 percent in Bombay) have regular contact with their families. Fifty four percent of those interviewed had never been enrolled in school.

Lack of access to adequate recreational facilities makes street children avid film-goers. Gambling and reading pornographic and pulp literature are some of their other pastimes. This leads them into various forms of sexual experimentation, including homosexuality and visiting prostitutes.

Street children are especially vulnerable when they fall ill. Characterised by qualitatively and quantitatively inadequate food intake, their health and nutrition status is poor. Inadequate access to medical care compounds the problem.

Public perception of street children is that they are thieves and indulge in delinquent behaviour. That there is little substance in this has been shown by a study in Madras, where only 12 out of a sample of 1662 children had committed offences such as drug peddling, robbery and theft. The biggest threat, as perceived by street children, comes from the police. Bound by the framework of the law, the police regularly round up children from public places. Beating, collecting caution money, getting them to do petty jobs under duress and using them as informers are other forms of harassment.

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The Law and Other Institutions

Street children are governed by the Juvenile Justice Act of 1986 (JJ Act), which states that 'the state shall provide for institutional care for neglected, destitute, delinquent and vagrant juveniles'. The word 'juvenile' itself is interpreted differently by different Acts. While the term implies a boy under the age of 16 years and a girl under the age of 18 years under the JJ Act, the Child Labour Restraint and Regulation Act mentions 14 years as the cut-off point. This means that large numbers of street children aged between 14 and 16 years have to exist in ambiguity.

Further, institutionalisation as the sole option for street children, needs to be reviewed in the light of emerging evidence. Only very young street children and those who have been on the streets for short periods of time take kindly to Remand / Observation homes. Most street children do not like the strict regimentation, lack-lustre existence and the harassment by institution staff. Identifying a means of escape becomes their pet preoccupation.

According to the law, the Remand Home authorities have to trace the parents within six months. However, this rarely happens and children are known to languish in the Home for periods ranging from 2-3 years.

Moreover, the absorption capacity of the state Homes is much less than the number of street children. The cost benefit analysis of institutionalisation also shows that it is expensive and requires an elaborate infrastructure. In this context, Shashi Mishra, former secretary, Social Welfare, Government of Maharashtra, has eloquently advocated a quasi-institutional model, where children have access to basic services on the streets.

Such creative initiatives on the part of the state are called for. Provision of non-institutional services for street children seems to be a promising alternative -- it is need specific, caters to a wider population and is cost-effective. NGOs have taken the lead in this regard in most metropolitan cities.

Work With Street Children : approaches

NGO intervention with street children covers a wide range of approaches. The first agency to start work was Sneh Sadan (Bombay), which promoted the idea of open institutions. The inherent limitations of institutional care resulted in experiments with non-institutional programmes. Certain NGOs provide street children with shelter, educational, health, nutritional, recreational, vocational and other services. Others have organised street children to articulate their demands and represent them to decision makers and urban planners. Most use a combination of the two approaches, while varying the emphasis. Almost all NGOs working with street children intercede with the police, the railway authorities and the juvenile justice system on the issues of these children.

The Coordination Committee for Vulnerable Children (CCVC), is the Bombay based forum of NGOs working with street children. It has made some breakthrough in coordinating city level action for street children with active support from Ms Mishra. Geographical zoning of the city and NGOs, establishment of contact centres for street children at key locations and effective liaising with the police are some of the elements. Similar fora also exist in other metropolitan cities. The National NGO Forum for Street and Working Children attempts to coordinate efforts nationwide.

These concerted attempts have been brought to fruition in the form of a recently announced central government, UNICEF aided scheme specially designed for street and working children. It is scheduled to be implemented, in phases, in the Eighth Five Year Plan. The first phase covers six major Indian cities. The scheme provides for non-institutional programmes for street children.

Radical Initiatives Needed

Notwithstanding the individual and collective efforts of NGOs, the fact remains that they will make only a marginal difference to the existence of street children. Substantive change will occur only if the NGOs are able to promote organisations of street children themselves, to collectively seek fulfillment of their rights as children. Experiences of such organisations in Brazil and the Phillipines have shown that 'a shout in the mountains has been known to cause an avalanche' - politically and socially aware, street children have demanded and got a greater slice of the cake.

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CHILDREN OF A LESSER GOD

Asha Vadair

We are Children of a lesser God,
That is what the world proves today,
We have no roof, we have no floor
We are alone today.
We know all about wars,
And all about crimes,
But when asked what a school is like
We have no answer at all.
We know we too can work,
We know we can be sold,
We know how it is to starve,
But we know nothing about love.
People come, ask and go,
They pity us for our state you know,
But beyond solace nothing we get,
Not even a piece of Bread --
We want to laugh,
We want to play,
We want a mother who will care --
Tell us, is there a mother available
Tell us if we can buy --
Not with money or influence, but,
With true love which is very rare .
Tell us! Oh! Pray! Tell us!

CHILD WELFARE SCHEMES
a critique

Audrey Ferreira

The well being of children, especially the socially and economically disadvantaged, is one of the most critical problems facing developing countries today. In India, although there are a number of Voluntary Agencies working in this sector the Government response is of crucial importance because of the magnitude and complexity of the problem. This article will therefore focus on the relevant schemes of the Social Welfare Department (SWD) with special reference to Maharashtra.

Classification of Schemes

The physical and social environment plays a pivotal role in the development of the child. Hence a useful criterion for classification would be the relation to the environment in which the child is growing up. Besides providing a comprehensive context and meaning to child development, it also indicates the directions of change in the approaches and strategies of programmes for children. Essentially this consists in the realisation that the best environment for a child is a healthy family situation. The most effective schemes would be those that help the child within its own environment. Often this implies impacting the environment itself, either at the level of the family or of the neighbourhood. Where this is not possible, efforts today are towards providing "quasi-family" conditions even in an institutional setting.The SWD schemes can be divided into three kinds :

1) **Replacing the Environment** for vulnerable children. This includes programmes like Foster Care, Institutions like Orphanages, Bal Grams, Remand Homes and Certified Schools.
2) **Helping the Child but leaving the environment as it is**. This is through Child Guidance Clinics, Balwadis, etc.
3) **Changing the Child and its Environment.** Often the environment itself has to be transformed so that it becomes conducive to the all round development of the child. This is the underlying premise of the Integrated Child Development Scheme (ICDS) which, in urban areas like Pune, comes under the purview of the SWD.

This article focusses on the first and third strategies. The first is important because it deals with the most vulnerable, who need the greatest attention. The hird strategy is the one with the greatest pay-off in the long run.

A Substitute Environment for Vulnerable Children

** Foster care*

In conditions where it becomes necessary to remove a child from a harmful situation for any extended period of time, this is perhaps the best alternative, since it provides the child with the nearest substitute to home life. At present this scheme is being run by three institutions. These are the Family Service Centre, the Maharashtra State Womens' Council, Bombay, and the Vidarbha Maharaj Sewa Mandal, Amravati. As yet, relatively few children benefit from this scheme. The main problem is to find families who are properly motivated and who have the necessary background and skills to handle problems that may arise because of the troubled pasts of these children.

** Orphanages/Bal Sadans*

The SWD has the facility to house over a thousand children in the Institutions it runs or aids.

Orphanages	19	Beneficiaries	455
Bal Sadans	55	Beneficiaries	622

The Bal Sadans are an effort to minimise the negative effect of traditional style orphanages by providing a form of living closer to that of a family. About ten children live under the care of a foster mother in an independent unit. Often, however, these are centralised into a Bal Gram consisting of 18-20 Bal Sadans. This, of course, could lead to a loss of the intimacy that is found in the smaller operating units, yet maybe the most practical option available today.

** Remand Homes / Certified Schools*

Children who come under the purview of the Courts are first placed under observation in a Remand Home, after which they are either released or committed to a Certified School. About 15% of the boys are hardcore criminals. Though the Juvenile Justice Act of 1986 explicitly requires two parallel streams for such offenders and for non-offenders, from custody to commitment, as yet there are no separate residential institutions. The entire structure is thus geared to the presence of the offenders, with adverse impact on the other 'innocent' children.

The Integrated Child Development Scheme (ICDS)

The ICDS was set up as a result of the 1975 National Policy for Children. This scheme has been acclaimed as one of the biggest and most successful of its type anywhere in the developing world and, in 1991, was awarded the Ligouris International Technology for Development Prize in the field of nutrition and children's health.

The ICDS seeks a two-fold integration :

1) Sectoral integration of various programmes in education, health and nutrition.
2) Integration with local communities where people's participation leads eventually to community management.

Operationally the key person is the Anganwadi Worker (AW) who actually implements the programme elements and provides the interface with the community. Initially she was a woman from the local community

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and her role was that of an Extension Worker. In the original concept, her success was to be measured by the quality of her interaction with the people and her ability to motivate the community. However in the actual implementation, the emphasis has shifted from community dynamics to administrative efficiency. The AW, overburdened with paper work, (each AW has to maintain 16-18 separate registers) has neither the time nor the incentive to interact effectively with the community, since this is not something that can be quantified in a way that meets bureaucratic reporting requirements. The ICDS, though well conceptualised, has been so bogged down by bureaucratic procedures, that it does not have the flexibility to adapt to local needs and conditions. This is partly a consequence of the funding linkages which require detailed but purely quantitative monitoring procedures. It is also due to the inherent characteristic of government functional style.

Need for a Human Face

The greatest need in the SWD Schemes is to provide a more 'human face' to its welfare programmes. This could perhaps only be achieved through a more effective collaboration of the SWD with Voluntary agencies (VAs). The existing attitude is primarily one of a paymaster, with the tendency to pull the VAs into its own bureaucratic mould. What is needed is a strategy by which the VA's forte of genuine involvement with the local community can be symbiotically integrated with the SWD schemes, thus revitalising them, while maintaining the state-wide scope of the programmes. The VAs, on the other hand, must take on the role of catalysts to enhance peoples' participation in the Departmental schemes, without themselves losing their specific rationale as VAs. One important initiative in this area has been the involvement of the SWD in Pune in a Network of NGOs called "Action For The Rights of the Child" (ARC). Such, and other joint endeavours, could result not only in improving the operational aspects of the schemes but could also influence the entire policy in this field.

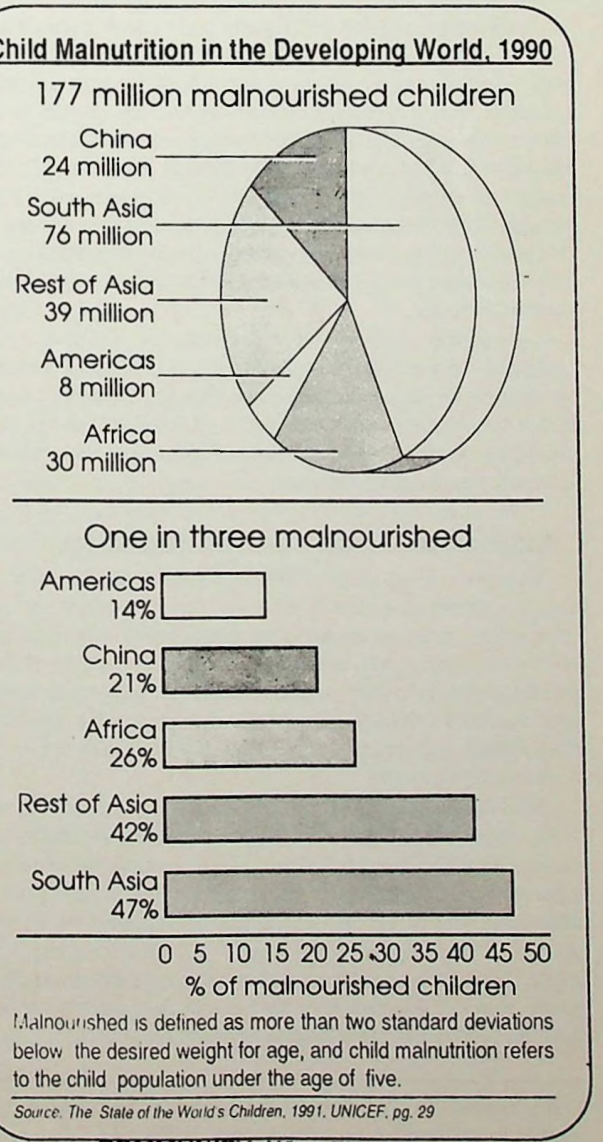
Specific Recommendations

More specifically there are certain areas of concern that need to be tackled on a priority basis.

* Much greater attention needs to be paid to the emotional needs of institutionalised children. Apart from being physically deprived, these have been often psychologically battered and the present structures to provide them psychological help are woefully inadequate. The Counselling and Therapy structures need to be radically improved and integrated into the day-to-day functioning of the institutions. Here too non-government resources could be effectively tapped through VAs in order to take advantage of the vast fund of knowledge and expertise available in the bigger cities.
* Another area of concern is the future of these children after they "graduate" from institutions. The trauma associated with such a transition is well-established. But very little is known in India about their adjustment, once they leave. The problems are both economic and social. They are given some kind of technical training to put them on a sound economic footing. The system however needs to be seriously evaluated in terms of effectiveness and utility in securing employment, etc.
* Institutional life can also be a great handicap to learning to live a normal family life. The institutions need to prepare the children for this, during the latter stages of their stay, with special programmes. The actual transition must be supported through Half-Way Homes, both for those who do have families to return to and those who have to strike out on their own. Existing structures are very limited with regard to the number of children that can be accommodated, as well as the kind of services that are provided. At present only Bombay and Kolhapur have such facilities. These cater to only a fraction of the total number of institutionalised children.

The Social Welfare Schemes for children, despite many positive aspects, still fall short, quantitatively as well as qualitatively. Budgetary limitations are, of course, one of the casual actors. But this is only indicative of a deeper malaise-a lack of awareness of real priorities and little political will to make hard options in the long term interests of the people. One can only marvel at the short-sightedness of a policy which, while reducing the welfare budget in the last allocation by 20%, increased the scope of the activities of SWD. A diversion of just 0.5% of the defence budget would make a difference of life and death to millions of children, who, in the last analysis, are the greatest natural resource that the country possesses.

Child Malnutrition in the Developing World, 1990



Malnourished is defined as more than two standard deviations below the desired weight for age, and child malnutrition refers to the child population under the age of five.

Source: The State of the World's Children, 1991. UNICEF, pg. 29

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FOSTER FAMILY CARE
A Substitute Home

Vinita Phatak

Parenthood is an experience that most couples look forward to. It is however not possible for all couples to have a biological child. On the other hand, there are babies who became destitute because their biological parents were unable to take care of them. It was for the care of such family-deprived babies that the Society of Friends of Sasoon Hospital (SOFOSH) set up a Child Care Centre called "Shreevatsa", meaning Children of God. Since its inception in 1973, Shreevatsa has provided a home for many babies who are victims of the unfortunate circumstances in which their birth parents found themselves.

Shreevatsa worked as a Remand Home for babies brought in by the Police, after they had been retrieved from harsh situations, babies relinquished by unwed mothers, as well as babies of patients admitted to Sasoon General Hospital, for short term crisis care. In every case the Social Workers at SOFOSH worked for their permanent rehabilitation. However the most immediate problem faced by the young child is the question of survival itself. Shreevatsa's Child Care Centre has a competent staff of nurses, helpers, ayahs, social workers, doctors, etc. But, in a group care situation the child is deprived of the most important ingredients of survival — the closeness and continuous watchful care of its very own family.

The concept of Foster Family Care has been developed in many countries in the world to provide a child deprived of its natural caretakers an alternate family known as a Foster Family. Such foster parents nurture the child within their own family unit, for a short period, till the institution works out its permanent rehabilitation, whether by restoration to its birth parents, or by adoption.

Adoption and Foster Care : the beginnings

With the lodging of these destitute babies taken care of, the question facing the Social Workers was to arrange for their rehabilitation. Adoption was felt to be the ideal answer to a mutual need for children permanently deprived of birth families and for childless couples longing for a baby, or parents wanting to add to their families, through adoption. Thus, in 1974, the Adoption Programme was started. Many children and adoptive families found a new meaning to their lives through this programme.

The Foster Family Care Programme prior to adoption was started in 1979. In the early stages of the programme the foster families were geographically scattered. This meant practical difficulties for supervision and monitoring as well as carrying out needed services. After some search and discussions a Foster Family Care unit was established in the campus of the Seventh Day Adventist Mission. The suggestion and invaluable assistance to start such a unit came from Ms Elionar Hetke, a volunteer from the Seventh Day Adventist Mission itself. Since a number of the foster family members would be housed on one campus, the supervision and monitoring of the programme would be very convenient. A group of foster families in the Seventh Day Adventist Mission was selected. The criteria defined for selection included the family constellation, family atmosphere, marriage stability, health and hygiene of the home. A home study of each family was conducted by the Social Workers of SOFOSH to ascertain all these points. After the selection, these families were then trained in Child Care - eg : feeding, bathing of children, first aid, knowledge of drugs and their administration. At the moment there are a total of 20 such families enrolled with SOFOSH. The babies put in their care are mainly new born babies relinquished by their birth-parents and sometimes babies in need of special care.

Organising the Programme : pains and pleasures

The financial input for this programme comes from SOFOSH. Apart from the daily allowance to the family, it includes all expenses to cover the physical, medical and transport costs needed in caring for the baby. Families looking after premature babies are given a special allowance for the extra care given. Besides the financial incentives, social activities and other schemes are devised to provide encouragement to the foster families.

The programme is monitored and overviewed by a trained social worker. Under her are two supervisors who maintain the health files and distribute supplies, medicines and clothes for the children. Over the years each foster family has nurtured and looked after hundreds of babies. They have watched a majority of these children going into their very own adoptive families. Each child's departure is a bitter sweet experience for the foster family, as they go through the invariable separation pangs, yet are happy to see their babies go into homes of their own. Sometimes, inspite of all efforts and their love, they have witnessed with sorrow the deaths of some babies for whom the efforts at survival proved very difficult.

Among the families there are some who have, over the years, displayed greater capacity to look after 'special needs children'. So children who might be premature or have chronic and serious health problems or genetic disorders like heart problems, cleft palate, etc., are placed in such families.

Being a foster mother is a full time job, requiring tremendous energy and motivation. Besides looking after her own children, a foster mother's day is full of nappy changes, boiling of bottles, washing of clothes, preparing feeds and feeding the babies. Sometimes a foster mother might have two or three babies to look after. So, as soon as she is through with one baby's routine, she may just be starting with the other. Sometimes, besides the normal chores, a sick baby may require an emergency rush to the doctor at an unseemly hour.

In any foster family, it is not just the foster parents, but also their children, who are involved very actively in looking after the babies. An

contd. on page 12

The author is the professional social worker handling matters related to foster care and adoption at SOFOSH.

COMMENT :
SPECIAL ISSUE ON THE HANDICAPABLE

Ms. Gladys S. Kothavala, Trustee, AWHM, Maharashtra, writes:

Thank you for devoting your March-April 1992, issue to the four major handicaps which handicap children and adults.

I have a little experience with the institution to which Mrs. Arnie Antia refers in her article. This school not only promotes the welfare of physically handicapped (orthopedically) children of an income level which needs the most help, but also it imparts learning on a sound educational basis. This is the work of dedicated volunteers and motivated personnel.

Job training and job placement — even in this group — require considerable effort by social workers and these handicapped workers have to compete in the same job market as non handicapped workers.

Based on my experience with the mentally handicapped, I commend the article by Ms. N. Rao. She quite rightly states that the blame is usually focussed on the mother and the majority of doctors have little knowledge and offer very poor advice.

The birth of a retarded child into a family of vocational or educational aspirations is a disaster. One can hardly blame parents for wishing to find an institution as far away as possible!

In the rural areas, the majority of the persons of lower mental ability can perform the tasks expected of them more satisfactorily. Therefore the IQ factor is not so important. It is in the urban areas where a lower mental ability stands out.

I think this is one reason that schools and training centres have grown in numbers in those states with large urban centers.

Although the number of facilities is greater than the chart on page 11 indicates, we must ask whether the quality of the institutions has improved as much as the quantity! It is a fact the best schools , etc., are run by parents , NGO's, including religious groups, not by the Government. We also ask about the quality of training in the teacher-training institutions.

Integration is another matter. A study, (published by TISS, Bombay) indicated that the government's proposal for the integration of the handicapped into schools was possible except for MR children. Crowded classrooms, high pupil-teacher ratio, and a marks-oriented system do not benefit the mentally handicapped. Social integration is also difficult. It works to a degree at the pre-school level and among older groups but becomes a problem at the school age, teenage and young adult level.

"Open employment" is much talked about. If we look at the cases where this has worked to a degree, we see that the person involved was marginally handicapped or very mildly handicapped. This is the majority of the MR persons in this country. They do not come to our attention very often as they can be absorbed into the average social and family situations.

We have in the school — and in the greatest problem to parents — the more severely handicapped who can be educated in some academic skills and who can be trained for social acceptance and for supervised work. This is best done in organised workshops and special schools — in other words, institutions. And their future living requires supervision, so there is a need for adult residential facilities.

To place these people in an open employment requires such an expenditure of professional time and energy and financial cost, that I do not think that it is feasible in India at this time.

The Association for Persons with a Mental Handicap in Maharashtra (AWHM) is studying the effects of early intervention in its clinics (handicapped children or children-at-risk aged 0-3 years). We are not sure which treatments are better or what benefits carry into the school years. But we do know that the clinics with their counseling and their treatments are of immense moral support to mothers.

It is parents who must organise and rise up for the welfare of the mentally retarded. It helps to be financially well-of and to have the benefit of a good special school and workshop. But the most important factor and need in the life of a retarded child is a good mother and a good father.

If I see a mentally retarded child or adult — whatever his economic level — urban or rural — who keeps busy (workshop, family circle, business, home) and who is socially acceptable in his family circle and in public, I know he has received good training from devoted, intelligent,disciplined and consistent parents. Such parents are hard to find. In India, discipline of children by parents is not easily practised.

These remarks merely supplement the article in your Newsletter. I was inspired to write to you because of my pleasure in seeing your issue on the interests and problems of handicapped people.

Year 2000 goals

Child Health:

* The eradication of Polio.
* The elimination of neonatal tetanus (by 1995).
* A 90% reduction in measles cases and a 95% reduction in measles deaths, compared to pre-immunization levels.
* Achievement and maintenance of at least 90% immunization coverage of one-year-old children and universal tetanus immunization for women in the childbearing years.
* A halving of child deaths caused by diarrhoeal diseases.
* A one third reduction in child deaths caused by acute respiratory infections.
* The elimination of Guinea worm disease.

Source: The State of the World's Children , 1992, UNICEF, pg. 61.

BOOK REVIEW

Roopashri Sinha

Working Paper of the 1st International Seminar Workshop on Children in Crisis, Nov. 27 Dec. 10, 1989, Protacio - Marcelino Elizabeth (Ed.) Children's Rehabilitation Centre, 5-B - Escaler, St. Loyola Heights, Quezon City, Phillipines, March 1991, Pgs. 257.

This book is dedicated to "our children and our children's children. May they find hope and peace in the future". A fervent prayer from sane minded humans in a world with increasing man-made disasters like wars, genocides, coups, foreign debt pressures, dictatorial and repressive regimes, racism, deprivation and degradation of earth. All these cause loss of physical and psychological damages. A world full of such organised violence is a frightening place for children who have faced it directly and indirectly.

The book is an attempt at focussing on the issue of human rights violations on children. It was brought out one year after the First International Conference on Children in Crisis and has a compilation of its proceedings and working papers. It collates and analyses the researches done in a few countries. The research is aimed at understanding the mechanism of organised violence and its impact on children and the effect of intervention programmes. The need to disseminate these findings in the widest possible manner and to create an awareness of the situation of children in crisis seems uppermost in the minds of participants.

The book contains six parts, out of which four are given to elaboration on research and action strategies. Part II consists of attempts at building a framework for national and multi-cultural research on the impact of human rights violations on children. It examines the scope of ensuing problems to a shared approach on aspects such as monitoring, assessment, diagnosis and intervention and treatment strategies. Parts III and IV consist of pilot studies done in the Phillipines and Denmark, while Part V elaborates on insights gained from various researches on children in crisis. The pilot studies are done with a participatory research perspective wherein the subjects - children and parents - are involved in seeking answers and new questions in the research process, thus making it a therapeutic and liberating process.

These studies have made use of descriptive, correlational, quasi-experimental research designs. They draw out the types of exposures to armed conflicts, the socio-cultural, economic and intellectual dislocation of the child and the family, the psychological and emotional effects on the child, the expressed needs of the child, the usefulness of community-based rehabilitation programmes. The Danish study takes on two more aspects of research - (i) to evaluate the validity of the examination methods in the context of different cultural backgrounds and (ii) to find suitable tools for improved diagnostics, with the aim of giving better treatment.

The reviewer is a researcher with the School Health Education Project of FRCH.

There are approximately fifty pages given to research methods, tools and tests. The need to formulate a common multicultural research framework makes it necessary, albeit an uphill task, to combine knowledge and research skills from various disciplines like social paediatrics, psychiatry, physiotherapy, psychology, sociology, social work and epidemiology. All this information leaves one quite dizzy but also arouses interest regarding their applicability and effectivity.

The ethics and sensitivity required to do such research come out in various chapters.

The annonated bibliography in Part IV reflects the thrust of researches done so far. This includes effects of war, evacuations, imprisonment, disappearance, violent death and exile of parents on their children. There are new explorations in the area of battered, maladjusted, sexually abused children, as well as Child Labour Research in learning of new behaviours and values by affected children. In order to cope with stress and trauma, the postulating of post-traumatic stress syndrome, intervention strategies and their efficiency have been done mainly in the recent past, in a period of 45-50 years. The reference to some pioneering research studies makes one want to rush up to a reference library.

An important section is the one giving country reports from Third World countries like Argentina, Pakistan, Phillipines and Greece and developed countries like Denmark, France, USA and South Africa. These country reports try to put their studies in the context of socio-cultural, economic, political and historical realities. In developing countries, the situation of human rights violations has not improved inspite of newly elected and so called democratic leaderships. There are economic and political pressures from inside and outside and lack of political will. The support of super powers like the USA and (former) USSR to dictatorship in Argentina, is only one glaring example of political malaise in the present world order. The pattern of repression and violence in all deprived, backward and semi-feudal societies is more or less the same. The Phillipine study records the situation of affected children in 1988 (Aquino regime) as :-

- 3,800,000 children suffering from forced displacement
- 1,44,000 children of political detenus
- 4681 children exposed to massacres or summary executions in their communities
- 1,38,600 children orphaned by disappearance or killing of parents.

While, on the one hand, these societies want and love children, the insensitive social system encourages rampant infringement and neglect of their basic rights (education, protection, health,) with impunity. The plight of child labour, child prostitutes, homeless, abandoned, street children, helpless victims of violence within domestic walls, need as much redressal as children affected by armed conflict in the outside world.

The developed country reports show work done with children of political refugees and asylum seekers from eastern Europe, Asia and South America. There is also a reference to stress factors emanating from lower socio-economic status and crumbling family structures, violence, abuse and battering in the family. In the case of South Africa, children's racial classification affects their lives, surroundings, the level of stress and the trauma of violence.

One should however honestly bring out the fact that human rights violations are prevalent even in developed countries. Amnesty International had recently chastised the U.S.A. for human rights abuse in three areas -

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ON THE RHETORIC OF PLANS
Pledges and Action

Shirish Kavadi

The second SAARC conference on children (Colombo, September 18-19, 1992) reiterated the commitments of the First World Summit on Children (1990) and the National Action Plans of the seven member nations.

The goals enunciated for children's welfare pertain primarily to their health, nutrition, education and social conditions. Strategies focus on increased resource mobilization and greater community participation. The working group on poverty reduction however expressed apprehensions that the structural adjustment process within most South Asian economies was likely to hinder the achievement of these goals. The group considered effective poverty reduction policies as imperative for speedier poverty alleviation and real improvement in children's lives.

The Colombo declaration suggested an alternative development strategy be considered to ensure human development. Children's welfare would be central to this strategy. However the proposition contradicts the ground reality. The current shift to free market economies indicates acceptance of the conventional economic model of development. By bowing to the dictates of multilateral funding agencies the governments have foreclosed any option for evolving an alternative development strategy.

It would seem that the emphasis on linking economic development with child welfare attempts to legitimise inadequate state initiatives. Professor Myron Weiner, in "The Child and the State in India" (1991), explains India's failure in child welfare as based, not in economic backwardness and mass poverty, but in the belief systems and interests of those in power. Weiner argues for compulsory education through legal enforcement of school attendance as the most effective method to remove children from the work-force. He observes, "Compulsory education laws usually precede child labour laws, and their enforcement substantially reduces or eliminates child labour". He rejects the argument that the elimination of mass poverty and a guaranteed basic livelihood are pre-requisites of compulsory education, as it has no basis in either past or current experience.

Through historical and comparative analysis Weiner shows the contribution of compulsory education to modernisation and the process of change. According to others, education, besides raising the capabilities and welfare of its beneficiaries, also has a positive impact on health, mortality, fertility and family life.

The Executive Director of UNICEF endorses the view that for economic progress, population control and children's health and well-being, a basic condition is education. In South Asia, Sri Lanka has experienced the gains of such a policy. Bangladesh has a national literacy programme focussing on primary education. In India, the Kerala experience has confirmed the value of education in reducing child labour.

Education is no longer children's right but the duty of the State. A long accepted doctrine in developed countries, it has found acceptance in several developing countries in recent years, with remarkable results. Contrary to this world trend, India has retreated from constitutional commitment to mandatory full-time schooling, to universal education. Simultaneously retrogressive legislation such as the Child Labour (Regulation and Prohibitory) Act, 1986 has effectively legalised Child Labour and violated Articles 24, 39 and 45, which ban child labour and ensure compulsory education. In India the concept of 'children's work' is widely accepted as a useful skill-acquiring experience and a necessary contribution to the family income and the nation's economy, although there is little evidence to substantiate the former and justify the latter.

Participants at the World Summit had pledged to act at the highest political level to ensure child welfare. The SAARC declaration stated investment in children to be a "non-negotiable" political commitment. At their press conference the SAARC ministers echoed the sentiment, "where there is a will there is a way". But, in India, where what Weiner calls "politics of doing nothing" prevails, will the pledge to act at the highest political level be redeemed? ■

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(1) police brutality, especially with racist biases
(2) the Haitian refugee crisis, when they sent back 14000 refugee Haitians, and
(3) the death penalty.

The refusal of developed countries to write off debts of poor countries, the interest of most debts being three times more than the aid, the expenditure on arms, the amount spent on advertising of tobacco in two years being equal to the amount needed to prevent 100 million child deaths in 1990, are crime enough.

The book will certainly provoke thought in academic circles, but its real worth will be found by activists, volunteers and new entrants in this field. ■

A Carpet Over Bonded Child Labour

Almost the entire carpet industry depends on children purchased from parents in Bihar, Madhya Pradesh, and Nepal at rates ranging from Rs. 200 to Rs. 2000 each. The Varanasi - Bhadoi belt in U.P., which accounts for 80% of the carpet exports from India, has, according to a U.P. government official, 83% of bonded child labourers. A survey of 858 cases in Palaman, revealed that 48% received only food (that too inadequate) for their labour. The maximum daily wage of a child was Rs. 5/-.

Compiled from the Times of India, 12th & 13th August, 1992

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older child sometimes takes on full responsibility for a baby, if there are more than one in a family. Many a time the babies and these children form a special bond. However, it is seen that foster children sense a permanency when they go into their adoptive families. As such, there have been no major transition problems when a child in foster care goes into his/her adoptive family.

Running a Foster Family Care Programme is not always smooth sailing. The sheer distance between the SOFOSH office at Sassoon General Hospital and the foster care programme at Salisbury Park proves to be a problem where transportation and communication is concerned. Sometimes the admissions of babies may be very high, or the ill health of a foster family member may force the transfer of their babies into other families and this may lead to a deterioration in the quality of care provided. There is a constant need for vigilance to see if the children are being given their due of medicines, food. Sometimes families have been discontinued. Discontinuation could come from the families side, because of retirement from the Seventh Day Adventist Mission, or ill health of any family member. The discontinuation could also come from the side of the Institution, if the care provided by the family was not found satisfactory and conducive to the health and well being of the child. Inspite of best efforts, years of looking after babies all the time may sometimes lead to a brief period of low motivation. The families, over the years, have learnt to take in their stride the invariable separation of a child that they have cared for over a period. In case of an older child this separation is always more difficult, but there is always a new baby to nurture. This helps in assuaging such separation pangs. Also, cost wise, it is an expensive programme for SOFOSH as each family is paid a daily allowance per child, besides the supplies and all other costs.

A Model for Indian Conditions

At any given point of time however, the merits of the programme largely outweigh the difficulties faced in running it. It has given babies handicapped by rejection by birth families, pre-maturity and other medical problems, optimum conditions for their emotional and physical growth and often, a new lease of life.

The Foster Care Programme of SOFOSH has successfully completed 12 years. The main credit for this goes to the genuine love that the foster families feel for each and every child and the care and missionary zeal that they have shown through the years. These gains exceed all financial price tags. The programme has thus proved a boon for all babies who await a home of their own with their adoptive families.

The adoptive families are also very appreciative of the programme. They are happy to know that before a child found a home with them he/she was well cared for in a foster home. This programme has given a tremendous boost to Indian adoption, as Indian families are particular that their adopted children have no previous emotional deprivation that can lead to future problems. This has been possible to a large extent, because of the successful running of the Foster Care Family Programme at SOFOSH.

FREE ABSTRACTING

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Setting The Right Priorities
A PROFILE OF SRI LANKA

Sonya Gill

This is the 5th article in the series, "Health Financing and Costs: comparative perspectives". (No.1 -- Japan; No.2 -- Zambia; No.3 -- China; No.4 -- Brazil).

Sri Lanka has achieved one of the highest levels of human well-being, not just in South Asia, but among the entire range of post--colonial, largely agrarian and poor countries. These achievements are the result of the public policies and public intervention programmes that, from the beginning of independent development, gave high priority to the satisfaction of basic human needs -- health, education and food. Sri Lanka, and countries as diverse as China and Cuba, have demonstrated the crucial role played by public support measures and the universal provision of amenities, to dramatically improve living conditions even in the absence of rapid economic growth.



Health Status

ust 21 percent of the 17 million population of Sri Lanka resides in urban areas, and the annual per capita income is a low US$ 410. And yet the health and education indicators -- life expectancy, mortality rates and levels of literacy and education -- have long surpassed the targets that India ia hoping to achieve by 2000 A.D. By 1986, the average life expectancy had risen to 70 years, the infant mortality rate had declined to 6 per 1000 population, and the maternal mortality rate was around 60 per 100,000 live births (Table I).

These health indicators had begun to improve from the early 1940s itself, when government intervention and health facilities expanded to combat major killer diseases such as malaria and tuberculosis. Throughout the first three decades of the 20th century mortality rates fluctuated sharply, as the island was swept by epidemics of malaria and influenza. During the 1935 malaria epidemic, IMR rose to 263 per 1000 live births, and the crude death rate of 36.6 per 1000 population overtook the birth rate (34.4/1000 population).

Modern allopathic medical care was, upto the 1940s, largely restricted to a network of hospitals and dispensaries in the main provincial towns, and the tea and rubber estates. Since the late 1930s, both, the major public health campaigns to control communicable diseases and the system of primary health units providing basic curative services to the rural population, began to be expanded. The war years were a period of acute food shortages resulting from the curtailment of rice imports. The IMR reached another peak of 140/1000 live births in 1945. Food subsidies in the form of a ration scheme were introduced to provide relief during this period.

After 1945, the coverage by medical services expanded rapidly and the malaria eradication programme produced dramatic improvements in mortality rates. Between 1946 and 1947, in a single year's span, the death rate fell from 20/1000 population to 14/1000 and IMR declined from 141 to 101 per 1000 live births. A comparable IMR for India as a whole was achieved only in the 1980s.

TABLE 1
HEALTH STATUS

Year	Crude Birth Rate (per 1000 pop.)	Crude Death Rate	Mortality Rate Infant per 1000 births	Maternal per 1 lakh* births	Life Expect. at birth (years)	Literacy Rate %
1946	38.4	19.6	141	---	43	58
1966	32.3	8.3	54	---	64	72
1986	24.0	6.0	22	60	70	87

*Sources: Anand and Kanbur, 1991; Annual Health Bulletin -- Sri Lanka, 1985; World Development Report, 1988. * Lakh = 100,000*

The author was formerly co--researcher in the above FRCH study. She is presently involved in revising and editing the forthcoming updated volume of "Health Status of the Indian People".

FOR PRIVATE CIRCULATION ONLY

A Unique Case

The Sri Lankan experience of effective public health interventions even under a colonial administration is probably unique and needs a more detailed historical study. As early as 1947, and on the threshold of Independence, Sri Lanka had made a qualitative break with the high mortality trend, as demonstrated by a sharp fall in infant mortality and reduction in incidence of malaria.

These improvements in health related indicators were sustained and consolidated immediately after Independence, in the 1950s and 60s itself, as public policy pledged itself to provide free universal health services, universal compulsory education and food subsidies. The near universality of these social programmes and their accessibility to the rural population stood in sharp contrast to the urban concentration of public programmes in other South Asian countries. Between 1948 and 1963, the medical care infrastructure and health investment increased rapidly; this is the period in which the bulk of improvement has taken place.

Apart from the availability of services, the high utilisation of the public health care system has been an important factor in raising the health status. This, in turn, is linked to both the quality of health services itself, as well as the rapid expansion of educational facilities. Education, which became free in 1946, was made compulsory after Independence. Adult literacy rose from 58 % in 1946 to 87 % by 1986, and secondary school enrolment had risen to 54 % of the relevant age-group by 1982. As a result of compulsory and free education, the enrolment of women at all three levels rose rapidly, resulting in the virtual disappearance of male--female differentials in educational levels. Higher educational levels have contributed to the increasing utilisation of health services.

However, the one blot on Sri Lanka's record is the condition of the Tamil estate labour. The discriminatory citizenship policies have deprived them of the benefits of welfare programmes. Whereas prior to Independence social indicators for this group appeared to be somewhat above the national average, in the Post-Independence period their general and infant death rates are almost double those of the national rates.

In the 1970s, persistent poverty and related health conditions, such as the high rates of morbidity and malnutrition, further intensified by the economic crisis of this period, have been the main concerns. The withdrawal of food subsidies in 1978, under an economic readjustment and liberalisation programme, appears to have contributed to an increase in severe malnutrition among infants and children.

Health and Social Sector Costs

In the ongoing debate on public policies in developing countries, a common assumption is that the latter cannot "afford" social security and public provision of basic needs. Reinforcing this assumption is the controversy surrounding Sri Lanka's social sector spending. It is argued that the provision of free health care, education and subsidised food had been "excessive" in relation to achievement, and has diverted resources away from investment in economic growth, output and employment. With the change in macro-policy towards greater trade liberalisation and private investment, there have been some cut-backs in public programmes and the withdrawal of food subsidies.

However, as Amartya Sen has pointed out, an examination of the growth and levels of public spending on health and other social sectors indicates that "the costs have been astonishingly low". In the two decades after Independence, public spending on health care ranged between 2 to 2.5 % of GNP. From the 1970s onwards public spending did not grow as fast as the national income, averaging 1.5 % of the GNP, and declining to 1.3 % in the '80s. The early and sustained commitment of resources, even at relatively low levels, to expanding public health care coverage, is demonstrated by the rapid growth of real per capita spending from SL Rs.8.86 per annum in 1950- 1951 to SL Rs. 15.86 by 1960-1961. Thereafter, real per-capita spending has ranged between SL Rs. 15 to 16 per annum.

Overall social sector spending is also linked to improvements in health status. The real per capita expenditures on education doubled in the 1950s and then grew slowly in the next decade. By 1982 it was SL Rs. 33.97, but its share of the GNP declined from around 4 % to 2.9 % in 1982.

While per capita public spending on health care and education has remained stable in the post--liberalisation period, the budgetary support to the universal ration scheme was withdrawn in 1978. In 1979, a targeted food-stamp scheme was introduced to enable poor households to buy basic foods in exchange for the stamps. However, inflation doubled the price of food within three years and halved the purchasing power of the food stamps, with the result that the per capita calorie consumption of the lowest income group fell from 1,335 calories to 1,181, and that of the second lowest group from 1,663 calories to 1,558.

The shift towards targeted interventions in welfare policy that accompany structural adjustment programmes, may, in principle, help to reach the needy sections more efficiently. However, in practice, as the experience of Sri Lanka has shown, the replacement of a universal approach by strict targeting of beneficiaries, can worsen the position of vulnerable groups.

The share of food subsidies in government expenditures dropped from 15 % in the mid - 70s to about 3 % in 1984, and its share in GNP dropped from 5 % to 1.3 %. At their peak, total social sector spending ranged between 10 to 11 % of the GDP, but had declined to 6.5 % by the 1980s.

TABLE 2:
HEALTH AND SOCIAL EXPENDITURES

Year	Total Million Rupees	THE/ GNP %	PHE/ THE %	Public expd. as % of GNP			
				Health	Educa- tion	Food	Total Social
1950	---	---	---	1.5	2.5	N./A	---
1963	254,000	---	58.6	2.2	4.7	5.1	11.01
979	1,299,000	2.7	63.8	1.5	2.7	5.7	10.0
1982	2,219,000	2.5	58.9	1.4	2.9	1.8	6.4

THE = Total Health Expenditure; PHE = Public Health Expenditures;N/A = not available.
***Sources** : Alailima and Mohideen, 1984; Anand and Kanbur, 1991.*

Public expenditure on health constitutes around 60 percent of the total health expenditures of SL Rs. 2,219,000 (1982). Over 90 % of the public finances are derived from Central Government revenues. The private sector is quite substantial and has been growing since 1978. The changes in policy, permitting private practice among public sector personnel and the growth of incomes in the post-liberalisation period, have probably fuelled the demand for private nursing-home care, diagnostic facilities and practitioner services among the urban based richer sections.

Health Care Services

The lack of access to medical care, a major problem in almost all developing countries, virtually does not exist in Sri Lanka. Allopathic medical facilities are available at an average distance of 4 Kms from any home, while ayurvedic services are even closer. An extensive network of government medical facilities covers all parts of the country. A well organised hierarchy of institutions, including Peripheral Health Units, Central Dispensaries, Maternity Homes and Rural Hospitals have ensured basic curative services to the majority rural population. Higher level care is provided by the District, Base and Provincial General Hospitals, with the Colombo Group of Teaching Hospitals providing specialist services. The ratio of 29 beds per 100,000 population is one of the highest in Asia, and the nurse-population ratio is almost double that of India. Underlying the remarkable decline in infant and maternal mortality has been the systematic provision of ante-natal care (98% pregnant women covered) and institutionalised or attended deliveries (87% of all births).

TABLE 3
HEALTH DELIVERY

Year	Physicians (Allopaths)	Nurses per 1 Lakh* pop.	Beds
1960	12	33	302
1975	16	42	287
1985	14	54	279

Source : United Nations, Statistical Yearbook of Asia and the Pacific 1988. Lakh = 100,000

The government sector offers mainly allopathic medical care. The allopathic system was introduced during the British period, expanding rapidly during the final years of colonial rule and in the post-Independence period. Today, it accounts for 80 % of all medical treatment. Sri Lanka also has a long history of organised systems of medicine and health care, namely the original Sinhala system, *'Deshiya Chikista'* and the Ayurveda system. The widely available Ayurvedic services are largely provided by private practitioners, while the government component is limited to a few hospitals and dispensaries. According to the 1983 data, there is one Ayurvedic practitioner per 1,280 population. And yet the Ayurvedic system accounts for a smaller proportion of the total utilisation of medical care. The dominance of the allopathic system is also reflected in expenditure patterns. Until 1966, private health expenditure on Ayurveda exceeded that on Western medicine, but by 1979 allopathic care accounted for 77 % of all private health expenditure.

The utilisation of private out-patient and diagnostic services has accelerated in the late 1970s, when public policy was modified to enable specialists and medical officers employed in the public health system, to supplement their incomes through private practice. This allowance was subsequently extended to paramedics, physiotherapists, radiographers and lab-technicians. The post 1979 import liberalisation policies and the pressure from multinational pharmaceutical companies eliminated the State monopoly on drug imports and prices. This overturned Sri Lanka's progressive drug policy as well as enhanced the scope for private practice. The data on the private sector is, however, minimal, as there is a virtual lack of monitoring or regulatory framework.

Sri Lanka also gave early emphasis to preventive care, which, until recently, was organised as a separate service through health units headed by a Medical Officer, with a team of public health inspectors, nurses and midwives. The preventive measures took the form of special campaigns against major infectious diseases, particularly hookworm, malaria and tuberculosis. The need to strengthen preventive services has once again received attention in the context of the high prevalence of poverty related illnesses, mainly malnutrition and diarrhoea. The wide availability and good functioning of the curative infrastructure has been crucial to the rapid improvement in the survival and longevity, but has not prevented the health of the people from remaining vulnerable to poverty and poor living conditions. The late 70s has also seen the resurgence of malaria, while the longer life span has resulted in the rising incidence of cardio-vascular diseases, cancer and the diseases associated with old-age.

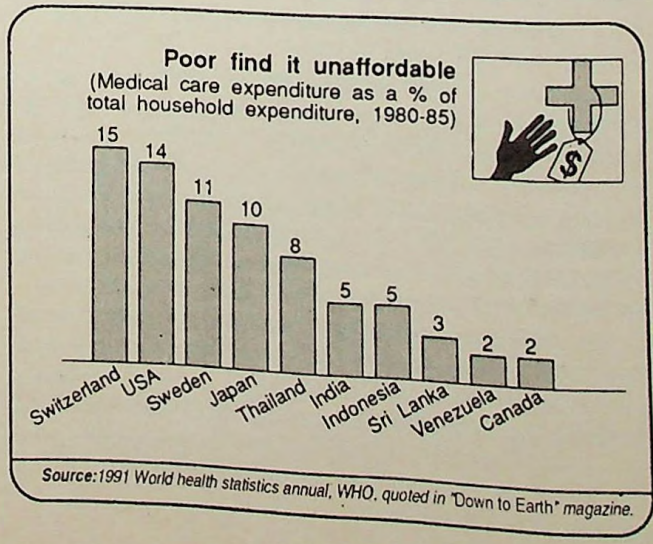
The organisation of health services is being restructured on a 3-tier health center model that will integrate the curative and preventive services, putting emphasis, in the future, on prevention and primary health care.

Future Trends

Free and widely available basic health services and high literacy levels have played a central role in the improvement of health status of the Sri Lankan people. Its distinguished record is the result of a sustained and systematic commitment to welfare programmes, and not the size of financial allocations. However, even that small social sector spending has experienced cut-backs since the change in economic policy after 1977. Even as per capita GDP growth has accelerated, there is evidence to show that the gap between the upper and lower income groups has widened. The cut-backs in social expenditures may have enhanced the vulnerability of the low income groups, among whom poverty - diarrhoea - malnutrition continue to form a vicious cycle.

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HEALTH RESOURCES IN A DISTRICT
A Survey of Medical Practitioners in Ahmednagar

Manjiri Sule

Development of effective health services needs the mobilization of adequate resources and their proper utilization. This requires sound policy formulation and planning, more so in an underdeveloped country like India, with low incomes and limited resources. Various studies in health economics are being carried out to generate information for facilitating the process of policy making and planning in India.

Health expenditure is an important component of health economics. The Central Statistical Organization report on National Accounts(1989) states that the total health expenditure in India is 2.69% of GNP, which includes 1.27% of GNP as state sector expenditure and 1.47% of GNP as private expenditure. Other studies have calculated private expenditure as ranging from 2 to 6 times of public expenditure (FRCH 1987, KSSP 1991, NCAER 1991). These studies have shown that 78% of health care resources are in the private sector; that 77% of people prefer private services for their illness and 88% of household health expenditure goes to the private health sector. Yet information about such a dominant section is neither adequate nor readily available.

The Study

To get an idea about the cost of health care it is necessary to look at the investment and expenditure done by health providers. The FRCH study on which this article is based is being carried out in two phases --

a) an extensive survey of health care resources in a district, and
b) investment and expenditure patterns for providing health care.

Ahmednagar, an average district in India according to CMIE index of economic development, was selected for the study. Its population (1991 census) is 33,62,359, of which 84% is rural and 16% is urban. Of 13 talukas in the district 5 are relatively developed, with sugar co-operatives, trade, industry and good infrastructure facilities. The remaining 8 underdeveloped talukas include 1 tribal taluka. The nature and distribution of health care resources in the district correspond to its socio-economic background.

The survey of health resources covered health personnel and establishments involved in providing health and medical services, from the public and private sectors. Health personnel includes qualified and non-qualified practitioners of modern and traditional systems of medicine, and paramedical workers. Health establishments include dispensaries and clinics having indoor facilities, hospitals, nursing homes and pharmacies. Based on the findings of the first phase survey, this article focuses on medical practitioners alone.

The survey was carried out by first tapping available official records like registration lists of councils of all systems of medicine and local self-government bodies. Available private lists prepared by medical representatives' association, pathological laboratories and various associations of doctors and pharmacists were also tapped. By cross checking information from all these sources, a master list was compiled. About 3060 doctors of all systems of medicine have been identified in the entire district. This was an arduous task, as the available information was neither updated, nor reliable.

To validate these data a sample-check study was carried out. Information about 127 doctors from selected villages of 4 talukas was physically verified. These places were selected randomly from the categories of villages and talukas made on the basis of doctor / population ratio. Of these 127 doctors, 72 (57%) were found actually working there. The rest had migrated or retired or were dead or simply untraceable. We found 42 doctors working in the selected villages who were not listed with us, making the total number of actual practitioners 114, 10% less than the number recorded.

A postal survey was also carried out, covering all 3060 doctors originally listed, to get some reliable data. The results of both these exercises are being analysed. The information which follows, however, is based completely on the compiled master list.

Nature of Medical Practitioners

Of the 3060 doctors identified, 51% are in urban areas and 49% are in rural areas. Of the total doctors 92% are private practitioners - including a very small percentage in the voluntary sector - and only 8% are employed by State government and local self-government bodies. According to collected information 84% of total doctors are male and 16% are female.

The system-wise proportion of doctors is : allopaths - 31%; practitioners of Indian Systems - 42%; homeopaths - 6%; dentists - 1.5%; RMPs - 3.5%; practitioners of more than one system - 0.5%; and non-qualified practitioners - 0.1%. The system of qualification of about 5.4% of total doctors was not available.

It may be presumed however, that the actual percentages of cross - therapeutics and non - qualified practitioners would be much higher than the above figures indicate. Cross-practice by non-allopaths is a well-known fact; with state measures to identify non-qualified practitioners underway, such information was also not forthcoming.

The levels of qualification are available for 2740 doctors. Of these 2740 doctors, 2506 (91.5%) are general practitioners and 234 (8.5%) are specialists. The specialists are gynaecologists (22%), surgeons (20.5%), physicians (12%), pediatricians (10%), ophthalmologists (7%), anaesthetists (6%), dermatologists and orthopedics (5% each), ENT specialists (4%), psychiatrists (2%), and others, including radiologists, pathologists, cardiologists, plastic surgeons, physiotherapists (6.5%).

Geographic Distribution of Medical Practitioners

The geographic distribution of doctors only confirms the generally known bias in favour of urban and developed areas.

The author is a researcher in the FRCH study, "Health Investment and Expenditure in a District".

TABLE I
GEOGRAPHICAL DISTRIBUTION OF DOCTORS

Taluka	Urban (%)	Rural (%)	Total
AHMEDNAGAR Dist.	1556 (51.0)	1501 (49.0)	*3057
Ahmednagar	836 (84.07)	150 (15.03)	986
Shrirampur	184 (52.8)	164 (47.2)	348
Kopargaon	189 (58.5)	134 (41.5)	323
Sangamner	193 (65.9)	100 (34.1)	293
Rahuri	89 (40.3)	132 (59.7)	221
Pathardi	36 (23.2)	119 (76.8)	155
Newasa	--	138 (100.0)	138
Akole	--	127 (100.0)	127
Shrigonda	29 (26.6)	80 (73.4)	109
Parner	--	105 (100.0)	105
Shevgaon	--	95 (100.0)	95
Karjat	--	85 (100.0)	85
Jamkhed	--	72 (100.0)	72

(Taluka and/or social geography of three doctors could not be identified)*

According to 1991 population figures in Ahmednagar district, 1099 persons are served by one doctor. The disparities within this district average are revealed in the following persons per doctor ratios: urban - 342, rural - 1885, developed talukas - 811, and underdeveloped talukas - 1804.

TABLE II
GEOGRAPHICAL DISTRIBUTION BY SYSTEM

	Urban (%)	Rural (%)	Developed Talukas (%)	Underdeveloped Talukas (%)
Allopathy	63	37	76.5	23.5
Dentistry	91.5	8.5	98	2
Indian Systems	48	52	68	32
Homeopathy	39	61	71	29
R M Ps & non-qualified	38	62	65	35

This shows higher proportion of all doctors in 5 developed talukas. The proportion of doctors of systems other than allopathy and dentistry is higher in rural areas. But most of the non-allopathic practitioners are practicing allopathy without having any institutional training. Also the higher proportion of RMPs and non-qualified practitioners in rural areas indicates a ready market for such practitioners in regions lacking qualified services. Of 234 specialists recorded, 207 (89)% work in urban areas and 27 (11%) work in rural areas, mainly in the developed talukas.

TABLE III
GEOGRAPHIC DISTRIBUTION OF SPECIALISTS

	Urban	Rural
General surgery	35(73%)	13(27%)
Gynaecology	44(86%)	7(14%)
Paediatrics	21(91%)	2(9%)
Dermatology	11(92%)	1(8%)
General Medicine	26(93%)	2(7%)
Anaesthesia	13(93%)	1(7%)

In rural areas, services of ENT specialists, ophthalmologists and orthopaedics are not available. Amongst a total of 234 specialists, 214 (91%) are working in 5 developed talukas and only 20 (9%) are in the remaining 8 underdeveloped talukas. Rural population in these 8 talukas gets the services of only 16 (7%) of total specialists.

The number of recorded female practitioners is 446 (16% of total practitioners). Of these total female practitioners 116 (26%) work in rural areas. Only 80 (18%) women doctors are working in underdeveloped talukas. There are a total of 50 female specialists in the district. Specialist services are being provided in rural areas by 5 (10%), and in underdeveloped talukas by 11 (22%) of them. Of the total 27 female gynaecologists in the district, only 3 (11%) are working in rural areas and only 2 (7%) are in underdeveloped talukas.

It is obvious that a small group of women having professional qualifications hardly provides services where they are most needed. It is generally known that the health problems of women do not get adequate medical attention, more so in rural areas, because of other social problems and cultural taboos. A substantial increase in the number of lady doctors will perhaps help women to achieve better health status.

Need for Planning

The number of vacant posts for doctors in the rural government services of Ahmednagar district is 82, the highest in the state (*TOI, 1st December, 1992*). With such inadequate public services and the geographic disparity in the availability of private health care resources a substantial proportion of the population in the underserved areas has to travel to better served areas. This increases the cost of health care for a population which already belongs to a lower economic strata.

The overall picture of medical manpower in Ahmednagar district is comparable to the Indian scenario. In order to achieve WHO standards for better health care, a proper policy is required to organize and regulate health services. Better policy for medical and health education and equitable distribution of health care resources would be amongst the essential components of planning to attain the goals set by the Alma Ata Declaration.

Forthcoming FRCH Publication

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Eds. N.H. Antia & Kavita Bhatia.

This book, expected for release by early 1993, analyses the development of existing health and medical serives in India. Authoritative views of eminent personalities in medicine, health administration, social and political sciences are put forth, leading up to the presentation of an alternative, decentralised people based model testable against sound technical, economic and socio-cultural considerations. This book is paritcularly significant in the context of the forthcoming Panchayati Raj Bill.
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THE CONSUMER PROTECTION ACT AND DOCTORS
Some Misconceptions

Anant R.S. Phadke

There is a widespread opposition to and even resentment amongst doctors against the Consumer Protection Act (CPA). This opposition is based, by and large, on ignorance and on an unenlightened view of the current status and future of the medical profession. At the same time, consumers should understand that CPA is only one of the measures to improve the quality of medical care; that there is a need to make many profound changes in our social culture as well as in the medical profession so that honest, competent doctors do not get frustrated. There are certain misunderstandings amongst doctors, about CPA, which are conveniently used by them to oppose its applicability to their profession. Let us, then, first deal with these.

Countering Misunderstandings

"Can CPA be applicable to the medical profession ?"

The first thing to note is that CPA is already applicable to doctors since its enactment in 1986. The only uncertainty is about the result of a case pending before the Supreme Court, challenging the application of CPA to doctors. It has been argued that CPA does not apply to those rendering service and since doctors fall under this category they should be exempted from its ambit. What is side-tracked here is that in the CPA, what is meant by personal service is a contract between a master and a servant. A doctor is not a servant of his patient, in the sense of a master-servant relationship. Hence a division bench of the Andhra Pradesh High Court has dismissed a batch of Writ-petitions filed by doctors and IMA (Indian Medical Association) on this ground.

It is true that a doctor is not like a shop-keeper, but is a professional bound by a code of ethics and answerable to its own professional body — the Indian Medical Council (IMC). But the point is, all other professionals — lawyers, architects, engineers — are covered under the CPA. Doctors, hence, cannot claim exception on the grounds that "a doctor is not practising commerce but a profession." After all a profession has its commercial aspect also and the consumer of a professional service needs protection from damage due to neglect by a professional.

"When doctors are answerable to and punishable by IMC why should there be a second body to do the same ?"

IMC operates through its State branches. As things stand, many of them are almost defunct. They hold their proceedings in the absence of the complainant and in-camera. Being an all-doctor body the consumers' views, interests, etc., are not represented in it. Above all, IMC has no powers to order any compensation to be paid to the patient. Consumers have no faith in IMC because so far it has failed miserably in protecting the interests of patients. By its very nature IMC cannot do adequate justice to patients.

"Doctors would be punished thrice for the same offence — by the IMC by the Civil Court and by the Consumer Redressal Forum (CRF). This is unfair".

No ! If a doctor is punished by the CRF he / she cannot be punished again by the Civil Court, for the same offence. The Medical Council, however, has a different role and its punishment is of a different nature. It is thus not a double punishment. Secondly, a `single offence' is many times violative of different sections of a law and hence, many times, draws punishments of a multiple nature. Medical negligence is no exception. The main point is whether the punishment is out of proportion to the offence, and not, whether technically there are multiple punishments.

"How can a non-medical panel decide about cases of medical, technical nature? Is it competent?"

The Civil Court also consists of non-medical persons as judges. These have been giving judgments about medical negligence. Judges take the help of experts whenever felt necessary. The CRF is no different from the Civil Court in this regard. The President of the CRF is of the rank of the District Judge — a fairly responsible and experienced judge.

"No doctor would take risky cases if CPA is enforced on the medical profession."

Failure of treatment is no crime, if the doctor has taken due care and has due expertise. If it is proved by the complainant that the doctor was negligent, that he/she did not apply the due care and expertise, then, and only then, is the doctor punishable. This well-established principle in medico-legal cases is applicable to CPA also. Thus, no doctor would be punished merely if a patient dies or if the treatment does not give him/her expected benefit. Even a mistake in diagnosis and treatment is to be condoned, provided the doctor had reasonable knowledge and had given reasonable care. A risky case can thus very well be taken up, provided the doctor is competent and conscientious.

"Doctors would do unnecessary investigations to be legally safe. This would increase the cost of medical care."

Contrary to widespread misbelief, a number of laboratory investigations are not always necessary, even if we were to follow Western textbooks. For example, Western textbooks on anaesthesia recommend no investigations at all in case of apparently healthy males below 40 years of age, undergoing "peripheral non-blood loss surgery" like herniogrhaphy, closed reduction of fractures, piles, fissure, etc. Secondly, what is `reasonable care' can be decided against local standards, which are different in London, Bombay, and a taluka-place in India. Thus, all the investigations or precautions mentioned in Western textbooks are not necessarily applicable in, say, Alibag. This is a well-recognized principle in medico-legal cases.

What is, however, necessary is that the local medical body, such as the IMA branch in the concerned town, lays down standard treatment

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The author is a medical professional, active in the Medico Friend Circle and Peoples' Science Movement. He is presently associated with FRCH on the project, "Cost and Utilisation of Drugs and Pharmaceuticals in Government Hospitals".

guidelines for medical practitioners in that area to follow. Today no such local standard guidelines are available and medical practice is quite anarchic. This must change. The CPA has offered a chance for socially conscious doctors to come forward and press for the preparation of such guidelines, to be formulated by the local professional bodies of general practitioners, surgeons, paediatricians, etc. So long as a doctor follows these well thought-out guidelines, he / she would be legally safe. It should thus be clear that, by and large, it would not be essential to do unnecessary, costly investigation for a rational and legally safe medical practice. Instead of opposing the CPA on irrational grounds, IMA should spend its energy in regulating the quality of medical care.

"Would not CPA lead to a loss of trust between the doctor and the patient? Would not the CPA be misused?"

There is already a certain amount of loss of trust between the doctor and the patient. The CPA merely provides a more accessible and speedy legal avenue for patients — no fees, no lawyers, judgement to be delivered in 90 days. If doctors become more conscious about their knowledge, follow scientific, ethical principles in their practice and, above all, are more communicative to the patients, this trust can be regained. The consumers should also be enlightened about the limitations of medical technology, about 'what is medical negligence', and about the functioning of the CPA. It is not true that the consumer can obtain justice by a simple letter to the CRF. Cases are dismissed by CRF without a hearing, if it finds that the complaint does not have any legal validity. Secondly, the onus of proving medical negligence lies with the patient. This is an extremely difficult task. The CPA cannot therefore be misused for harassing and blackmailing doctors. A doctor can always appeal to the State CRF if he / she is not satisfied with the judgement of the District CRF; and later even to the National CRF Thus there are no summary trials or instant or irreversible judgements.

"Does it mean that the CPA needs no improvement ?"

No ! The following improvements are necessary :

i) If the CRF finds a complaint to be frivolous or vexatious or mischievous, then the doctor should be paid the same amount of compensation claimed by the complainant and this fact should be widely publicized.

ii) Cases against doctors (or for that matter anybody) should not be reported in the lay media before the verdict has been given.

iii) There should be proper guidelines in the selection of the non-judicial members of the CRF and these guidelines should be strictly followed. In cases where CRF deals with medical negligence, a doctor should also be co-opted as a member of CRF.

The first of these three modifications has already been suggested by the working group set up on the advice of the Central Consumer Protection Council, to suggest suitable amendments to the Consumer Protection Act, 1986, and the MRTP Act, 1969. These are likely to be passed in the coming session of Parliament. Medical bodies should lobby to get the other two modifications to be accepted.

Broad Reforms Needed

Lastly, a word about the limitations of the CPA. If the irrationalities and malpractices in the medical profession are to go, a number of reforms are needed in the medical field. These include, a ban on capitation-fee medical colleges; a ban on polypathy (a doctor using different pathies) without adequate training; compulsory continuing medical education of doctors; ban on irrational drugs and irrational drug combinations; pre-censorship of advertisements and other drug-information supplied by drug companies, so that only correct and adequate information is supplied to doctors and lay-people; strict restriction on the promotional activities of drug-companies and corporate medical enterprises; proper health education in schools and through the lay media; incentives and disincentives to reduce urban congestion of doctors; standardization of doctors' fees on a rational basis. Unless these and other such measures are instituted, mere use of CPA is not at all sufficient to improve the medical profession and hence the quality of medical care to the patients. Consumerism, the illusion that 'there is a pill for every ill' should also go. Consumers should also recognize their role in improving the quality of medical services. Consumer organizations and organizations of doctors should come together, sit across the table and negotiate the terms of reforms to bring about such changes. Is it too much to expect this to happen ?

We invite readers to respond to the debate on the above subject. Selected responses may be published in future issues - Editor

A PHC DOCTOR SPEAKS OUT

It is my personal opinion that if our Tuberculosis Control Programme goes on in the way it is going at present, Tuberculosis will be one of the leading killers in the Indian community. And let me say that this is destined to happen. Allow me to state in short the reasons for it.

Right from the top to the bottom — from the apex officers to the field workers — everyone is nowadays working for his pay and personal interests outside of his job. An officer may be interested in promotion, a medical officer in practice or a MPW may not at all be interested in work, as is the plight of all government workers. No one is motivated morally to do something for the sake of humanity.

.... When I joined a PHC I felt sickened by what I saw. There is so much political and administrative dominance on a worker's technical skill and job satisfaction. Therefore, right from 'new case detection' to complete treatment, everything is hampered. The worker is bothered only to collect the sputum samples as per his population. The M.O. relieves his headache by giving figures in the M.O.'s meeting so as to avoid firing by the DHO. The higher officers themselves are bothered only about the figures and ranking of the District. Family planning is given top priority - the District targets and state targets are completed above 100% -- but the birth rate is rapidly increasing. In a district level meeting it is unfortunate that important aspects like Malaria and Tuberculosis etc. are given less importance by higher officials. These diseases also, as past experience has shown, will one day be rampant and out of control.

So the " *lall* " (saliva) — not sputum proper — is collected and examined, giving a negative reading. The case detection (process) thus

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The above has come in response to a questionnaire sent through the FRCH project studying the 'Social and Operational Constraints in Tuberculosis Control'. Extracts are shared here with the writer's express permission.

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suffers, the patient remains undetected and the disease spreads. We take our monthly pay passively, give anti-koch's treatment on cards somehow continuously maintained — and fill in our target figures. Shameful, isn't it?

Talking about private practitioners — here, in this tribal area, the doctors only want money. They would advise a pregnant female to take 2 injections — one for herself and one for the baby — and would charge her doubly. Both the injections, unfortunately are of teramycin (bad for the foetus) or B-complex — not even tetanus toxoid.

Just as we sit in a taxi and the meter is started — the private doctors catch a patient and put him on I.V. — no matter what he complains of — the (I.V.) meter is on — the bill drips on, increasingly. Today, such is the condition of the society due to misguidance by the private doctors, that a patient comes smiling to me and says that he feels a little weak and asks me to fill 2 bottles of saline — injecting a yellow injection in the saline bottle ! Now, how should I alone wipe out this belief and how should I morally educate people ? If I say that a patient doesn't require an injection or I.V. — he looks at me as if I am a fool — or tries to give me money for it. It is very disgusting.

Patients themselves are so illiterate that they do all "*Dev- Bhagat*" (consulting religious quacks and shamans) stuff and then come to the PHC. It is shameful also that a field worker doesn't refer a case to the PHC in time. The community is not that poor but their tendency is very wrong. They sell the milk in the dairy and buy biscuits (which are costly) for their child, but won't think of feeding milk to the child.

Being tribal, the community gets everything free of cost from the government — cattle, roof tiles, wells, electric motor, bank loans — that too under 100% subsidies. They look at the PHC as cheap, the ANMs as public figures, the MPWs as good-for-nothings and doctors as unsocial animals. They think that all the government people are their servants. If a police constable or a simple 'Talathi / Gramsevak' visits a village he is welcomed warmly. But even if an ANM walks 2—3 kms to a village, no one will offer a glass of water.

You will be surprised to know that we have to take the signatures of the 'sarpanch' or police 'patil' on the family planning accounts, while submitting it to the DHO office. Such is the belief of the government in a Class II Gazetted Medical Officer. We are reprimanded by persons who are illiterate and know nothing about the medical field or PHC administration, at Panchayat Samiti meetings. Only the paper records, and not the work, seem important.

So how can Medical Officers working in such a society for years together keep their motivation positively? Their attitude becomes negative and administration, laissez-faire. The Medical Officer who has good relations with the local and other politicians and brings no complaints to the higher officers is thought to be good — no matter how many new tuberculosis cases he has found or how regular he has been in treatment and follow up. Same is the story of most of the national programmes. There is only one satisfaction — that I am serving the needful.

Logically, as taught in school, one bad mango spoils all mangoes in the basket. But one good mango in a basket of all spoilt mangoes does not purify all — that too gets spoilt. But believe me, I have not yet got spoilt. Firstly I am a human being — then a doctor — then a government medical officer. I sincerely strive, as per my efficiency, to follow the rules in all national programmes, without hurting my superiors or the community. It is sort of a tight-rope walking job. . . . .

FREE ABSTRACTING

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