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# MOTHERHOOD
## *A Social Obligation?*

Nagmani Rao

Societies the world over, and Eastern societies in particular, have attached a special status to the 'achievement' of motherhood — of course 'legal' ( spelt within wedlock ) motherhood. Mothering a male child is supposedly the ultimate state of ecstacy that a woman can reach! The necessity of motherhood invades our psyche so deeply, it is hardly surprising that even women who take a conscious decision against motherhood are periodically beset with self-doubts and confusion as to the wisdom of their choice. That mainstream society sees such women as uninspiring aberrations, who are selfish and foolish enough to interfere with nature's endowment to womanhood, is itself enough to throw them in a state of emotional turmoil and create a sense of inadequacy and insecurity.

Fertility, thus defined and controlled by patriarchal norms, serves to control, subvert and encage women, rather than to empower them. Below, I cite some instances (from my experiences) of a cross-section of rural and urban women who sharply reflect the burdens of fertility and motherhood.

A
Very Happy New Year
to
all our readers

☐ **Pamma:** A *dalit*, agricultural labourer, who was married to a no-good, alcoholic man. Her first pregnancy, which ended in a spontaneous abortion during the fifth month, revealed that she was an epileptic. Despite the risks involved she conceived again immediately, lost her foetus this time also and nearly died. During her third pregnancy (within a span of two years), her parents managed to raise a loan to keep her under constant medical supervision and ensured that she also received the rest and care she needed. Fortunately for her, she delivered a boy. Her parents could therefore persuade her marital family to allow her to be sterilised to prevent further pregnancies. Incidentally, despite the delicate state of her health, it was considered perfectly normal that it should be Pamma, not her husband, who should be sterilised. Her parents rationalised this by saying that this was easier than convincing her husband and would save their daughter from the trauma of repeated pregnancies.

☐ **Seema:** A professional and a divorcee, had subsequently married a friend, some years younger than her. His mother, despite having nothing personally against Seema, found it difficult to accept the marriage of her only son to an older woman and a divorcee. Seema was determined to build a bridge to reach out to her mother-in-law. She discovered that the best way to do so was to give her a grandson and therefore planned to have an early child. Her first pregnancy ended with a very painful miscarriage of a male foetus during the sixth month. She was deeply depressed. The feelings were further enhanced by a superstitious mother-in-law who drew unnecessary correlations between the marriage and loss of the baby. She, therefore, immediately went in for a second pregnancy. When there was once more the threat of a miscarriage, her gynaecologist advised a precautionary partial sewing of the cervix. In the process he carelessly stitched the bladder also. This led to serious complications, almost killed Seema, and necessitated termination of her pregnancy. It was yet again a male foetus and she felt completely shattered. She was adamant about proving to her family that her body was capable of producing a healthy child and convinced her worried husband that she would be fine once she conceived again. With all precautions taken, she did manage to see her third pregnancy (in three years) to term and felt 'victorious' after giving her family a son.

☐ **Vithabai:** Came from a marginal peasant background, but did

*contd on pg. 12*

The author has been a social activist, working with rural women since many years. Presently she is working in the Publications Unit of FRCH.

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# WOMEN'S BELIEFS ABOUT ANATOMY

Manisha Gupte

Why is it necessary to find out about women's beliefs about their anatomy? It may seem rather pointless perhaps, to delve into obscurantism, glorifying the old traditions, when our job as modern educators is to take the people forward. When people, especially women, have suffered so much through tradition and culture, it may also seem a little insensitive to indulge in such a meaningless enquiry. But in our well-meaning efforts, we try to replace traditional models of understanding the body with the new Western anatomical model. The underlying belief is that the latter is better than the former. On the other hand we are also aware of the fact that Western medicine is not value-free and that it is heavily biased against women. Is it then a case of the proverbial devil and the deep blue sea, or is there a third option ?

The Women's Movement brought about a breakthrough in the understanding of our own bodies. We rediscovered ourselves with pride, and we learnt to be suspicious of male-defined constructions of our bodies and minds. Our experiences were valid, too! The form of knowledge was as important as the content and so was the vocabulary. We searched for new words and many of these came from our own feelings and existence.

To create visibility and space, then, becomes the central theme of becoming autonomous, and this process has to continue forever. Women, even if they are rural, illiterate and traditional, have to speak out about how they see their bodies, their illnesses and the subsequent cures. With this in mind, we have been talking to women about various aspects of physical and emotional health, reproduction and sexuality. This article is only one part of a series of enquiries.

As a health educator and 'trainer', one's consistent experience was that women responded heartily to all the information we provided about reproductive biology. Nowhere did we find women reluctant to discuss their experiences and problems. That made us think. Weren't women supposed to be coy? Or was that something that the Sanskritised version would have us believe? The best way was to ask women to fill in the missing third dimension to our knowledge.

The following article attempts to listen to what women have to say, without a running commentary all through. No judgement is attempted, either way, on the information that women have shared. The questionnaire is extremely tentative, being based on one's limited knowledge of local religio-cultural perceptions. As mentioned earlier, this enquiry is only a part of an ongoing interaction with women and men in our villages. During March and April 1992, we interviewed 55 women from Malshiras village regarding their perception about the body and about certain afflictions caused by local gods, goddesses and spirits. Twenty-seven questions were asked, and women were asked to point out a body part or an affliction on a line drawing of a woman's body. The first 19 questions related to the location of organs (entities, apparatus or spaces) and of physiological functions. The remaining 8 were related to location of sites where certain deities affect the body.

The author is a feminist and a health activist. She is a trustee of MASUM - Mahila Sarvangeen Utkarsha Mandal - a self-help group of women at *taluka* Purander, District Pune.

## Demographic Data

**A: Castewise: (1).** Maratha/Mali 50% **(2).** Brahmins and Privileged *balutedars* (artisans) 4% **(3).** Unprivileged *balutedars* and Scheduled Tribes 33% **(4).** Muslims 13%

**B: Agewise: (1).** Between 20 - 30 years 18% **(2).** Between 31 - 40 years 33% **(3).** Between 41 - 50 years 32% **(4).** Between 51 - 60 years 13% **(5).** Above 60 years 4%

**C: Educationwise: (1).** No formal education 74% **(2).** Upto Std IV 14% **(3).** Upto Std VII 10% **(4).** Upto Matriculation 2%

We tried as far as possible to interview women who had not been exposed to the Western model of understanding physiology and anatomy. The responses to most questions did not vary with respect to caste, age or education. Two women who are with MASUM (Mahila Sarvangin Utkarsh Mandal - the development group we formed) for the past two years, showed some typical responses. The rest of the women were quite consistent in their understanding/ perception of body and illness.

## I. Location of Body Parts or Functions

*1. The Brain:* All 55 women unanimously agreed that the brain is located in the skull, above the forehead.

*2. Jaundice:* Jaundice is 'located' near the eyes. In its early stage, it affects the eyes, turning them yellow. At this point, it is not dangerous and can be cured by herbal remedies and also by tying a sacred, or 'charged' string of herbs tightly around the neck. The string 'grows' (earlier the roots are wet; as they dry up, the string around them loosens) and hangs down upto the abdomen in a week after which jaundice recedes. However, if the jaundice travels down into the abdomen one finds a swelling in this region. This jaundice is not related to *kaleej* or the liver.

*3. Kaleej:* This word is not understood as liver, sometimes synonymous with heart as well as with the mind (i.e *mana*). It is located between the breasts, or just above or below them, in the centre of the body. It is of vital importance to our existence.

*4. Mana, or mind:* The concept of mind or *mana* is close to that of heart, rather than that of brain. It 'feels' rather than 'thinks'. It is located along with the *kaleej.* Three women out of 55 said that the *mana* was

located at the base of the throat; one said that it was located in the brain, and one woman said that it was located inside the mouth and it 'speaks on our behalf'. One woman, who pointed out the *kaleej* in the abdominal region, said that the *mana* was located there, too. The location of the *mana* unanimously was in the central and interior part of the body.

*5. Lung:* This is a single entity, not a pair. It is located near the mind, again between or just above the breasts, the centre of the body.

The above five questions were related more or less to 'vital entities', all of which are located near the breasts. The three questions that related to 'digestion' were :

*6. Stomach:* This is located above the navel.

*7. Intestines:* They are also located above the navel, around the stomach.

*8. Nall:* They are two vertical 'muscles' or 'nerves' in the abdomen, close to and above the navel.

Four questions were asked about physiological functions :

*9. Where is urine formed?* Out of 55 women, one woman said that she didn't know. One woman pointed to the centre of the abdomen, above the navel. Two women said that it was formed in the uterus. All others said that urine is formed below the navel, sometimes in the groin, in the 'front' of the body.

*10. Where are faeces formed?* Two women pointed to the abdomen, above the navel; one woman said that they were formed in the lower backbone; while one woman said that they were formed in the uterus. All others said that they were formed below the navel, in the posterior region, 'behind the urine'.

*11. If 'germs' enter through the mouth, where do they spread? How are they eliminated?* and

*12. If 'germs' enter the body through the nose, where do they spread and how are they eliminated?* Five women out of 55 said that they did not know the answers to the above questions. Two women said that the germs entered the brain, where they got killed and then they just stayed there. Most others said that the germs entered the abdomen and were thrown out through the anus. Five women said that the germs spread all over the body and might be eliminated through the urine or along with faecal matter.

The following 7 questions were related to the reproductive system:

*13. Where are the otipot and pishvi, or uterus? Otipot* is the uterine region, whereas uterus and *Pishvi* are the same entity. It is the most important organ related to conception.

*14. Where is the baby conceived? Where does it grow?* The baby is conceived in the uterus. It grows there, too. In the latter part of pregnancy, the baby grows beyond the *otipot* region and reaches upto the abdomen, or chest.

*15. Where is the placenta?* Forty-five women felt that the placenta was always attached to the child. However, when the baby is born, the placenta may not come out "because it could have got stuck to the chest". This is an emergency in obstetrics and "only a good *dai* can save the delivering woman". Three women said that the placenta was attached `anywhere' in the lower abdomen; one said that it was attached to the woman's navel and two said that it was attached to the uterus. One woman said that the placenta was attached to the urinary bladder.

*16. Where is the vaygula located? Vaygula* is located in or around the *otipot.* All women agreed that it had a tendency to wander around in the lower abdomen in the *kusati* (both sides of uterus) after delivery, and it had to be set in its place by an expert *dai*, through repeated massages. If left to wander, it causes obesity, pain and post-natal complications. (The understanding of *vaygula* — crudely translated as 'a ball of wind' — is a little different from Aristotle's 'wandering uterus' that causes hysteria. *Vaygula* is related to post-natal complications and sometimes to pain during menstruation , not so much to psychological disorders). Three women said that they did not know anything about this entity.

*17. Where is menstrual blood formed?* One woman said that it was formed in the brain, one said that menstrual blood was formed all over the body and then eliminated through the urinary orifice, and one woman specifically mentioned that it was formed in the *pishvi* or 'bag' — meaning uterus. One respondent said that it was formed in the finger nails. One woman said it was formed in the 'egg'. This young woman (a Muslim with no formal education) had seen our Women's Reproductive Biology slide-show three years ago — this might account for the idea of the 'egg'. Two women mentioned the *otipot*, without specifying uterus as the site where menstrual blood forms or 'collects'. The rest pointed to the area below the navel.

*18. Where is the 'Tambi' or Copper - T fitted?* Eleven out of 55 women said that they did not know the answer to this question. This category includes women who are as young as 22 years of age. Two women said that it was fitted in the uterus and one said that it was fitted upon the 'mouth of the uterus'. Seven women said that it was fitted in the urinary apparatus. While 10 women pointed to the pubic region, the rest (24 women) said that the IUD was fitted inside the vagina.

*19. Where is the 'operation' or tubectomy performed?* Twelve women said that tubectomy was performed on the navel. Nine women mentioned the *oitipot*, whereas the rest pointed to the area just below the navel.

## II. Role of the Supernatural

The second set of eight questions was related to the effect of a few revered and fearsome gods, goddesses and spirits on the body.

*20. How does Mari Aai affect the human body?* Twenty-two women said that they did not know as to what exactly Mari Aai did. Twenty-three women said that she caused itching all over the body, created 'heat' and constipation. Three women indicated three different areas of itching: the face, the chest, and the inside of the mouth. Both men and women are affected by the curse of the Mari Aai.

*21. Where does Mothi Bai affect the body?* Five women were not sure as to how Mothi Bai acted — the others said that this goddess was a 'heat producing' deity, causing boils, blisters, burning in the stomach, and rash in the mouth, on the face and on the body. If one does not recognise the affliction as the goddess's anger and does not immediately offer penance, then an abscess forms or a wound refuses to heal. If medication is sought, Mothi Bai gets particularly angry and then she causes pain, fever and psychological disorders leading to complete exhaustion of the person. Men, women and cattle are affected alike by Mothi Bai. Different Mothi Bais can affect a person. There is a *brahmin* Mothi Bai, a *gurav*, a *mali*, a Muslim, a Gujarati, a nomadic and a Germal (German) Mothi Bai, too! (During World War II, German prisoners of war were kept on Purandar Fort in our *taluka* — perhaps that is the connection). Each Mothi Bai has to be pleased in a specific fashion, for example : vegetarian food for the *brahmin* goddess, flowers for the *mali* goddess, etc.

*22. How does Kalubai affect the body?* She causes headaches, bodyaches and fever with rigours. She affects the whole body, and people get bedridden. She can torture a person beyond reason, causing madness and she can even 'hang you to death'. The entire household is affected , quarrels start brewing and family peace is shattered. Twenty-two women were ignorant of Kalubai's specific effect on people.

*contd on pg.5*

# REPRODUCTIVE HEALTH
## *An Evolving Perspective*

FFWH Team

Any issue-based group faces a dilemma after a few years of its activities. Ours was strictly an issue-based group — the Forum Against Sex-Determination And Sex-Preselection, now also known as Forum For Women's Health, formed in 1986. We, individuals and representatives of groups active in different fields, tried to come together for this issue-based work. We worked without any formal structure and without having any official spokesperson. The issue was of sex-determination and sex-preselection which can be achieved with the help of prenatal diagnostic techniques like chorionic villi biopsy and amniocentesis — the latter being a more popular technique. Around this issue, it was possible to build a convergence of issues like human rights issue, women's issues and people's science issues. Our main demand was: legal regulation of this technique. Along with this, were attempts to create awareness amongst people regarding women's oppression and sex-discrimination in society.

Since then many changes have occurred in our initial position. First, we were concerned with the life and existence of female foetus, and the emphasis was that it was a human rights issue, an issue of right to be born as a female. This changed very early in the group to a women centred emphasis. The whole stress was then on the issue of women's oppression as also it being a misuse of science and technology.

The experience and the realisation of futility of regulation on sex - determination techniques in the state of Maharashtra, and overall societal attitude towards male child forced us to rethink. A persistent struggle to get a regulation passed by the central government was continued, but at the same time we were rethinking about our method of campaigning. Newer and newer invasive techniques were developing in the area of sex-determination and they were becoming a part of 'development'. These 'developments' in science and technology in the name of helping the society solve its problems made us broaden our vision. The hazardous implications of stress on finding technological solutions to social problems, which was an implicit issue in our campaign, was becoming more and more explicit.

The composition of our group has changed over the last few years. Now most of us are women, active in health issues and women's issues in general. The focus is on the broader issue of reproductive health. Starting from issues related to prenatal diagnostic technology, we have now focussed on all technologies of reproduction. The group is presently active in campaigns against contraceptive methods that are long-acting, provider controlled and make systemic changes in the body. This has brought us face to face with the societal attitude towards reproduction especially in the context of global population control ideology.

Today, it is being argued openly, even by the progressive and environmentalist groups that population is a major problem. They go on to the extent of saying that any means necessary can and should be used to curb this population explosion. While projecting population as a grave problem, they are being unable to differentiate between birth control and population control. On the other hand, for us, now, these are issues that are more clearly understood today than ever before. Our demand for birth control is in fact : a demand for the right to determine our existence in ways that we want; our efforts at reclaiming our personhood, at denying the bounds of motherhood imposed by society which have crushed our 'person' in more ways than one. It is this need that is being exploited for population control, to crush any efforts at redefining ourselves on our terms.

### Our Rationale

A woman cannot perceive her individual existence as a separate entity. She can think of herself only in relation to and with respect to others. In case of sex-determination tests it is very difficult to determine whether it is the woman's desire to produce a male child or whether this particular technique is being forced on her. Women have been made to perceive their existence only as providers of sexual pleasure to men, or as reproducers and that too preferably of a male child. This understanding of their role is being perpetuated through generations and is reinforced with the advent of new technology.

A striking example is of menstrual bleeding and its repercussions on a woman's life. No understanding achieved by science, of the beautiful and delicate menstrual cycle, has been of the kind which will allow her to accept it as something which is not a dirty or hideous phenomenon happening to her every month. At the same time, in fact, if any woman complains about her difficulties during menstruation, it is considered by society and hence by medicine as her psychological problem which has no 'scientific' explanation. This same society makes her accept the hormonal contraceptives. The changes in bleeding pattern after use of hormonal contraceptives are also labelled as psychological and not as an alarming factor to be taken cognition of. This attitude of society and science is so much imbibed by the women that there is no questioning of any kind. Everything is accepted as a *fait accompli*.

This attitude of women towards their own self not only alienates them from their own bodies, but allows them to undergo any torture. This attitude does not differ from the developed world to the under-developed world or from the rural to urban areas. It is just that the form of torture may vary with the geographical situations and the extent of advent in the technological aspects. In the developed world women are

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Forum For Women's Health (FFWH) is a group that began as Forum Against Sex-Determination and Sex-Preselection, in 1986. Since then the group has widened its sphere of activities, which now include also the issues in reproductive health, especially contraception.

forced to produce more children because of the problems of shortage of human power and in the under-developed world it is forced on women to control their fertility at any cost under the pretext of 'population explosion'.

The difference is again not so important because the emphasis on curbing the population is also very much a part of certain sections of the first world, and in the same way, in the third world, fertility is promoted in certain sections of society. We want to dwell on this point because we feel that all these attempts of forcing to produce more or less children oppress women.

To achieve this, society makes use, to the fullest extent, of the psychological make-up of women which is an outcome of societal oppression of centuries. Stressing reproduction as the primary role of women, while taking away any freedom to be able to make any independent decisions, can in no way help towards making women's health and existence a positive reality.

We do not consider health of women as an autonomous entity. It is very much a part of the societal milieu. And hence a single, strong, independent, tribal woman getting murdered for being a root cause for accidental happenings in the community becomes a lesson to all women that they must exist only within the prescribed norms of society. Roopkanwar's *sati* and apparent transformation into a goddess does not give us any different message. Similarly, the recent news from Germany, of a pregnant woman injured to death being kept alive for the foetus to grow, re-emphasises the same outlook of the society and its science. All these happenings are similar as far as their rationale is concerned.

## We are not Alone

In 1989, there was an international conference held in Comilla, Bangladesh, to discuss all the issues related with reproductive technology. The 'Declaration of Comilla', a document brought out by the participants at the conference, indicated the various linkages mentioned above. A correspondence was seen among the neglect of young girls, development of modern technologies related to reproduction, and those that make interventions in nature.

As an outcome of this conference, a need was felt by Indian participants to come together and have a discussion on health related issues at national level. We, as a group, took an initiative to organise a workshop in October 1989. Many groups working in the area of health participated. Due to the diversity of issues related with health, the point of emphasis of each group was different. Because of this, it was felt necessary to arrive at a definition of health. Suprisingly there was total agreement on the definition that evolved. Health was defined not as an absence of ill-health, but as the overall well-being of a person in her socio-economic and cultural context.

Both these conferences really helped us broaden our vision and realise the vastness of the issue of women's health. As a result, it has become imperative on us to sharpen our arguments and politics. Although the group is still issue-based and although the emphasis is still on the reproductive technologies, our understanding of women's reproductive health is being further developed.

We believe that although women need contraception, they are not the only ones responsible for reproduction. Reproduction and all issues related to it, have to be made the joint responsibility of men and women. At the same time, contraception is a process which should empower women to be able to make decisions about themselves as persons. It is something that should intervene at the level of the meeting of the egg and the sperm, from both of whom the story of reproduction begins.

***contd. from pg.3***

*23. How does Mhasoba affect the body?* He causes weakness, giddiness, vomiting and fever. Limbs ache. All family members start getting affected, once Mhasoba curses a person. When angry, Mhasoba kills. Twenty-eight women did not know how Mhasoba affected them or anyone else.

*24. How does Khandoba affect the body?* He causes madness in a person. The head of the household and the senior males are particularly vulnerable. Economically, the household is shattered. Family members start getting suspicious of each other, become inhuman, aliented and cruel. Quarrels, mentally unsound and delinquent behavior are characteristics of Khandoba's anger. Twenty-eight women were not aware of the details of Khandoba's anger.

*25. How do the Saati Asras — Apsaras (seven nymphs) affect the body?* They torture women. They cause nightmares and adversely affect menstrual cycles — making them irregular and painful. The uterine region gets affected, becoming tender and painful. The Saati Asras cause abortions and infertility. They enter a woman's body, causing writhing and hysterical behavior. Twenty-five women reported that they did not know how exactly these nymphs tortured the body.

*26. How do the Mavlyas affect the body?* (They are the seven sisters of Khandoba) These sisters are very secretive and cunning. They cause vague, unknown symptoms in women. They cause delay in conception and sometimes even infertility. Menstrual chaos, and abortions are also the effect of the Mavlyas affecting a woman; children die repeatedly. Thirteen women out of fifty-five did not know how the Mavlyas affected people.

*27. How does Satvai affect the body?* Twenty-one women did not know the exact behavior of Satvai. Others agreed that she affects young children, if she is not adequately appeased on the fifth day after delivery. She writes the child's future, whether good or bad. Children get boils on the head and body, they become cranky, they contract scabies and ringworm as a punishment from Satvai. Children become malnourished, ricketty, lose weight and get emaciated. Satvai can also kill children. She can cause the mother's milk to dry overnight and can also cause secondary infertility, premature deliveries, still-births, and problematic positions of the foetus during delivery.

## Observations

Responses of women reveal a wholly different understanding of the body when compared to the Western model. Yet, surprisingly, women's answers are remarkably similar — suggesting an oral communication or a collective belief about anatomy. Caste and age do not seem to alter the cultural understanding about one's own body:

- There are spaces (or entities) in the body - rather than definite 'organs'. The body is a continuum rather than a set of disjointed organs.
- The thorax and the abdomen (upto pubis) are one connected region, thus it is quite possible for the placenta to travel upwards and to stick to the chest after delivery. It is also possible for the growing foetus to 'rot' in the mother's undigested food. Similarly, it is possible for the uterus to 'collect the impure menstrual blood' from all over the body, and to eliminate it from the urinary orifice. The concept of a reproductive canal is absent.
- The navel seems to be a fulcrum of all reproductive activities. Sometimes the placenta is attached there. The uterus is located at the navel. The 'operation' or tubectomy is also performed here.
- The Copper - T is fitted in the vagina. This may explain women's fear that it will interfere with intercourse and that an IUD can't be kept a secret from the husband.

***contd on pg.9***

# OCCUPATIONAL HEALTH OF SELF-EMPLOYED WOMEN
## *Some Experiences*

Mirai Chatterjee

*This Paper, which refers to piece-rate workers, was presented at the West-Asian Workshop on Health and Safety, Bombay, Sept. 1991.*

Self-employed women are among the poorest and the most exploited of workers in India. Despite their large numbers and very significant contribution to the national economy and society, these women workers in the unorganized sector are often not even considered to be workers. Even when they are considered as workers, their role and contribution are not given the importance that is due. As these workers are ignored or 'invisible' to policy-makers, planners, researchers and the public at large, it is hardly surprising that their occupational health problems are also neglected, much less understood.

However, our experience with self-employed women workers reveals that they are faced with definite health problems associated with their work. Further, being among the poorest in our society, these workers live in small, badly lit homes with little or no ventilation. Few have access to basic amenities like water supply and sanitation. Such living conditions, together with undernutrition and occupational health problems trap them in an endless cycle of infection, disease and general poor health.

At the same time, these workers' body and health are literally their only wealth. As long as they are able-bodied and healthy, they are able to work and earn. However, if they or their families are sick, it means that they lose their daily wages. There is no provision for 'sick leave', or any other paid leave, if they have to stay at home either because they are ill or to take care of sick family members. Thus their own health and that of their families have important economic implications for them.

In addition, there are hardly any policies, programmes or legislation for self-employed women workers. Nor is our health care system oriented towards the health problems, particularly occupational ones, of these workers. Furthermore, health care practitioners of all types and levels of expertise are virtually unaware of, and unfamiliar with, the kinds of problems which this group of workers have, and the magnitude and prevalence of the problems.

Finally, there are very few studies focussing on the occupational health of women workers. Longitudinal studies which could be important indicators of what women experience through their lives, are particularly conspicuos by their absence. Similarly there has been very little research on and designing of protective and preventive equipment for workers or work processes. In light of the conditions described above, the need to study, understand and learn these workers' special health problems hardly needs to be emphasised. As a first step towards working for the improvement of women's health, we felt that it was necessary to increase our own understanding of the nature and scale of health problems experienced by self-employed women. We also decided to focus on occupational health, as this is a particularly neglected aspect of workers' lives. Our information on this issue was hitherto anecdotal and impressionistic. While we believed that this was valid and important, we also felt that some supplementary data was required. Thus we began a process of collecting and documenting the health experiences of women workers. They themselves were researchers and resource persons in this process. In addition, we hoped, from the start, that the data collected would support us in collective action to influence policies, programmes, public opinion and even legislation regarding workers' occupational health status. Further, we thought that our research might indicate areas of study which could be taken up by national research institutions. Finally, we hoped that the data from this research process would lead to greater awareness among workers and thus contribute to the struggles of workers for a safe and just work environment.

In this paper, the results of four community-based studies on workers' occupational health will be discussed. These are :

i) Ready-made garment workers of Ahmedabad.
ii) *Bidi* workers of Indore.
iii) *Agarbatti* workers of Ahmedabad.
iv) *Masala* workers of Ahmedabad.

## Research Design

All four studies were participatory, initiating a process in which all involved would learn, share experiences and collect data together. This methodology was chosen because of our belief that workers must be involved in all stages of research if this is to be a part of the empowerment process. We also believed that some of the best research and data is generated when the workers themselves are involved.

**1. Area visits and discussions with workers:** SEWA organisers and some workers' representatives visited all the various neighbourhoods where women live and work. We not only observed their living and working conditions, but also learned about the magnitude and range of problems that they face every day. We spoke to individual workers of all ages and communities, their representatives and leaders affiliated to SEWA and other organisations, and had informal discussions, in small

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groups. Some of the SEWA organisers were workers themselves and lived in the same neighbourhoods; this naturally helped greatly in terms of establishing rapport with workers and facilitating the learning, sharing and data-collection process.

**2. Group-meetings with workers outside their workplace:** Over a period of an year, we had several meetings with workers at the SEWA office, in community halls or in schools nearby. Generally, workers from different neighbourhoods who participated in earlier meetings came to the subsequent ones as well. At every meeting, the health aspect of workers' lives was discussed, alongwith other issues like low wages and identity cards. Women articulated specific needs and recommendations with regard to health which we have incorporated in our discussions on recommendations.

**3. Discussions with local health functionaries, doctors, government welfare officers and social workers:** We tried to collect and exchange information from a wide range of sources in order to access the level of existing knowledge and examine attempts, if any, to solve or alleviate women's occupational health problems. In addition, we wanted to learn about existing government and non-government programmes and policies concerning these workers.

**4. Surveys:** Four surveys were undertaken to obtain data on the prevalence of certain health conditions, specific to each occupational group. The surveys were intended to be cross-sectional studies and we did not involve other women workers as 'controls'. For all four surveys, samples of workers were taken from the city in question, and an attempt was made to include all the major areas where workers live and work. We also tried to obtain a cross-section of workers in terms of age, years of work and community. The survey questionnaires were designed to collect this data which the women themselves considered relevant.

The sample sizes for each group and the estimated total number of workers of each occupation in Ahmedabad city or Indore are given in the table below. The total number of workers are SEWA's estimates, based on years of work with the women. However, no systematic census of these occupation groups has ever been conducted.

| Occupation group | Sample size (N) | Estimated total number of workers in the occupation. |
|---|---|---|
| 1. Ready-made Garment workers | 100 | 10,000 |
| 2. Bidi workers | 156 | 7,000 |
| 3. Agarbatti workers | 150 | 10,000 |
| 4. Masala workers | 150 | 2,000 |

Each questionnaire was divided into three sections. The first was aimed at collecting some general socio-economic data about the sample of workers. This included questions about age, community household size, literacy, hours of work, years of work and income.

The next section was designed to obtain information about **a)** the kind of health problems women experienced while actually working in a particular occupation, **b)** health problems experienced after the day's work in that occupation was complete and **c)** whether treatment was sought for these health problems and, if so, what type was preferred. In addition, all the health problems mentioned were those that a worker experienced at the time of interview and not regarding any previous illness. Finally, we recorded all responses of the workers, regardless of whether we felt that a particular health problem was work-related or not. As we were not doing a case-control study over a period of time, we were aware that our studies had limitations in terms of conclusively establishing cause and effect relationships between an occupation and a particular health problem.

The third section was aimed at collecting data on other health problems (those other than the ones experienced while actually working in a particular occupation). What emerged in our discussions with the workers was that the gynaecological problems were very prevalent. Hence, in this section, questions related to specific gynaecological symptoms were asked.

## Results and Discussion

**1. Socio-economic profile:** In Table 1, some socio-economic indicators of the workers of the four occupation groups have been portrayed. This profile reveals that the self-employed women are poor, work long hours for low wages and many are illiterate. The *masala* workers had the highest percentage of illiteracy. Fifty per cent or more of the workers in each sample worked between eight to twelve hours a day. This work, of course, refers to wage labour and excludes the time taken for household chores and childcare. Finally, the majority of workers reported daily incomes of no more than Rs.10/-. Only *masala* workers were earning more than Rs.10/-. However, it should be emphasized that their work is seasonal.

**Table 1**
**Selected Socio-economic Indicators of the Four Trade Groups (% tage of workers in each sample group)**

| Socio-economic Indicators | Ready-mades workers N=100 | Bidi workers N=156 | Agarbatti workers N=150 | Masala workers N=150 |
|---|---|---|---|---|
| Married | 65 | 86 | 88 | 84 |
| Illiterate | 28 | 56 | 37 | 66 |
| Hours of work per day 8-12 hrs | 89 | 62 | 50 | 53 |
| Dailly Income: | | | | |
| Rs. 5—8 | 57 | — | — | — |
| Rs. 9—10 | — | 77 | 65 | 16 |
| Rs. 11—15 | — | 15 | 19 | 41 |
| More than Rs. 15 | 9 | 7 | 2 | 42 |

**2. Occupational health profile:** In our numerous individual and group discussions with women, what emerged was that both while at work (that is, sewing garments, rolling *bidis* or *agarbattis* and crushing *masalas* into powder) and immediately after work, women experienced several health problems or symptoms. The nature of some of the major problems portrayed is evident in Tables 2 and 3. It should be emphasized that this data was obtained by careful questioning and interviews of the workers, and not by clinical examinations. The basic premise, as mentioned earlier, was that the workers themselves know best what their problems are, as they experience these every day and throughout their lives.

From Table 2, it is evident that pain in the limbs, namely hands, arms, legs and feet, is the most common and was reported by 80% of garment workers and 63% of *bidi* workers. Back pain and headache were also commonly reported. From our observations and from discussions with the workers, it appears that posture adopted while working may be contributing to the pain experienced.

**Table 2**
**Distribution (%tage)of Occupational Health Problems while at Work**

| Health Problem | Ready-mades | Bidi | Agarbatti | Masala |
|---|---|---|---|---|
| Back Pain | 47 | 56 | 17 | 9 |
| Pain in Limbs | 80 | 63 | 7 | 38 |
| Headache | 41 | 37 | — | 1 |
| Dizziness | 23 | 44 | — | 1 |
| Eye Problems | 26 | 25 | — | 2 |
| Exhaustion | — | 46 | — | 1 |

In the case of problems experienced immediately after or on completion of the day's work, *agarbatti* and *masala* workers reported more problems or symptoms on the whole. Seventy-three per cent of *agarbatti* and 39% of *masala* workers, for example, complained of back pain, as compared to 12% of *bidi* workers. Interestingly, only *masala* workers (51 %) reported that they developed blisters and calluses on their hands after work and that they experienced a burning sensation (45 %) especially in their hands. This could be due to their work process which involves repeated pounding with a metal rod. This rod repeatedly rubs against the palms and fingers, thus causing blisters.

**Table 3**
**Distribution (% tage of sample size) of Occupational Health Problems Reported Immediately After Work.**

| Health Problem | Ready-mades | Bidi | Agarbatti | Masala |
|---|---|---|---|---|
| Back Pain | — | 12 | 73 | 39 |
| Pain in Limbs | 33 | 9 | 78 | 16 |
| Headache | — | 21 | 23 | 11 |
| Dizziness | 49 | 47 | 11 | 23 |
| Eye Problems | 18 | 16 | 7 | 11 |
| Exhaustion | 47 | 63 | 2 | 6 |
| Blisters & Callouses | — | — | — | 45 |
| Burning sensation (especially in hands) | — | — | — | 45 |

**Table 4**
**Distribution (% tage of sample size ) of Occupational Health Problems**
A = While at Work B = After Work

| No. of health problems | Ready-mades | Bidi | Agarbatti | Masala |
|---|---|---|---|---|
| **A** | | | | |
| Less than 2 | 16 | 6 | 91 | 69 |
| 2 — 4 | 74 | 77 | 9 | 31 |
| More than 4 | 10 | 15 | — | — |
| **B** | | | | |
| less than 2 | 44 | 24 | 6 | 20 |
| 2 — 4 | 56 | 73 | 81 | 75 |
| More than 4 | 0 | 0 | 13 | 5 |

Furthermore, as Table 4 shows, workers experienced several of the problems they reported, simultaneously, and both while at work and immediately after.

As our community-based studies did not incorporate experiences of a group of workers as 'controls', conclusive statements about statistical significance, associations and causality cannot be made. Our studies were aimed at involving workers in studying their own health, particularly at work, and increasing their awareness of health problems by collectivizing their experiences. Based on these, we suggest that longitudinal, epidemiological studies on these workers' health problems be undertaken.

**3. Gynaecological problems:** In the course of questioning the workers about their work-related health problems, we found that many women wanted to tell us about their gynaecological problems. Thus, although we had not intended to do so originally, we began to question the women on this aspect of their health. We found that there was considerable gynaecological morbidity among all the four occupation group samples. Fifty-eight percent of the *bidi* workers, for example, reported early periods. Fifty-four percent of them and 57% of readymade garment workers said that they had white discharge. Fifty four percent of *masala* workers experienced burning sensation while urinating, more than any other group who reported this symptom. Finally, the majority of workers in all four groups reported pain in the abdomen.

**Table 5**
**Distribution (% tage of sample size) of Gynaecological Problems Among Workers**

| Health problems | Ready-mades | Bidi | Agarbatti | Masala |
|---|---|---|---|---|
| Early periods | 7 | 58 | 7 | 6 |
| Heavy bleeding | 14 | 21 | 9 | 3 |
| Burning sensation while urinating | 33 | 28 | 16 | 54 |
| White discharge | 57 | 54 | 26 | 28 |
| Itching sensation while urinating | 30 | 23 | 24 | 56 |
| Pain in lower abdomen | 80 | 62 | 63 | 53 |

**Table 6**
**Distribution (% tage of sample size) of Gyaenecological Problems Occuring Simultaneously**

| No. of Problems | Ready-mades | Bidi | Agarbatti | Masala |
|---|---|---|---|---|
| Less than 2 | 7 | 4 | 12 | 8 |
| 2 — 4 | 42 | 47 | 69 | 40 |
| More than 4 | 51 | 48 | 19 | 51 |

When we attempted to determine how many of these gynaecological problems occurred simultaneously among the workers, we found that the vast majority of them reported more than two at a time. In fact 51% of ready-made garment and the same percentage of *masala* workers reported that they experienced more than four gynaecological problems at a time.Forty-seven percent of *bidi* workers and most of the *agarbatti* workers (69 %) reported that between two and four problems occurred simultaneously.

We did not conduct pelvic examinations or laboratory tests to diagnose gynaecological diseases based on the symptoms or problem

reported by the women. This data, however, does reveal that there is considerable gynaecological morbidity, which, for the most part, remains undetected. There is, therefore, a need to study these problems and to find out how they can be prevented, detected and treated at the community level.

## Applicability of Findings

This paper has briefly attempted to outline four community-based studies undertaken by women workers in those particular occupations. Workers' own experiences were not only considered valid, but formed the basis of the studies. This resulted in a kind of 'health audit' of each occupation and also served to collectivize and quantify what had hitherto been workers' individual experiences. From this 'health audit' a few suggestions may be made if we are to work towards the improvement of women's health status in our country.

**1. The need for research on occupational health:** We found in the course of our research that there were virtually no studies on the occupational health of self-employed women. One important recommendation from our studies would be: undertaking of in-depth, epidemiological studies of these workers as a priority. This research would include the ergonomic aspect of women's work about which very little is known, the prevalence of occupational morbidity and the prevalence of stress among workers. The research also needs to focus on possible preventive measures and even simple, affordable equipment to safeguard workers' health. Workers should be closely involved in the research process, both for their own learning and awareness and for finding solutions suitable to them and their living conditions.

**2. The need for research on gynaecological diseases:** Research should also focus on gynaecological morbidity which appears to be widespread among poor women. Appropriate preventive measures could be suggested or developed, alongwith workers' own recommendations.

**3. Orientation of existing health facilities to workers' needs:** In areas where large numbers of workers live, the out-patient dispensary (OPD) of the nearest health centre should have a special division for self-employed workers. The timings should be fixed according to women's needs. The findings of research, as discussed above, should be used to both orient the health functionaries with regard to workers' health and to organise health services accordingly.

**4. Provision of safe, subsidized tools of production:** Safe, subsidized tools (for crushing *masalas*, sewing garments and so on) should be made available to workers, to improve their work environment and to reduce work-related health and safety problems.

**5. Provision of preventive equipment and health education:** Safe and low-cost preventive equipment should be provided to workers at a subsidized rate. Through the Workers' Education Board, preventive health education, both with respect to occupational and other health problems should be initiated. Unions and other organisations working with self-employed workers should have access to these health education programmes, and should be involved in the planning and actual implementation of them.

**6. Provision of benefits:** Weekly day off, paid holidays, sick leave, maternity leave, old age pension and creche facilities: Self-employed women workers do not have any fixed employer-employee relationship, if at all. And yet, whether provided by the employer or the state, certain minimum benefits are needed which would affect women's overall health status.

**7. Provision of health insurance:** Health insurance should be made available to self-employed women workers. Health cards should be given to workers entitling them to receive health care of their choice and free medicines at any state public health facility and/or recognised private facility upto a certain limit.

The suggestions made above are those which are directly health-related. However, we would like to emphasize that in order to improve women workers' living and working conditions, and thus their overall health status and well-being, certain interventions are essential. These include provision of identity cards to women, thus recognizing them as workers; enforcement of minimum wages; regulation of working hours and provision of basic amenities such as adequate housing; water supply and sanitation. These have not been discussed here but it is important to note that without simultaneous efforts towards obtaining these, all interventions designed to improve self-employed women workers' health will necessarily have limited effect. Women workers' health is closely interwoven with the nature of their work and working conditions. Thus attempts to understand and improve their health must be undertaken in the wider context of their overall efforts for justice in the workplace.

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We have covered only eight of the various deities affecting people's health. None of the ghosts and ghouls have been covered here. Many illnesses, dysfunctions, deficiencies are considered as the result of disobeying or displeasing a particular deity. Mental disorders and poverty are also caused by malevolent (or angered) spirits and gods.

- Many Muslim women were not aware of the ill-effects of those gods which 'possess' a person. However, they all agreed that many gynaecological complaints were caused by the nymphs and the Mavlyas or that Satvai affects children.
- Only two women out of 55 categorically stated that malevolent spirits do not affect the body and mind. Both these women from unprivileged *balutedar* families are between the age group of 30-40 years and have been working with MASUM for the past two years.

As mentioned earlier, I have deliberately refrained from taking positions on what my women friends had to say about their own bodies. Later on, after a series of related enquiries, I hope to understand these observations within a feminist theoretical framework. For the time being, the space to speak out, belongs entirely to the women of my community.

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# WOMEN'S HEALTH, TRADITIONAL MEDICINES & EMPOWERMENT

Renu Khanna

It is now increasingly being acknowledged that women's health-status is a composite of many factors : women's lack of power; their secondary status in family and society and the resulting discrimination; lack of knowledge and information; certain harmful cultural and traditional practices, most of which have had their roots in patriarchy; and lack of access to safe and empathic services. Among other things, it is women's perceived lack of power which pushes them into a situation of early marriage and consequently early child-bearing. Powerlessness in the face of social pressures makes them go through the rites of womanhood: multiple pregnancies in quick succession so that they can never be anything but exhausted and weak. It is their lack of power and the inability to have any control over their bodies, which make many women yield to the brutalities of conjugal life — in many cases it takes on the hue of more chronic suffering through the transmission of sexual diseases and their sequelae.

Gender-discrimination which often begins even before birth, affects the nutritional status of females. Gender-discrimination in the allocation of food — as well as in health care and education — is a widespread and well-documented phenomenon in much of the developing world. Nutritional deficits contribute to certain lifelong handicaps such as stunted growth and chronic anaemia, two of the main factors behind complications of pregnancy and childbirth as well as other chronic gynaecological problems. Cultural and traditional practices which restrict nutritional consumption when women most need it, that is during pregnancy, further compound the nutritional deficit. A patriarchal and male-dominated health care delivery system which views women only as objects and as instruments of population control, further alienates women : even when their health problems become very serious, women hesitate to approach the health care services. The reason for this is their perceptions of themselves in relation to the health care system; their belief (of course, based on past experience) that they will not be able to negotiate with the system to their advantage.

## Empowerment in the Context of Health

A very important part of the effort to improve women's health must thus be directed towards empowerment of women and improvement of their status. Once women have the confidence, the ability to analyse the situation and to take their own decisions, their health status would improve.

What then is empowerment of women in the context of women's health ? We, at SARTHI, have visualised empowerment related to women's health as follows: Empowerment of women could be manifested along a continuum. At an **intrapersonal** level, empowerment begins with individual women having a changed perception of themselves. What they earlier thought as dirty and a cause of *sharam* (shame, embarrassment), they now begin to claim and own. The physical problems which earlier went undiscussed, now begin to come out of the shrouds. At the **interpersonal** level, women begin to realise how certain relationships, and their subordinate role in them, directly affect their bodies. An example of this is the relationships with their husbands. In small ways they begin to negotiate these relationships so that the power differentials are gradually lessened. At the next level, **groups** of women get together to negotiate relationships in the environment. For instance, a small group of women may decide to accompany their village sister to the health centre to make sure that she gets the service which she requires. And finally at the **community** level, women organize themselves, for collective action, around their own issues. They may organize to demand their health rights from the state; or they may organize to draw attention to issues which directly affect their bodies and health — issues like rape and other forms of violence which were till recently left unaddressed.

## Redefining Women's Health

From the above, it is evident that women's health is much more than just the maternal health and family planning that our country's health system has restricted it to; programmes for women's health need to be wider in scope — they need to incorporate care for common gynaecological, psychological and emotional health problems. The programmes for women's health also need to take the 'life cycle approach', that is, deal with health problems of women right from their adolescence (and even before that) to menopause and beyond.

## Women's Health and 'Ethnomedicine'

The time is perhaps right to recognise that despite many efforts, indicators reflecting women's health status (eg. maternal mortality, anaemia etc.) do not show significant improvement. Some of the more conscientious community health projects in the country have reported that beyond a point, despite all their efforts at high risk management, maternal mortality rates are not going down. A major reason may perhaps be the dominant use of the biomedical model which fails to take into account local beliefs and practices related to women's health.

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Health interventions which are divorced from the local cultural context are likely to be resisted, if not totally rejected by the local people. In several parts of Gujarat, for instance, women believe that an intra-uterine device like Copper-T once inserted, will be irretrievably lost as it will 'climb up in the internal cavity'. Women also believe that a big danger of using the Copper-T is that it can cause the man and the woman to get 'entangled' during intercourse, and nothing short of a medical intervention can result in a 'separation'. If health care providers do not acknowledge these beliefs, and do not base their health education on them, no matter how hard they try to impose their health education on local women's concepts of their bodies, women will not accept IUDs.

## Beliefs and Perceptions

In the course of evolving the women's health programme at SARTHI, we compiled a list of beliefs related to women's health. Listing out these beliefs alongwith our women health workers (all local women) was a very important exercise. The approach in dealing with the beliefs was to help the women look carefully and critically at them, in order to avoid the harmful and preserve the best in them. The idea was to emphasize that which is valuable in the local tradition, and to explore ways that build on them rather than ignoring or rejecting them. For instance, the women of the area believe that if a pregnant woman consumes too much yoghurt and milk, these will 'stick' to the foetus and make the delivery difficult. This notion formed the foundation of a session on the digestive system and how the foetus receives nutrition. Similarly, the beliefs about green water from the vagina (if the water from the woman's vagina on the onset of labour is green, the woman should be taken to the hospital) and presentation of a baby's hand or foot as medical emergencies, gave an opportunity to build upon the topic of emergencies further.

Most of the beliefs fell into the grey area of neither being harmful nor particularly health protecting; for example, burying of the placenta alongwith some rice and money or that healers should never speak aloud the names of traditional medicines. These beliefs were left unchallenged or unaddressed although we made a mental note of them for future reference (for instance, we learnt never to ask the healers about names of traditional medicines — we learnt that if we wanted this information we had to ask the healer to show us this plant).

Some of the beliefs were analysed in the light of scientific information available to us. After one such discussion, the women realised that onset of menstruation was independent of the marriage or whether the girl had intercourse or not — menstruation was dependent on the physical development which in turn was dependent on her age. Another belief that was dispelled was the one of pregnant women not being able to see at night. Information on Vitamin A deficiency and its effects was provided to counter this belief. Some of the beliefs were analysed in the light of progressive feminist theories. The ones that fell in this category related to pollution rites and taboos: for instance, a menstruating woman cannot enter the kitchen or fetch water or touch vessels. The feminist world-view, that pollution taboos were a means to disempower women, was very novel and mind-blowing to the local women.

A surprising aspect of some of these beliefs for which no logical explanation could be found was their universality. Indication of the sex of the foetus by assessing bumps on the abdomen is a widely prevalent belief in different parts of India as well as in ayurveda. Similarly the belief, that slipping the root of *Echinops echinatus* into the woman's braid would hasten labour, is to be found in parts of Uttar Pradesh and Madhya Pradesh.

In dealing with the local women's beliefs, a point that was recognised was that the beliefs had a role in healing. Healing can take place much faster if interventions are compatible with the belief system of the patient. Thus the task of understanding the belief system, of deconstructing and reconstructing the belief system, is a sensitive one. Starting with the analysis of the local beliefs and using their own terminology during the training, made us partners in the training process. First, we had to understand their modes of thinking about health. Then we could analyse the harmful beliefs and practices and substitute them by not so harmful ones.

## Traditional Medicines

A second aspect of 'ethnomedicine' that can play an important role in women's health and empowerment is the use of traditional medicines in service delivery programmes. Women, through the ages, have been repositories of knowledge related to locally available flora that can be used for common health problems. An action research done by SHODHINI (a network of 'women's health' activists working with grass-root women) revealed that about 175 of the 300 plants, used in different parts of India by local women, were mentioned in available literature as having the same properties the women used them for. These, classified as 'A' plants, indicate the extent of knowledge of the local healers. The 'B' category of plants (about 111) are not confirmed by the existing literature as being used for the symptoms that the women use them for but certainly may have the properties that the women attribute to them. Only 14 plants, categorised as 'C' were positively harmful and contraindicated in the available literature. The local women healers who are a part of SHODHINI feel certainly strengthened when they are informed that *Asparagus racemosus* which they have been using for years for various forms of bleeding in pregnancy and delivery, is known for its tonic and astringent properties. Or that *neem (Azadirachta indica)* which they use for skin infections is a disinfectant and can be used for certain kinds of vaginal discharge. Similarly, garlic *(Allium sativum)* which they use for trichomonal infections has anti-bacterial properties.

This kind of validation of the traditionally used plants by external agencies has succeeded in elevating the status of herbal remedies and has given the community (men and women) a new confidence in their own knowledge. Additionally, it has radically altered the relationship between the local women and the external women who have been working as facilitators. Learning about their belief systems and their traditional medicines and sharing our knowledge based on modern scientific concepts has made us partners in this process. The mutual exchange of knowledge and experiences has both been humbling and empowering. Another empowering feature, of the use of traditional medicines in women's health, is the increased sense of control that the women have: they do not have to depend on external medical professionals to tend to their common problems, they can use the locally available materials to take care of their symptoms.

## Conclusion

In summary, empowerment is the bottom line. A meaningful health programme for women can take roots only if it has empowerment as its basic objective; and in the process facilitates greater control for women over their own bodies, and minds. Women's subjectivity, their experiences of being in this world, have been negated and rendered invisible. The layers of negation and devaluation need to be peeled off so that women are empowered, their experiences validated and they are enabled to develop their self-image within a context where they can exert control over their bodies an recognise their intrinsic strengths, both individually and collectively.

*continued overleaf*

The above article has briefly described the role of ethnomedicine in empowerment. We have outlined an action research model that tries to take the 'best of both the systems'. This means, in effect, straddling at least two different paradigms and two different knowledge systems — the traditional and the modern. In the process of creating a synthesis, we are filtering, taking some in and weeding some out. What goes in this decisive process of filtering and weeding out ? Which or whose knowledge and moral system decides what is good ?

Admittedly, we as facilitators use the 'modern' paradigm to evolve yardsticks for good or bad. But that is only at the initial stages. In a health programme, which is based on a participatory discourse, the collective consciousness of all women evolves decision criteria for what are good or undesirable health practices. Ultimately, the only common criterion is what is empowering according to the subjective experiences of the women involved.

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not go out for labour because of indifferent health. Also, there was a regular income from her husband, who was the village postman. After two living daughters, Vithabai was desperate to have a son. Over three years, she went through three successive full-term pregnancies and each time delivered a male child. The first was still-born; the second died two weeks after birth; and the third, born rather weak, also survived for just three days. Her husband, who was relatively understanding, tried to convince her that they were not 'destined' to have a son. But Vithabai was not ready to give up and went through her seventh pregnancy in nine years. This time, ironically, the female baby survived but Vithabai suffered acute anaemia. The social worker, doctor and husband were finally able to convince her that her body would not survive further pregnancies. Her husband then immediately underwent sterilisation out of the fear that she might change her mind once she regained her health!

☐ **Meena:** A city-bred social worker, was working in a rural area. Due to contraceptive failure, she conceived soon after marriage. She and her husband were totally unprepared for such an early parenthood and therefore decided to abort the foetus. But this was easier decided than done. Women members of their group exerted pressure, specially on Meena, saying that the decision was foolish and immoral and that they would regret it. They saw the issue of 'unpreparedness' as superfluous and saw no reason why a first child should be planned. They put this attitude down as one of 'urban eccentricity' and exhorted Meena not to be so selfish. Frustrated and angry, Meena asked her colleagues why she was being singled out for the bombardment when it was a decision jointly taken with her husband. But beyond a single line appeal of 'why don't you change your mind', there was no further dialogue on the matter with the husband. The women justified this on the ground that, as a woman, they expected Meena to appreciate the feelings of motherhood better and it was up to her to convince her husband. All these, on the eve of the abortion, served to confuse and depress Meena. They, nevertheless, went ahead with the decision. However, in the villages, her colleagues spread the word that Meena had had a miscarriage. They advised her to carry on with this falsehood that they had consciously perpetuated. They convinced her that this was done keeping her interests in mind, as the villagers would never understand the justification to abort a 'legally conceived child'! Too exhausted to protest and weakened by guilt feelings, Meena decided to toe the group's line.

☐ **Sheetal:** An educated, yet to be employed young woman, who had grown up in a village and had moved to the city after marriage. Her husband, who still did not have a regular job or an income steady enough to support a family, was not in a hurry to start one. But Sheetal felt anxious about the reaction of the villagers if she was not able to show 'results' within a year of marriage. Without resorting to necessary precautions, she thus happily managed to give the 'good news' of a pregnancy within six months of her marriage. Her husband agreed that it was likely to create family tensions, as he was nowhere near a position of 'settling down', but expressed helplessness under the circumstances.

☐ **Vimalbai:** An agricultural labourer. She was prevented from cohabiting with her husband because there was a fourteen Rupees shortfall in her dowry. After two years of a torturous existence, her husband married a second time on the grounds that his first wife was 'barren'. Vimalbai suffered deep turmoil as she witnessed the second wife enjoying everything that was rightfully hers. Yet, for years she patiently bore with the physical and mental abuse in the hope that she would manage to win over her husband and still be able to prove that she was not barren. But this proved impossible. In her desperate urge to prove her fertility she succumbed to an illicit relationship, got pregnant and was almost murdered by her husband, as a result. She managed to escape with her life, but her natal family was ready to accept her back in their fold on the condition that she clandestinely aborted the foetus and continued to perpetuate the myth of her 'barrenness'. Since the man responsible for her pregnancy was not prepared to 'lower' his prestige by standing by her, she bitterly succumbed to social pressure.

The case studies could go on endlessly. The point, however, has been made. In most of the cases presented above the message which comes out loud and clear is the desperation of the women to prove their fertility and to mother at least one male child. In some instances, as in the cases of Vithabai and Seema, the husbands displayed unusual sensitivity and rationality. Yet, these are exceptions. In the ultimate analysis, the desperation of the women is more pronounced because they have more at stake. Society would condone, even encourage, remarriage of a 'deprived' male. He would, after all, only be fulfilling his social obligation of preserving the patriarchal lineage. But a legally wedded, non-mother would be looked upon with suspicion, be humiliated and face overt and covert ways of ostracism. In short, her life would supposedly be meaningless minus a motherhood tag. Another fact that emerges from these cases is that the social construction of motherhood is a universal phenomenon which cuts across all classes and educational backgrounds.

This does not mean that reproductive roles are always borne under duress. They are and can be happy experiences. But unless women are given the liberty and space to have control over their own fertility, reproduction becomes a mere social exercise — a duty borne with or without pleasure, a process to buy an elusive 'gift' called status.

# WOMEN, FERTILITY AND PLANETARY SUSTENANCE

Mira Sadgopal

*This is a modified version of the Paper presented at the Sixth National Conference on Women's Studies, University of Mysore, 1993.*

As the apocalyptic timbre of 'the year two thousand' strikes our eardrums again and again, we citizens may be all too prone to get carried off in the current of global fervour to 'meet targets'. To keep sane, we must exert to recall that there will be no real difference between December 1999 and January 2000, except by dent of our human minds (...unless, of course, the uncanny but possible event of global nuclear holocaust occurs at that very midnight hour).

The fact is that today, at this moment on this frail planet, we are already in enough of a mess. Many have made us realise this with facts and figures. Rather than mindlessly panicking over the proverbially ticking 'population bomb' or seemingly inevitable nuclear destruction, it is imperative right now that people try to understand a deeper controlling reality. Some thoughtful persons across the globe are identifying this as a 'paradigm crisis' unparalleled in human existence.

## The Paradigm Problem, Human Fertility & Feminism

A paradigm means a set of values, a model or a world-view. The existence of every distinct society or particular civilization is backed by one. At times of passage from one major stage of development into another, the paradigm shift is a fundamental, revolutionary event.

There is a growing understanding that the great problems of today's world, including the drastic economic 'solutions' like the NEP (New Economic Policy) and structural adjustments being launched in all 'developing' countries, are parts of a single crisis of perception.

They are symptomatic of the untenability of the dominant paradigm which originated from eighteenth and nineteenth century Europe and America and was disseminated through nineteenth century colonialism to countries like ours. This was a 'rational' and mechanistic world-view spawned in the industrial revolution, which saw nature as an enemy to be conquered by human civilization. Although this control over nature was meant to benefit human beings, the few were always more 'equal' than the many others, and the mass of human beings tended to be confused with nature, that is, to be controlled and used. The Malthusian theory regarding poor populations was tailored to fit this outlook. The value system is based on domination and exploitation for more and more production in the name of 'progress'.

The global tendency is to force upon the world's people, and indeed upon the planet, more of the same. However, now the stark and horrifying limits have appeared at every frontier and horizon. The crisis can only be resolved through a historical paradigm-shift to a holistic and ecological world-view and a value system based on partnership and planetary sustainability. For this shift to occur, we have to learn a lot from our traditional societies. They were sustainable ones, albeit at a lower level of development. Further development from this level need not be at the expense of sustainability.

Although the dominant paradigm assaults the entire physical and social environment through the gigantic crisis brought about by modern 'development', to see the paradigm-problem through the issue of women's control of human fertility is especially instructive. Immediately, it links the 'personal' with the 'political', a pre-requisite for appreciating the complete meaning of paradigm, I feel. Secondly, it helps us to clarify our view of population, touted as the single greatest threat to world survival. Thirdly, it places reproductive rights in the same sphere as environmental sustenance, which is where they should be. Furthermore, it gives us a natural context for assessing contraceptive needs and for judging the appropriateness of present and future contraceptive technologies. Finally, it allows us to select what is relevant from what is irrelevant in government policies affecting health.

The central role of women in traditional societies characterized by sustainable forms of production has been highlighted by Vandana Shiva. Also in traditional and tribal societies (from ancient times to present day), we have scattered accounts of women's awareness and adoption of varied practical means to curb their fertility in the interests of well-being and survival within the given habitat, climate or season of mobility, for example, among the Kung and Bantu people of South-West Africa, the Tasaday of the Philippine rain-forest, and native North Americans,etc. We may have heard or read horror stories of birth accidents and abortions in eighteenth and nineteenth century, when male physicians in Europe (and later in the colonies) were performing their well-known coup to wrest health care away from women and midwives. In much of rural India still, such tragedies are not uncommon for women, and are often singly attributed to lack of access to 'proper' health services. In fact, however, never before have women been in danger of becoming more alienated from their bodies, health, and their own fertility.

Paradoxically, although not surprisingly in the given paradigm, modern birth control technology has often contributed to this alienation despite it's potential for individual liberation. This schism of women from their bodies and reproduction is paralleled by deep alienation in human

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society from older forms of livelihood and production, which did not destroy but rather consciously preserved nature at the same time.

## Population and Reproductive Rights

During the June 1992 Earth Summit at Rio de Janeiro, the Global Forum passed the Treaty on Consumption and Lifestyle. While not ensuring any of the radical changes necessary if our planet is to survive, it records a historical recognition: "While overall population growth is a danger to the health of the planet, it must be recognised that population growth in the North, due to extremely high levels of per capita consumption, is a far greater threat than population growth in the South." In spite of this fact, women's reproductive rights are being trampled in the name of population policy without a genuine attempt to tackle the basic issue of destructive development.

As a case in point, Thailand gives us one of the success stories in population control, reducing its fertility rates by 50% since the sixties. This has been parallelled by a phenomenal deterioration of Thailand's environment, as the country has been converted into an economic colony of Japan, the world's largest consumer of tropical forest products (wood). Japan is currently also exporting industrial pollution on a massive scale to the same region. With it has exploded 'sex tourism' and STDs....

Experiences of many countries tell us that women's development is the best contraceptive at a social level. Some countries or areas of the South with low per capita income levels which have successfully brought down their growth rates are instructive for us. These are Sri Lanka, Kerala, China and Cuba, with fertility rates having been reduced nearly by 40% or more between 1960 and 1985. In each case, there has been staunch government committment to social welfare, including supporting distribution of basic foods, old age security and specific measures to liberate women. The latter range from women's employment opportunities, child-care, women's education, to comprehensive women's health services (including contraception). In addition, in Cuba after the revolution, women were not only granted the right to divorce, but a husband's refusal to practice or allow contraception could be legal grounds for the woman to sue for it! In China, the severe 'one-child' policy could have gotten nowhere without the priority given to land-reform, education, health services and relative food security, etc., for the vast majority of the population including women equally.

Hence, in addition to general welfare, women's enhanced social status, economic and health rights and access to education are vital in lowering birth-rates. This consensus, probably quite evident to most of us, is stated in the 1992 World Development Report issued by the World Bank.

However, recent developments in China are not good, providing negative lessons in population control. Massive economic reforms which began in the eighties have brought privatization of agriculture and industry though there is a rapid increase in production. There is rapid erosion of social security mechanisms and widening inequalities. Thrown back on their own family's resources, many Chinese again see having children, especially boys, as beneficial, both as a substitute for lost public protections and as a means of taking maximum advantage of the new economic system. China's birth-rates, and notably female infanticide, have increased since the eighties.

What China's experience in the 1980s suggests is that the 'structural adjustment programmes', that the World Bank and the IMF have imposed on large parts of the South during the same decade, will actually increase fertility-rates, owing to the income and widespread social stress accompanying the privatisation, deregulation, and elimination of social subsidies that have been central elements to restructure 'inefficient' Third World economies.

Linking all this with the previous discussion of women's traditional roles in sustaining the habitat, I mean to suggest that complete reproductive rights of women are not in essence contradictory to ecological curbing of population growth. In fact, reproductive rights should be seen in the holistic context of total health rights and the right to fulfill women's traditional and necessary ecological role to ensure the sustenance of the planet.

## Contraceptive Needs and Technologies

As they say, an 'ideal contraceptive' should be safe, acceptable, effective, user (not provider) dependent, not too difficult to use, and reversible in case pregnancy is later desired. It holds equally true that for such contraception 'to work' ideally, people have to want it to succeed, and they have to understand and use it properly. In other words, mainly people must think. This is from the point of view of the 'user'.

Much research has established that simple barrier methods (condom, diaphragm, etc.) with spermicides, and even periodic abstinence based upon women's fertility symptoms can achieve extraordinarily high effectiveness rates (92 - 98%) when couples' motivation is high and they understand the method (and their bodies) well. Not only this, but barrier methods and periodic abstinence are virtually hazard-free and totally in control of the user(s). Unfortunately, the rubber diaphragm has never been made available for women in India, due to a prejudice that they won't be able to use it (no water, soap, privacy...) or don't want it (too messy, or 'shameful'). In general, men don't 'like' to use a condom. The AIDS fear has begun to change this attitude in outside sex, but not in that with wives. Fertility-awareness-based contraceptive practices require the most personal and dedicated involvement of women and their male sexual partners.

In the last two decades in our country, and globally, we have seen the increasing administrative tendency to retreat from appreciating the person's point of view. During these years it has not been difficult to detect a general elitist attitude about people as if they are inherently stupid, or that if they use their brains they do so unreliably, irresponsibly and even dangerously. Hence the technologies which international population control agencies and governments choose to 'offer' (without real choice for people) are progressively more provider (not user) dependent, long-acting, of dubious safety and untested reversibility, and supposedly highly effective, especially since, once in place, the so-called user cannot discontinue the method easily. Progressively, we have seen the IUD, the pill, vasectomy (quickly abandoned), manual and then laparoscopic sterilisation, the long-acting hormonal injectibles and implants, and the upcoming anti-pregnancy vaccines. Data is accumulating on the adverse effects of these invasive contraceptives. In Bangladesh, IUDs and tubectomy each are associated with sevenfold higher incidence of PID (pelvic inflammatory disease). Here in India, as a result of mass sterilisation camps with poor follow-up, untold numbers of women suffer and die off the record. Even at the philosophical level, many of us can appreciate in this progression a trend of increasing alienation of women and human beings from fertility.

## Government Policy and Women's Lives

Professor Ashish Bose has pointed out that the major weaknesses of the Indian Family Planning Programme have been,

1) that it has revolved around technology,

2) that it has been corrupted by incentive money (and biased by the same towards sterilisation rather than spacing),
3) that planners and policy-makers became prisoners of targets to satisfy donor agencies, where 'family' is nowhere in the picture, and
4) that it has seen increasing bureaucratisation to facilitate the management of huge allocated funds where people do not count.

As importantly, on the people's side, he has pinpointed what he calls 'demographic fundamentalism' expressed in the pervasive desire for sons. Hence, the rural masses fix their own 'minimum needs programme' with a cut-off point at two boys. Given the statistics, to have two living sons, a woman must give birth to three, but she might also have three daughters or so, meaning six births per family on average...

Further, Prof. Bose contends that, since 58 % of couples are "below the son line and will therefore resist family planning, no matter how efficiently our Family Planning Programme is run, or how modern our contraceptive technology is, there are limits to what a programme centered around contraceptive technology can do. At most, it can get forty-two percent in the net, and that is the figure we are nearing... in short, our Family Planning Programme has reached a dead end."

Professor Bose's prescription for cure, I think, is simple, practical and campaignable:

I. Disband the redundant Department of Family Welfare and merge it with Health, making contraception part of good all-round health care. Dr. N. H. Antia recommends the same.
II. De-bureaucratise the Family Welfare Programme and hand over the entire motivational work to the NGO sector, particularly women's organisations.
III. Introduce a policy of positive discrimination in every field in favour of women, thus making them assets and not liabilities.

We should note that since his prescription was offered in 1990 before the NEP began, it should be fortified in this light.

With regard to women's reproductive health, some issues should be specifically mentioned:

1) Infertility is a large and growing problem among women, due to factors such as rising incidence of STDs, the failure to curb tuberculosis and its probable future increase, unsafe contraceptive methods, etc.
2) India's rate of cancer of the cervix is the highest in the world, and can be detected at the earliest (curable) stage by screening of women with a simple, inexpensive test called the Pap Smear.
3) Contraceptive choice for women at present is a farce. Even without further research, more options like the diaphragm, cervical cap, sponge, spermicides and female condom can be arranged (through the Movement) and provided (by Government or otherwise) for 'field trials' all over the country, with well organised standardised (but locally sensitised) fertility awareness education. Sterilisation, the frequent choice for terminal birth control, could be made safer and more humane. Right to unconditional, safe abortion is essential as the last resort for all women.

### Facts on World-Wide Contraceptive Use

The following information gives an over-view of what kinds of contraceptives are being used in the world.

- ☐ 400 million married couples or a little less than 50% use a contraceptive method.
- ☐ 155 million rely on sterilization.
- ☐ 80 million use the IUD (58 million in China alone).
- ☐ 61 million use hormonal methods mainly the Pill (55 million).
- ☐ 38 million use condoms.
- ☐ 58 million rely on traditional methods.

*Source : Asian and Pacific Women's Resource and Action Series : Health.*

## Recommendations

The following are some relevant, interconnected steps that the Women's Movement in India could take up and carry into the next century:

1. Continue the day-to-day fight against violent abuses like amniocentesis (female foeticide), dowry torture, physical and sexual abuse within and outside the home, custodial rape, etc., without forgetting that nothing will really begin to change until part III of Prof. Bose's above prescription is insured.

2. Begin campaigning widely, boldly and steadily for deep and far-reaching changes for and by women in government and society because upgrading of woman's status and her education are the essential preconditions for safeguarding her general and reproductive health and hence these two general measures are so important.

3. Support setting up real models of women's health care in every part of the country, and provide a broad information and action network of all groups actually working on this. Participate in and support necessary research in these centres. Concerning reproductive health, let us remember that men require such services, too.

4. Focus on safe, appropriate contraception for women in light of the entire above discussion, and considering the previously neglected need for protection against reproductive tract infections.

5. Support and stimulate initiatives by men (and women, when needed) to come to terms with violence and with the oppressive social pressures and values that perpetuate violent, exploitative patterns of behaviour. We can link this with anti-communal action at large.

6. Integrate women's health concerns with an ecologically sound perspective and environment-friendly action. For example, use alternatives to indestructible and toxic, 'disposable' menstrual hygiene products, oppose wasteful overuse of high technology, fight pesticide contamination of food distributed to the public, protect the remaining forest habitats and people including their dwindling wealth of medicinal plants, and support practical 'green' initiatives in rural and urban areas.

Government concurrence and backing of the law may be sought to support much of this. However, it is obviously not a prerequisite. The greatest task will be winning over the masses of women, and the people at large. Ultimately, "if the people lead, the leaders will follow"!

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*Tuberculosis Control*

# THE PUBLIC HEALTH SERVICES

Sheela Rangan & M. W. Uplekar

*This is the fourth article in the series from the project Social and Operational Constraints in Tuberculosis Control.*

The previous articles in this series discussed the problems that people at large and the patients of tuberculosis have in seeking help when they suffer from TB. The study undertaken by the FRCH to identify social and operational constraints in tuberculosis control also focussed on the role of the public health services. This article, which looks at the health providers in the public health sector in Pune district, addresses the following queries :

* What are the facilities that the public health facilities offer for tuberculosis patients?
* What is the attitude of the staff towards the disease and the patients ?
* What is the knowledge of the various functionaries about the disease and what are their practices as regards the control programme ?
* What are their problems with implementing the TB programme and what solutions do they have for these ?

**An Illustrative Case**

When Vitthal was told by his family doctor that in order to cure his cough and chest pain, he would have to take treatment for 10-12 months, which would cost him close to Rs. 5000, his world totally collapsed – he had already spent Rs. 2000 for the treatment of his cough by 3 doctors in the village and the nearby town and had taken a loan of Rs.1000 for this.

His brother-in-law, on seeing his misery, suggested he go to the nearby Primary Health Centre (PHC) and find out if he could be treated there. But Vitthal had had a bad experience with the PHC – the last time he had been there with a wound on his leg, he had to pay the compounder for the dressing given every alternate day; the doctor had asked him to buy some expensive medicines from outside and had also asked him to take injections from his private clinic for 5 days. In the end, Vitthal had spent almost as much as he would have spent with a private doctor and had also wasted a lot of time waiting for his turn at the PHC. His brother-in-law assured him that this time there would be no waiting since he knew the local *panchayat* member who would put in a word for him with the new doctor – the Medical Officer (MO) who had treated Vitthal a year ago had now been transferred.

He was finally convinced and went to the PHC. It was a Monday and he was informed that the doctor would be available only on Thursday. When he did meet the MO, he was given a cursory examination and told to get a sputum examination and a chest X-ray. The lab-technician informed him that since the microscope was not working, he would have to go to another PHC 25 kms. away for the sputum test. Further, for his X-ray he would have to go to a private X-ray clinic or to yet another PHC 10 kms. away. When Vitthal inquired if there was a simpler way of getting both his tests done together and at a lower cost, he was advised to go to the Sassoon General Hospital in Pune city.

After a week, Vitthal landed at Pune one morning, at 11.30 am. On reaching Sassoon, he had to spend half an hour at the campus before he could locate the chest out-patient department (OPD). By this time the OPD had already closed and he was asked to come back the next day. Having nobody to stay with in Pune and since he was low on finances, he decided

Both the authors are medical doctors and researchers involved in the completed IDRC sponsored study on which this article is based.

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to stay in the hospital campus itself.

The next day, after a half-hour wait in the queue, he managed to meet the doctor, who recommended investigations. At the laboratory, he was told to pick up a large leaf, go to the back of the building, face the wall and spit on the leaf. He was then asked to get his chest X-rayed and come again the next day with a second sputum sample in a glass bottle. On the third day of his stay in Pune, his reports were seen by the doctor who declared that he needed to be hospitalized. Since the beds in Sassoon were full, he was given a slip and sent to Aundh Chest Hospital. After a series of enquiries, he reached Aundh, only to be told that he was 115 on the waiting list. A security guard informed him in undertones that Rs.100 would help him jump the queue. Desperate that he was, Vitthal coughed up the money and got himself admitted. A series of tests and X-rays later, he was started on treatment and after a fortnight, when his physical condition improved, he was asked to go back to Sassoon.

Though he was at his wit's end, Vitthal went back to Sassoon, where his treatment card was made. He was told by the clerk that he had two choices – he could give a false Pune city address and collect his drugs every month from Sassoon or they could send his card back to the PHC close to his residence. Having had enough to do with the city, Vitthal chose the second option and went back to his village.

The next month, when he went to the PHC for his drugs, he was informed by the compounder that only one of the 3 drugs he was advised was available at the PHC and he had to buy the rest from the chemist. Vitthal, who by now had totally exhausted his funds, preferred to take only the drugs given by the PHC. Over the next two months, he visited the PHC whenever he had time and collected and consumed whatever drugs were given to him – sometimes one and at others three. His condition started deteriorating and soon he became totally bed-ridden and stopped taking treatment from the PHC. But his treatment card at the PHC showed that he was a regular patient. Ten months later he was declared to have 'completed optimum period of treatment' (COPT) by the PHC and his card was closed. Vitthal had thus become one more person among the 40% patients started on treatment that year who, on the records, had "successfully completed his treatment and got cured" by the public health system!

**The TB Programme : On Paper**

The role of a PHC is very well-delineated under the National TB Programme. Since most patients of TB do present themselves to the public health services, the doctor at the PHC is supposed to subject all cases with cough for more than 2 weeks to a simple sputum examination. Patients need to be explained carefully about the method of bringing out sputum, as, often, they give only saliva for examination. The doctor himself, or the laboratory technician, is supposed to explain this method and provide a sputum cup to the patient for collecting the sample. Under the programme guidelines, sputum examination is to be done on the same day and the patient is to be started on appropriate treatment if the sputum shows the presence of the TB bacilli. If it fails to show any bacilli, the patient is referred to the nearest public health centre with X-ray facility. If the X-ray shows shadows suggestive of TB, the patient is started on treatment and sent back to the referring PHC for continuation of treatment. Whenever the patient does not report to the PHC for collecting his monthly quota of drugs on the due date, he is sent a reminder either by post or through personal home visits by health workers. Follow-up sputum examination is done at the end of 2 months and again before completion of the treatment course. After completion of the entire course, the patient's treatment card is closed and sent to the District TB Centre (DTC).

**What Ails the Public Sector**

Vitthal's story acquaints us with some of the problems afflicting the TB programme today :

- The non-functioning Primary Health Centres
- Frequent referrals without consideration to the physical condition of the patient
- The poor quality of case finding tools
- Non-availability of drugs and supplies
- The blatant manipulation of records and reports

It is well-known that for most illnesses people prefer to use the expensive services of the private sector. This is because of the near total non-functioning of the PHCs – they are viewed as doing only Family Planning and Immunization work (which is a fact acknowledged by the health functionaries as well). Moreover, the public health functionaries themselves do not have enough confidence in the quality of their own services. This percolates to the users of the services as well. This, however, does not seem to be true of all the PHCs. In one of the PHCs that we studied, things did appear to work efficiently, though only for the few influential in the community and those with political connections.

As far as TB services are concerned, even in PHCs where diagnostic facilities are supposed to be available, very often either the microscope or the X-ray machine does not work, or there are no chemicals or X-ray films available. In some cases, the personnel to perform these tests are not in place.

The inefficient functioning of the peripheral health institutions results in an excessive load on the DTC, to which patients flock. More than 60% of patients attending the DTC are from rural areas. This leads to a decline in the quality of case finding, especially sputum microscopy. Consequently, there is an over- reliance on X-rays for confirming diagnosis. The excessive load on the DTC also results in the functionaries being unable to offer supervisory and technical support so vital for the proper functioning of the programme at the level of the PHCs.

Unfortunately, the non-function of the programme at the PHCs does not come through when one examines the data available on the programme performance. Our observation is that the maintenance of records at the PHCs is very poor – treatment cards of patients are not always made, most of them are incomplete and cards of patients who are irregular or have completed treatment are at times simply torn up instead of being sent to the DTC. Hence the DTC, which is at a loss at the time of preparation of annual reports,

resorts to manipulation of data. An attempt made by us to perform independent cohort analyses of treatment cards for two consecutive years showed wide variations in the results. While the DTC reported 27% and 25% of the patients put on Short Course Chemotherapy(SCC) for the 2 years and 35% and 29% of those started on standard regimens (SR) as completing treatment, our analyses showed the treatment completion rates to be 8% and 14% for SCC and 4% and 9% for SR for the same years.

**Justifying the Lacunae**

Quite a few of the problems affecting the programme are acknowledged by the functionaries themselves – but they have their own reasons to justify these. The priority given to the Family Planning and Immunization programmes and the pressures on the PHC personnel to achieve the targets set by these programmes are the reasons quoted for the failure of the TB programme. Though there are targets for the TB programme as well, these may be ignored in the absence of any pressure from the top. The low priority accorded to the programme also results in the lack of supplies – drugs are always in short supply, chemicals, stains and X-ray films become unavailable for prolonged periods, and there is insufficient budgetary provision for posting letters to defaulting patients (as recommended by the programme). Sometimes, even if drugs are available at the DTC, these do not reach the PHCs for a variety of petty reasons – the indents do not reach the DTC on time, there is no vehicle to deliver the drugs or the PHC staff refuse to go to the DTC since they do not get reimbursed for their travel expenses.

Sputum examination, the simplest but most important tool for detecting TB cases, meets with problems at each of its steps – right from collection to microscopic examination. The multi-purpose workers (MPWs) who are supposed to be collecting sputum specimens from people from the community with chest symptoms do not always do so – very often they blame people for refusing to give sputum samples. Sputum cups, which are supposed to be provided for collecting the samples, are not available – hence, even at the DTC the samples are, at times, collected on leaves. Spirit, which is required for preparation of the smear on a glass slide, is not available and the workers complain that when the slides are sent to the PHC for examination, there are long delays in receiving the reports and sometimes even loss of reports. The PHCs and the DTC in turn blame the MPWs for sending them slides of poor quality and at times even broken slides. A study on quality of sputum microscopy done by us showed that the quality of sputum examination, even at the DTC, was very poor – upto 21% of slides were found to be wrongly reported.

The training offered to the PHC staff with regard to the TB programme is also very poor, as reflected by their knowledge regarding the disease and its control and their practices. Very few MOs knew the correct treatment regimens. Rarely were any defaulter retrieval actions, as recommended by the programme, taken by the health workers. The functionaries, however, feel that it is the patients who are to be blamed for poor treatment adherence.

**Ad hoc Solutions**

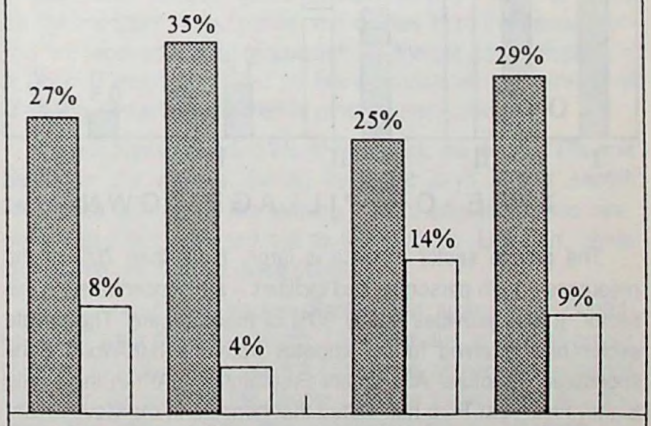
Most functionaries believe that the only solution to making the TB programme work is to make it a vertical programme – introduce the practice of incentives along the lines of the family planning and leprosy programmes and set strict targets for each level of functionaries.

Having closely observed the functioning of the health services in general and its tackling of the serious problem of TB, we wonder whether the solutions proposed by the health functionaries themselves – of setting strict targets, offering incentives and using "whips" for non-performance on paper – would provide a sustainable alternative. Our team of researchers had prolonged interactions with health functionaries and discussed with them, at length, the issues involved. In order to enable us to build a "working" model, we made special efforts to evoke responses from them, based on their first-hand experiences of ground realities. Their responses raised several questions in our minds.

When the family planning programme, which received topmost priority at each level, could lead only to a dismal failure, why would the health workers want the same approach to be adopted for TB control? Have we been brain-washed so much by the "vertical" approaches that we cannot think otherwise? Or truly, is this the only approach to the problem? Can we learn from other experiments outside the system? How can these be adapted to the present system? And would these be sustainable?

***Acknowledgment*** - The authors have based this article on information collected and analyzed by the research team of the IDRC-funded project on tuberculosis.

**REPORTED TREATMENT COMPLETION RATES FOR TWO YEARS UNDER THE TB CONTROL PROGRAMME**




(Diagram by Aruna Deshpande, Statistician, FRCH)

# PUBLIC-PRIVATE HEALTH SERVICES IN A DISTRICT

## *a note on their location*

Shirish Kavadi & Manjiri Sule

Nearly fifty years after independence and seven Five Year Plans later, India is still far away from achieving universal and quality health care. The problem is not so much with the availability of health resources. Inaccessibility and non-availability of health facilities are actually a problem of their distribution. Here, an attempt is made to explain this unequal distribution of health services in a district and its significance for health care planning.

Developed regions and urban areas tend to have a concentration of health care services – both public and private. It has also been observed that the private sector tends to be concentrated in areas where public facilities already exist. The private sector, utilizing to its own advantage the dissatisfaction of the general populace with public facilities, is thus assured of a large clientele.

The private sector in India is large. More than 70% of the resources – both personnel and facilities – are concentrated in this sector. It also provides nearly 80% of medical care. The private sector has received further impetus from the IMF/World Bank sponsored Structural Adjustment Programme (SAP) in India. The Eighth Five Year Plan has stated that henceforth the Government of India would encourage private initiative in health care, while it would curb further expansion of the government sector health services. As a part of this general process, decentralization of health care is also being encouraged. The new Panchayati Raj Act has incorporated health care as a subject for Panchayati Raj institutions.

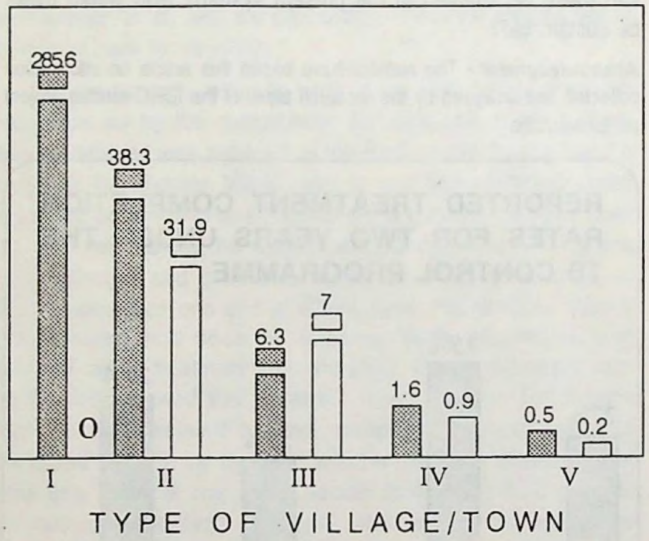
Notwithstanding the criticism about SAP, decentralization of health care has been welcomed, both by health researchers and health activists, on the grounds of enhanced accessibility and local control over health services. But a decentralized health care system would necessarily call for a redistribution of resources.

Against this background, all efforts to ensure equitable and quality health care would have to take into account the maldistribution of health resources. Policy makers and planners, health researchers and activists, will all have to work out a plan and policy to ensure an equitable distribution of health resources. For this, reliable and accurate information on the nature and pattern of this maldistribution would be in order.

The FRCH study in Ahmednagar district, which involved preparing an inventory of health resources, has brought this out reasonably well. The district, according to the study estimates, has 3059 doctors, a small percentage of which belongs to the public sector. (For a detailed explaination see Sule M., FRCH Newsletter, Nov.- Dec. 1992). Ahmednagar has 13 *talukas* with five of these falling in the developed category and seven in the under-developed. The district has 10 towns and around 1500 villages. Here an attempt is made to identify the location of doctors against public facilities in the towns and villages of the district. The diagram and table presented above indicate the tendency of doctors to set up practice in towns/villages where public health services already exist.

It was observed that villages having no or limited accessibility to public services also have the least number of private doctors. Many private doctors, when not located in a town/village with public facility, are usually based in a neighbouring village within a radius of five to ten kilometers, which is also the area covered by a PHC. The villages falling outside the periphery of a PHC area thus have no immediate access to either public or private health providers.

**AVERAGE NUMBER OF DOCTORS PER TYPE OF VILLAGE/TOWN**




| TYPE OF VILLAGE/TOWN | ▒ : DEVELOPED TALUKAS | | □ : UNDER DEVELOPED TALUKAS | |
|---|---|---|---|---|
| | No of Villages /Towns | No of Doctors | No of Villages /Towns | No of Doctors |
| I. Towns with Civil Hospital and/or Municipal Facilities | 5 | 1428 | 0 | 0 |
| II. Towns/Villages with Rural Hospital | 3 | 115 | 9 | 287 |
| III. Villages with PHCs | 37 | 233 | 39 | 273 |
| IV. Villages with Sub-centres | 182 | 284 | 240 | 237 |
| V. Villages without any Public Facilities | 324 | 163 | 673 | 107 |

*Quenching the Thirst for Knowledge*

# THE VILLAGE LIBRARY PROGRAMME

Savita Kurhade

*This is the last article of the current series based on the Public Information Project.*

If we look at the social life of people, we find that this is closely interlinked with various factors such as politics, economics and education. But still we find much variation in urban and rural life.

At present, in Maharashtra, there are over 40 thousand villages in which reside over 60% of the state's population. A majority of the villagers are far away from economic and industrial development. One reason for this is lack of knowledge.

It is observed that with proper information and guidance the villagers themselves stand firmly for their development. This fact had become clear in the course of the **Public Information Project**.

There are many media in cities for providing information. In villages these are relatively few. Seeing this gap, in April 1992 FRCH launched a programme of starting Rural Libraries in villages of Purandar (Dist-Pune) and Parner (Dist-Ahmednagar) *talukas*. The intention was to enhance the interest of children, neo-literates and students of adult education classes. It was also intended to create social awareness and make villagers familiar with the current affairs and work towards their own development.

We felt that a library is the best medium to educate people and to motivate different social activities. We also felt that these libraries should be planned, organized and managed by the people themselves. Libraries were started only in those villages where people showed some interest in the idea. The financial support for these village libraries came from Parle Products.

### The Working of the Libraries

While starting the libraries FRCH issues a set of 100 books to each library in which different areas such as farming/agriculture, health, entertainment, literature, science, fiction, etc., are covered. Similarly there is one daily Newspaper provided with it. The P.V. Mandlik Trust of Bombay provides two magazines – *Sadhana* and *Samyayog* – to each library.

To manage the library in a village, a committee of local people is set up by the village people at a public meeting. This committee decides about the admission fee, monthly fee and the rules of the library in that village. The amount gathered for the library is deposited in the bank in the name of the library and this account is operated jointly by a member of the committee and the local FRCH representative.

The expenses, like the purchase of new books and the honorarium of librarians, is to be borne by FRCH project funds till the library obtains recognition and grants from the state Government. Thereafter, the salary of the librarian and certain running expenses would be managed from Government grants and other overhead/extra expenses would be met from the membership fees deposited in the bank. The library generally functions for two hours in the morning and two hours in the evening.

While starting a library in the village the main question that arises is that of location/place for the library. In some villages this problem is solved by *gram panchayats* or *Mahila Mandals* which provide the place. But in some villages, where there is no common place available, the library is started at the librarian's home. In some villages librarians are also self-employed, like tailors. In such cases the library is started in the shops or business premises.

### Learning through Experiences

In this way libraries have been started at Kasare, Manewadi, Kalewadi, Wafarewadi and Gargundi villages in Parner *taluka*. The initial response to most of these libraries was far below our expectations. We realized that the main reason was that the villagers would not come to the library merely out of interest in reading the books; also they were unaware of the role of the library in development. But our conviction is that library is indeed an important ingredient for social reconstruction and change. To reach information to villagers and to inculcate the reading habit it became necessary for us to modify our approach to initiate the programme.

We started the activity as part of the *Granthashala*. In the evening, when villagers gather at the library, the librarian reads out the important news, stories and articles from the newspaper. This has received a good response from illiterate adults, especially in Dhoki (Parner). Enthused by this response we are thinking of arranging similar programmes in other villages also.

*Vachan Saptah* (Reading Week) is similar to the religious *Dharmik Saptah* in the villages. During the eight days of this *saptah* information on subjects like farming, health, education, child care, women and law, are read out to the villagers. Later on, group discussions are held on these subjects.

As an experiment *Vachan Saptah* was arranged at Dhotre-Budruk (Parner *taluka*) in March 1994. But due to lack of proper planning and adequate publicity for the same the people's response was poor. By the time the people came to know about this, the week had ended. Using this experience proper planning and advertisement was done for future programmes. A neat selection of reading material was also an added feature responsible for the success of the later programmes. Information about agriculture, education, health, atrocities on women and similar other subjects were read out as well as slide shows and street plays arranged to reach out to the villagers in an effective manner. Due to the projects like *Vachan Saptah*, slide shows, etc., the village libraries, which initially met with a none too enthusiastic response, began to be run with renewed vigour.

***(Contd. on pg.7)***

The author is a researcher on the Public Information Project.

## FRCH PUBLICATIONS UPDATE

A number of studies have been produced by FRCH during the past year. We present below information in brief about each of them.

1. **Javoo Arogyachya Gava** (in Marathi, April 1993) : This set of 4 manuals is the outcome of the 5-year (1988-1992) School Health Education Project which trained 34 urban and rural teachers and their 1467 students (of Standards 5 and 6). The distinction of these manuals is that while broadly adhering to the defined curriculum on health, these have gone beyond conventional teaching patterns. While covering the basics of nutrition, physiology, prevention and treatment of common diseases, the emphasis is on the social aspects of health. Additional information covers the symptoms, causes and treatment of common diseases, first aid and the misuse of medicines.

| Cost | In India | Abroad |
|---|---|---|
| | Rs.100 *plus* | U.S.$ 20/ £ 10 *plus* |
| | Rs.11 (postage) | Rs.110 (Air Mail) |
| | | Rs.65 (Sea Mail) |

2. **Employee Medical Benefits in the Corporate Sector** (Nov. 1993 pgs. 61) : This exploratory study looks at the medical care benefits provided to the employees in the organized industrial sector (public and private). The author has made a detailed study of 143 companies, looking at the types of medical benefits and the costs incurred. The analysis is made against the background of the current socio-economic policies of the State and employee medical benefits are looked upon as 'social wages' rather than as benefits provided due to the 'goodness of the employer'.

| Cost | In India | Abroad |
|---|---|---|
| | Rs.40 *plus* | U.S.$ 8/ £ 4 *plus* |
| | Rs.10 (postage) | Rs.53 (Air Mail) |
| | | Rs.35 (Sea Mail) |

3. **Strengthening Health Education Services : An Action Research Study** : (Dec. 1993, pgs.165) : This book documents the experiences of researchers who lived over a five-year period in Malshiras village in Purander *taluka* of Pune district. They covered three PHC areas in Purandar and Baramati *talukas* of this district through comprehensive health education inputs. The rich experiences gained and the perspectives developed through these efforts provide valuable insights – insights which confirm that if 'Health for All' has to become a holistic concept, health education should not only develop consciousness about health care activities, but should also aim at creating critical consciousness among the people for improvement in all aspects of life.

| Cost | In India | Abroad |
|---|---|---|
| | Rs.100 *plus* | U.S.$ 20/ £ 10 *plus* |
| | Rs.10 (postage) | Rs.53 (Air Mail) |
| | | Rs.35 (Sea Mail) |

4. **A Study of Household Health Expenditure in Madhya Pradesh** (Jan.1994, pgs. 137 ) : This book documents the findings of the household health expenditure study carried out in Sagar and Morena districts of Madhya Pradesh. The analysis looks at household expenditure as a part of consumption expenditure and examines its components against such differentials as class, gender, age, social geography, etc. Corroborating the findings of earlier health expenditure studies of FRCH, KSSP, NCAER, etc., this study highlights the fact that a massive chunk of the already meagre earnings of the poor goes towards acquiring health care, that too of a dubious quality, in the private sector.

| Cost | In India | Abroad |
|---|---|---|
| | Rs.60 *plus* | U.S.$ 12/ £ 6 *plus* |
| | Rs.12 (postage) | Rs.98 (Air Mail) |
| | | Rs.47 (Sea Mail) |

5. **The Private Medical Sector in India** (Apr. 1994, pgs.63) : This monograph makes a critical review of the private medical sector, discussing features such as costly, sub-standard, private medical colleges, irrational drug use and prescription practices by private practitioners, lack of Continuing Medical Education among doctors and other factors which impede the development of a rational, affordable and socially just medical system. Wide-ranging reforms have been suggested to regulate and render the private medical sector accountable to its clients. Considering the relative paucity of data concerning this dominant sector, further areas for study have been suggested. Given the growing trend towards privatisation of health care services in India, this volume raises several pertinent issues.

| Cost | In India | Abroad |
|---|---|---|
| | Rs.50 *plus* | U.S.$ 10/ £ 5 *plus* |
| | Rs.8 (postage) | Rs.55 (Air Mail) |
| | | Rs.25 (Sea Mail) |

*(Contd. on pg.7)*

6. **Health Research Studies in India : A Review & Annotated Bibliography :** (May 1994, pgs.195) : An outcome of a comprehensive appraisal and review carried out by the FRCH team, this study was commissioned by the Ministry of Health and Family Welfare, Government of India, in 1993. The volume carries, in Section 1, a review of the documents scrutinized, organized under the headings, **Service Delivery, Epidemiology, Health Education, Community Participation and Alternative Strategies.** The second Section presents annotated bibliographies of all the 211 documents included in the study. The time frame covered in this review is the decade covering the early 1980's to early 1990's. It has involved an exhaustive collection of studies that have been carried out by social science research organizations academic institutions, government and non-government market research agencies as well as NGO's. The review, apart from documenting the research studies, provides a critique and identifies the gaps in knowledge and methodology of these research studies.

| Cost | In India | Abroad |
|---|---|---|
| | Rs.175 *plus* Rs.10.50 (postage) | U.S.$ 35/ £ 17.50 *plus* Rs.119 (Air Mail) Rs.47 (Sea Mail) |

7. **Ralegan Siddhi ; A Model for Village Development** (May 1994, pgs.95) : An English updated version of the earlier Marathi book published by FRCH in two editions (1989 & 1991) was a need expressed by the non-Marathi readership. This book documents the process of socio-economic transformation of the famed Ralegan Siddhi village in Ahmednagar district of Maharashtra, under the charismatic leadership of Anna Hazare. It highlights the aspects of self-help, inspired leadership and committed efforts to being about transformation in rural areas.

| Cost | In India | Abroad |
|---|---|---|
| | **Hard Cover** Rs.100 | U.S.$ 10/ £ 5 |
| | **Soft Cover** Rs.75 *plus* Rs.8.50(postage) | U.S.$ 15/ £ 7.50 *plus* Rs.55 (Air Mail) Rs.25 (Sea Mail) |

8. **Panchayati Raj and Health : Proceedings of the Seminar** (July 1994 pgs.17) : This report documents the proceedings and discussions of a seminar on this subject organized by FRCH in April 1994. The seminar, which brought together persons from such diverse fields as medicine, social and political science, economics, and civil servants and social workers, discussed the various dimensions of decentralization; made a critical appraisal of the experiences of states like West Bengal, Kerala and Karnataka in implementing Panchayati Raj; and pinpointed the areas which can be effectively managed and implemented through the decentralized Panchayati Raj system. Health was seen as one such prominent sector whereby Panchayati Raj could be used as an effective instrument for eliciting community participation in the health programme as well as providing supervision, which is so essential for effective health care services at the grassroots.

| Cost | In India | Abroad |
|---|---|---|
| | Rs.20 *plus* Rs.8 (postage) | U.S.$ 4/ £ 2 *plus* Rs.30 (Air Mail) Rs.18 (Sea Mail) |

Copies of the above publications may be ordered from :

**The Publications Unit**
**Foundation for Research in Community Health**
**3-4 Trimiti - B Apartments, 85, Anand Park,**
**Aundh, Pune - 411007, Maharashtra.**

* Bulk Orders of 5 or more copies would be entitled to a discount.

** Buyers abroad, please specify if you would like to receive your copies by Air Mail or Sea Mail and remit postage amount accordingly.

*(Contd. from P.No.5)*

It is now planned to hold *Vachan Saptah* at Dhoki (Parner *taluka*) and Dive (Purandar *taluka*) villages, where new libraries have been established. It has also been planned to start a library at Kaldari (Purandar *taluka*).

The insights gained from the initial experiences in Parner *taluka* proved useful while starting the libraries in Purandar *taluka*. In Parinche area an essay contest was arranged among the *Mahila Mandals* and *Tarun Mandals* from a number of villages. The subject was 'Our Plan to Develop our Village'. The first three winners of the contest were given prizes. Also five consolation prizes were given to the five villages (Parinche, Bandelwadi, Veer, Satalwadi, and Shindewadi) which had sent participants. The consolation prizes were in the form of a library for each of these villages. These were started in January 1994.

**The Current Position**

Presently there are libraries in 11 villages (in Purandar and Parner *talukas*) which are functioning satisfactorily. A meeting is held every month of all the librarians. The meeting of Parner *taluka* librarians is held at Takli-Dhokeshwar and that of Purandar *taluka* is held at Parinche. During these meetings various matters are discussed concerning the progress of libraries, difficulties faced and their solutions, proposed schemes, response to the existing schemes, etc. It is here where the future planning for the programmes of the village libraries (such that they become effective vehicles for

***(Contd. on pg.8)***

*FROM THE SENIOR LIBRARIAN'S DESK . . . .*

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18) WHO **Health Education in the Control of Schistosomiasis**, 1991, B. R. Publishing Corporation, Delhi, Pgs. 61.

19) WHO **Health Education Strategies in South-East Asia**, 1991, World Health Organization (SEARO), New Delhi, Pgs. 96.

20) WHO **Information and Education for Health in South-East Asia**, 1992, World Health Organization (SEARO), New Delhi, Pgs. 96.


*(Contd. from pg.7)*

development) are discussed. Also the books of different libraries are exchanged at regular intervals.

An example of deep motivation was found in an essay, which was sent to an essay competition held by '*Lalit*' magazine. the subject of the essay was '*Asahi Ek Granthpal*' (A Librarian Such As This). The essay contained information on how the librarian of village 'Gargundi' had maintained the library excellently and how the villagers are themselves managing and co-ordinating activities and heading towards independence in this matter.

The successful running of a library at Gargundi village has deeply motivated a 9th std. boy of Karandi village (Parner *taluka*) to take the initiative and help the villagers to start a library without any financial help from FRCH or the government.

### Going Beyond the Libraries

Despite all these it would be wrong to claim that the establishment of the library, by itself, is sufficient for the development of people. If the consciousness of the people is to be enhanced and they are to be motivated for development, different schemes have to be undertaken. Hence, in addition to library, other projects like *Balwadi* and Adult Education as part of the library programme, have also been undertaken. These programmes are made attractive, informative, full of variety and close to the lives of villagers.

It is observed that children are also taking an active interest in reading books and hence turning to libraries. To keep children attracted towards libraries we are planning to organize reading, drawing and elocution competitions. Among the children of standard first to tenth, the competitions will be held by the respective village libraries. The first three to five winners of each village will be brought together and a second round of competition will be conducted. These two rounds will be held at Purandar and Parner separately. If possible, we would have a final round of competition between winners of Parner and Purander *talukas*.

Though the people living in cities get much more facilities for their intellectual growth and therefore develop at a faster rate, it is also important for the villagers to be equally equipped in this world of competition. The approach of the government and other agencies towards the development of villagers is to treat them as ignorant people. Equipping villagers with knowledge and information will serve towards the realization of their potential as dynamic forces in the development of the country.


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# THE NEW DRUG POLICY

## *For Health or for Profit?*

Wishvas Rane

Now that the economic liberalisation has been accepted as a state policy, it is no wonder that the new drug policy has to fall in line with the accepted industrial liberalisation. While different sectors in the drug industry have succeeded in lobbying for concessions and greater profit margins, the voice of the consumers is conspicuous by its silence. Unused to participating in decision making or even in analysing and expressing their views regarding health and drug policies, the academic and professional medical bodies and faculties of medical colleges and health professionals have very little to contribute. Thus, the medical establishment is not in a position to safeguard the health of the people. The government looks to pharmaceuticals as an industry of profit making and does not have any consideration for the safety of the people.

**A Very Happy New Year to all our readers**

Dr. Amit Sen Gupta has stated in The Economic Times issue dated 24 Sept, 1994 that the drug companies have tried to obfuscate the issue by claiming that the profits to sales turnover ratio is not adequate. The pharmaceutical industry is not a capital intensive industry. Table 1 shows that both sales and profits have, in fact, been growing at a faster rate in the pharmaceutical industry. Ranbaxy, in its advertisement in Times of India issue dated 21 Oct. 1994, has claimed " Profits up 120%" for half year ending 30 Sept, 1994.

**HFA : Health = Medicines ?**

India is committed to the slogan " Health For All By 2000 AD". The year 2000 is not very far off. The politicians, bureaucrats and the medical profession wrongly equate health to medicine. The government is thus bent upon increasing the present yearly sales of drugs from Rs. 6000 crores to Rs. 15000 crores by the end of the century. India has one of the most developed pharmaceutical industries in the Third World. According to UNIDO, India's pharmaceutical industry belongs to category V, i.e. technologically developed enough to be self-reliant. Even then our drug production and distribution has not been in keeping with the health needs of our people. While on the one hand there is shortage of essential and life saving drugs, on the other, even rural markets have been flooded with costly brands of irrational drugs of doubtful therapeutic value and need. This is abundantly clear from Table 2.

The new drug policy, announced recently, treats the pharmaceutical industry more liberally through the following changes.

* Number of price controlled drugs to be slashed from 142 to 73 [ this had earlier been reduced from 343 to 142 when mark-ups (total profit) were increased from 40 per cent to 75 per cent in category I (life saving and other important drugs) and from 55 per cent to 100 per cent for category II (some other essential drugs) ].
* Greater profitability (up by 4 per cent) will be allowed for bulk drug manufacturing.
* 51 per cent foreign equity participation will be allowed automatically and these companies will be treated on par with Indian companies.

By offering such a liberal drug policy, the government has conveniently forgotten that even developed market economies treat the drug industry differently from consumer goods industries. Price and production

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FOR PRIVATE CIRCULATION ONLY

**Table 1**

**GROWTH IN SALES & PROFITS OF TOP DRUG COMPANIES**

| COMPANY | SALES (in Rs. crores) | CHANGE (%) | PROFIT (in Rs. crores) | CHANGE (%) | DIVIDEND (%) |
|---|---|---|---|---|---|
| TOTAL | 7028 | 25 | 605 | 48 | --- |
| RANBAXY | 688 | 22 | 79 | 71 | 40 |
| GLAXO | 551 | 28 | 32 | 49 | 27 |
| HOECHST | 351 | 23 | 32 | 136 | 25 |
| SANDOZ | 290 | 1 | 22 | 3 | 25 |
| ALEMBIC | 262 | 56 | 5 | 1 | --- |
| CIPLA | 244 | 24 | 24 | 21 | 32 |
| TORRENT | 229 | 39 | 25 | 54 | 30 |
| AMBALAL SARABHAI | 220 | 7 | 11 | 783 | --- |
| PFIZER | 214 | 25 | 20 | 86 | 30 |
| PROCTER & GAMBLE | 206 | 41 | 17 | --- | --- |
| DR. REDDY'S | 175 | 31 | 33 | 23 | 30 |
| BURROUGHS WELLCOME | 169 | 20 | 10 | 61 | 22.5 |
| KOPRAN LTD. | 159 | 18 | 18 | 59 | --- |
| BOOTS | 154 | 18 | 16 | 23 | 38 |
| GOLDEN HERBERT | 142 | 188 | 4 | 101 | 20 |
| IPCA LABS | 140 | 22 | 15 | 49 | 25 |
| PARKE DAVIS | 137 | 7 | 17 | 13 | 35 |
| WOCKHARDT | 136 | 38 | 22 | 46 | --- |
| SMITHKLINE | 123 | 15 | 14 | 25 | 24 |
| EMERCK | 121 | 2 | 9 | 85 | 15 |
| NICHOLAS | 108 | 19 | 22 | 38 | 22.5 |
| T.T.K. PHARMA | 103 | 32 | 6 | 48 | --- |
| UNICHEM | 103 | 11 | 5 | 76 | 60 |
| LYKA LABS | 103 | 20 | 5 | 39 | --- |
| CORE PARENTERA | 103 | 127 | 28 | 114 | 40 |

***Source*** : Sengupta, Amit, **"Wrong Prescriptions....** *The Economic Times*, Sept. 24, 1994.

controls are enforced in all the developed countries.

**A Profit Oriented Drug Policy**

Truly speaking, the Drug Policy should fall in line with the National Health Policy. But we have a National Health Policy only on paper, and the Drug Policy that we have is not meeting the health needs of the country. The statement on National Health

**Table 2**

**SALES OF IRRATIONAL DRUGS IN 1992**

| DRUG | DESCRIPTION | SALES (in Rs.crores) | GROWTH % |
|---|---|---|---|
| BECOSULE | Irrational vitamin combn. | 23.92 | 0.5 |
| DEXORANGE PLUS | Tonic | 20.11 | 17.0 |
| LIV 52 | Useless liver drug | 17.80 | 15.8 |
| NEUROBION | Irrational vitamin combn. | 15.88 | 31.0 |
| ELECTRAL | Irrational oral rehydration | 16.83 | 24.4 |
| REVITAL | Oral ginseng tonic | 15.05 | 19.0 |
| COREX | Irrational cough mixture | 13.83 | 12.2 |
| BENADRYL | Irrational cough mixure | 13.56 | 2.1 |
| AMPOXIN | Irrational antibiotic combn. | 13.30 | 0.3 |
| BARALGAN | Hazardous anti-spasmodic | 13.17 | 10.2 |
| COBADEX FORTE | Irrational vitamin combn. | 12.88 | 39.3 |
| COMBIFLAM | Irrational analgesic comb. | 12.78 | 23.4 |
| POLYBION | Irrational vitamin comb. | 12.48 | 10.4 |
| PHENSEDYL | Irrational cough mixure | 11.96 | 1.2 |
| GELLUSIL MPS | Irrational antacid combn. | 10.72 | 21.0 |
| NOVALGIN | Hazardous analgesic | 10.53 | 15.3 |
| COMPLAN | Food products (non drug) | 9.23 | 6.0 |
| VICKS VAPORUB | Useless cold remedy | 8.71 | 27.6 |
| OSTOCALCIUM | Irrational calcium comb. | 8.67 | 6.3 |
| HAEM-UP | Irrational tonic | 8.50 | 18.2 |
| ENTEROQUINOL | Hazardous anti-diarrhoeal | 8.43 | 16.5 |
| MACALVIT | Calcium syrup | 8.09 | 6.3 |

***Source*** : Sen Gupta, Amit, **Wrong Prescriptions...** *The Economic Times*, Sept. 24, 1994.

Policy reads ".... **The existing picture :** The mortality rates for women and children are still distressingly high; almost one third of the total deaths occur among children below the age of 5 years; infant mortality is around 129 per thousand live births.... High incidence of diarrhoeal diseases and other preventive and infectious diseases, specially amongst infants and children, lack of safe drinking water and poor environmental sanitation, poverty and ignorance, are among the major contributory causes of high incidence of disease and mortality.[1]

**"Medical Industry :**The country has built up a sound technological and manufacturing capability in the field of drugs, vaccines, bio-medical equipments, etc. The available know-how requires to be adequately exploited to increase production of essential and life saving drugs and vaccines of proven quality to fully meet the national requirement, especially in regard to the national programmes to combat malaria, TB, leprosy, blindness, diarrhoeal diseases, etc. The production of the essential, life saving drugs under their generic names and the adoption of economical

packaging practices would considerably reduce the unit cost of medicines, bringing them within the reach of the poorer sections of society, besides significantly reducing the expenditure being incurred by the governmental organisations on purchase of drugs."[2]

These were the ideals set by the government and measuring these against the New Drug Policy one finds that we are far be low the minimum standards. Maharashtra state is supposed to be progressive. Yet the State Government here has been continuously reducing the allocation of health as the budgetory figures indicate — 1986-87 : 3.40 per cent of the state budget; allocated to health care; reduced to 2.78 per cent by 1992-93 and a mere 2.5 per cent in 1993-94. Most of this scarce funding is erroneously spent on buying irrational drugs and drug combinations. The Government of India has effected more than a 25 per cent cut. The Finance Minister has saved Rs. 100 crores and offered around Rs. 3000 crores as exise relief to liberalise the Indian economy.[3] And now the pharmaceutical industry has been further liberalised to further worsen the health status.

**The Issue of Public Interest**

While referring to the Supreme Court judgement by Dr. Chennappa Reddy in the Cynamide case, in his legal notes in Indian Express, issue dated 27 Apr. 1994, M.J. Antony says, " The most significant aspect of the judgement from the viewpoint of the public is that the price control measures are now to be tested against the interests of the consumers, and not just those of the manufacturers. Since price fixation has been held to be a legislative act, it follows that the government will take into account the consumers' interest more than the profit margin of the producers in essential commodities. The judgement emphasises that `the right of the citizens to obtain essential articles at fixed prices and the duty of the state to provide them are tranformed into the power of the state to fix prices and obligation of the producer to charge no more than the price fixed'. This stress on public interest is a leap forward from some of the leading Constitution Bench judgements which had also laid down that price fixation is a legislative act." But now, with the new drug policy, the drugs selected for price control are not necessarily essential, but those with a sales turnover of over Rs. 4 crores. Thus the right of price fixation for many essential drugs goes to the manufacturers and only the price of the trash will be controlled.

The last (December 1986) Drug Policy statement says, "the present production pattern does not adequately reflect the genuine requirements of the health care needs of the country. The proliferation of formulations and packs without adequate therapeutic rationale is a matter of concern." Kelkar Committee Report reads, "In other words there has been diversion of scarce managerial, technological and capital resources in production of inessential bulk products. The explosion in the production of cough mixures, balms, vitamins combinations, expectorants are notable examples of the phenomenon. Similarly, the price regime encourages the proliferation of unnecessary combinations of drugs as that helps companies to avoid rigid price control. Consequently, India has become the home of one of the largest number of combination formulations in the world.... according to them (experts) these combinations are not just unnecessary but also can be harmful to the health of the people. Once again the government will have to take a number of steps on various fronts to reduce this menace..."[4]

But the New Drug Policy has not taken any steps in this direction. The policy has no control on such proliferation of irrational drugs and drug combinations. With the multinationals with their extensive marketing network, now given a free hand, one can expect that these irrational drugs will, in fact, multiply. The multinationals are willing to come to India because of the big potential of an unexplored market and lack of legislation. I am sure, if they are made to follow the same rules and regulations about manufacturing and marketing as prevalent in their parent countries, none of them would show any interest. From past experience we have seen that in spite of specific ratio parameters (bulk-drug-to formulations), the multinationals have managed to create a shortage of essentials and gained on irrationals. There is no ethical code of marketing and the government has no control on promotion of pharmaceuticals. Monitoring of unethical promotional and marketing practices must take place. Screening of promotional material must be ensured, especially where controversial drugs are concerned and where it is pointed out that false claims have been made. The problem is further compounded by the fact that there is almost no source of regular, unbiased, authentic information on drugs available in the country. A majority of the medical practitioners depend on promotional material supplied by pharmaceutical companies. None of these provisions are found in the New Drug Policy.

In the New Drug Policy just five drugs are reserved for the public sector. It is important to bear in mind that the public sector started production of vital drugs like antibiotics in India, which led to a drastic fall in drug prices. The small scale sector has also contributed in a big way to reducing the prices of essential bulk drugs through manufacturing done by more economical processes. These bulk drugs were, and are, used by the multinationals to manufacture formulations and earn maximum profits. They were not interested in the bulk drug manufacturing, because, in their opinion, the bulk drug prices were not remunerative. Now that the New Drug Policy has removed all the previous restrictions and compulsions on bulk drug manufacturing, the multinationals will import bulk drugs for the prices that they want. Mismanagement, deliberate neglect, corruption, and sabotage at various levels has brought the public sector to its present condition. In a way, the demise of the public sector will strike off the indigenous drug industry and a stage will come when bulk drugs will be imported at exhorbitant rates. In any case, after five years, when the new Patent Act under intellectual property rights comes in, all the new raw materials will be priced at whatever the manufacturer charges.

**Quality and Price Control Failures**

Based on BICP (Bureau of Industrial Cost and Prices) cost studies, the goverment had fixed prices of some of the bulk drugs produced by Glaxo, Hoechst, MSD and other multinational drug companies. This was in 1980, and till today the companies have not paid for the exhorbitantly charged differences. Table 3 clearly shows the difference in rates. These companies obtained stay orders from High Courts and continued to overcharge for these bulk drugs and earn maximum profits on their formulations. This was when there

**(Contd. on page 6)**

# EVOLVING A HEALTH CURRICULUM FOR SCHOOLS

## *A Perspective and an Experience*

Mohan Deshpande

"The positive assessment of health curriculum emerges more in recommendation for change than in celebration of what exists.
**- Sue Rodmel & Alison Watt**

Introducing health education in schools is considered rather useful by everyone concerned about the well-being of today's children and tomorrow's adults. It has therefore been one of the major concerns of various Committees since 1941. The general consensus and the legitimacy of school health education, however, appears to be based on a reductionist model comprising mainly of instructions on personal hygiene and nutrition. This is despite the emphasis laid by the Committees on its 'comprehensiveness.' The question is, what is comprehensive ?

**Health Education : What Does it Mean ?**

If we begin addressing this question, the prevalent general agreement appears more and more dubious and therefore, not acceptable. The concept of health necessarily has a complex and open-ended (and therefore contestable) meaning in reality. While deciding on health syllabus, our education policy makers have never examined this concept in its width and depth. Teachers have continued to feed the children with (more and more) piece-meal information and, at best, instructions that have to be learnt by rote to somehow pass the examinations.

If, by health education, we mean helping people to develop capacities for their physical, social, intellectual, emotional and aesthetic fulfilment, we allow almost everything to come under its umbrella. We surely need to choose what is most appropriate from the health and perihealth areas, while determining the scope and the content of health education. Once we accept the broad concept of health, however, it would be erroneous to say that health education is just a technical or neutral area of 'science'. For instance, when we look at the multi-factorial causation of disease, we consider the factors ranging from `the insensible to the material (as aptly put by Wood and Bradley), the economic and social conditions, environment, culture, working conditions, urbanization, sanitation, caste, etc. This spectrum can be further expanded by including the health care services, their inadequacies (also not to forget, family structure and status of women and girls) and of course, the germs. Thus, the central area of health education seems to be overwhelmingly socio-political. The term 'socio-political' must allow for a certain reasonable exploration into the inequitable distribution of, and access to both material and knowledge resources.

Ironically, health education in schools has always been confined to educating children on individual health behaviour when in reality, there are virtually no limits to its scope. One need not feel disconserted in recognising that this entails a fundamental change in the social order. At the same time, we also need not say that health education is worth nothing in the absence of such a change.

The author is a doctor and a researcher at FRCH who has been associated in a prominent capacity with the various school health education projects which have been and are presently being carried out by the Foundation.

**The Current Lacunae**

Such a critique of the existing reductionist model can itself attain a reductionist form if overstated and may vanish into a protracted socio-political excursion. But what we have to recognise is that the present health education imparted in schools has helped only to produce increasingly educated dependents, who are passive consumers of pills and silent spectators of the health scene around them. Another effect, which is even more dangerous, is that they have learnt to victim-blame the people who are deprived of basic facilities for healthful living. They tend to see poor people as individuals devoid of good, healthy habits, estranged from their socio-economic and cultural milieu. The model has, in fact, ideologically helped the elites to absolve themselves of their social responsibilities and to look (down) upon the poor as 'uneducated' people ridden with superstitions and blind faiths and lacking the will to change, as well as breeders of diseases.

As correctly stated in the Bhore Committee's report in 1946, "The theoretical instruction on personal hygiene given to students in the classrooms would necessarily fail to influence their lives in the absence of essential facilities to enable them to practice what they are taught". The continuation of such unhelpful education in schools can probably be traced to our narrow concept of adequacy of material and knowledge resources available to the people. What we think as adequate may actually be inadequate. If adequate, they may not be accessible, and in some cases, may even be totally absent. The extent to which children and their parents especially in the rural areas are physically, intellectually and emotionally deprived is difficult to gauge from the mental framework of the educated and elite. Could enormous deprivation be the reason why conventional health instruction methods have failed in the past fifty years to bring about a change in the health behaviour of yesterday's children and today's adults? It is perfectly right to make an attempt to change for the better in spite of the conditions of deprivation. But it can be done with more sensitivity and subtlety. To us, any health instruction that is intrusive, abrasive, loud and top-down in its approach is unacceptable. Such instructional methods have also led to developing unresolved contradictions in the child's mind as s/he cannot see the solution to the basic health problems in the immediate surroundings, no matter how hard s/he tries to apply what is learnt. This creates a 'burnt-out' feeling and frustration. Some children 'fortunately', are able to alienate the class-room teaching from real life and are able to manage such alienation without feeling very uncomfortable. This situation is deeply despairing for a sensitive health educator. Most teachers initially feel helpless and later, indifferent. It is not that they do not see the obvious, but, as an easy way out, they soon fall back on the easy, relatively didactic methods of teaching. They find it increasingly

difficult to come out of this situation as the years go by. Thus the agents of change become the agents of status-quo.

**A New Definition of School Health Education**

While the conventional trilogy of school health (viz. periodic health check-ups, education in personal hygiene and nutrition and mid-day meals) remains relevant, a new definition of school health is needed. It would see the school as a centre of a broad range of activities of health education, carried out by children and teachers for themselves and for the community. Specific activities will be in relation to a comprehensive understanding of etiology of diseases, acquiring knowledge and skills to prevent diseases and to cure some common ailments, creating demand for facilities for healthful living and taking actions that would positively influence their own and the community's health.

Actually, these are some of the issues and questions regarding whether the schooling provides an adequate preparation for life. The makers of the National Policy on Education (1986) seem concerned about the attitudes, values and skills that would provide such a preparation for life, though they do not indicate the ways and means on how to go about introducing and sustaining these aspects of education in the given system. The policy touches even less upon health education per se. We believe that the groundwork done in the School Health Education Project (SHEP) may provide some insights into these aspects of education.

All these issues greatly influenced the way in which we set out to interact with children and teachers of 34 rural and urban schools in Maharashtra. There was a clear and conscious shift towards a more comprehensive health communication. The initial fear that the children ( with ages ranging from 10 to 13) may not understand the complexities of the broad concept of health soon disappeared. In fact, we, and also the teachers, were convinced that it was easier to communicate with the children in this way. Dr. V.G. Kulkarni of the Homi Bhabha Science Education Centre, Bombay has stated, "The children are quite aware of social problems and the impact of scientific progress on the society. They have the desire that science and technology should be used to solve the problems of society,... They firmly believe in causal relationships and always seek scientific reasons for the events..." With our school children too, the experience was not any different.

**The SHEP-Curriculum**

The following criteria needed to be fulfilled while developing the curriculum':

* It should be **appropriate** for the **V & VI Standard** children (agegroup between 10 and 13 years).
* It should be comprehensive enough to include **all** the **essential** elements of health.
* It should have certain **natural order** so that a logical sequence of topics/lessons could be drawn.
* It should have a positive and practical approach.

While we were communicating with children and their parents to figure out what their needs were, we also looked into the text books to identify health and related areas which were already covered. We decided to include even these so as to make the curriculum cohesive. The sequential order of topics was finally arrived at after several detailed deliberations with teachers. The curriculum was divided into four groups :

***Human Body Structure and Functions :*** A brief account of evolution of human and other animal species - their similarities and differences; human anatomy and physiology, taught together, system by system (no scholastic details were given since the study had mainly a functional value); growth and development; body care, personal hygiene.

***Food, Nutrition and Water :*** Importance of food in relation to the body, its growth and development; building resistance against diseases; locally available foods, their nutritive values, what would make a square meal; food-constituents, food habits and concepts; how to improve food value by introducing simple modifications; deficiencies, how to identify them; corrective measures; tinned foods; vitamin tablets, tonics, alchohol; growing vegetables; distribution of food and scarcity of food; water - safe and unsafe.

***Diseases and Defects :*** Common, frequent and widely prevalent diseases/ ailments - diarrhoea, dysentery, malaria, respiratory infections, tuberculosis, leprosy, jaundice, skin infections like scabies, lice, ringworm, tetanus, diphtheria, worms, dental caries, ear and eye infections; simple curative and preventive measures; home remedies; First Aid measures in case of wounds, dog-bite, snake-bite, burns, high fever, etc.

***Environment, Responsibilities, Habits and Rights :*** Community and personal hygiene, sanitation, latrines, pollution of water, air; vectors of diseases; safety measures; health rights; health care facilities - public and private; national health programmes; health organisations; health communication.

The following considerations helped us while designing the curriculum :

* While teaching anatomy and physiology we realised that children always wanted to know how and wherefrom humans came to exist on earth and how we are different from other animals. Hence, a brief account of 'evolution', with a special emphasis on the organic relationship of human beings with the environment, was included.
* No artificial divisions were maintained between anatomy and physiology. We utilised our own bodies as a teaching aid. Besides observing the physical growth as an indicator of development, movements of muscles and joints, observation of the eyes, ophathalmic check-ups with the help of Snell's chart, checking of the teeth, oral cavity, respiration, pulse, heart beats etc., were also introduced as learning aids. Instruments which were but simple extensions of sense organs, like hand-lens, microscope and stethoscope were thought to be not just fascinating but also helped to demystify medical knowledge and skills. Drawing and painting of internal organs on one's own body to show their correct placement and some simple observations and tests of urine and stools were also introduced.
* We believed that an undue emphasis on a square (balanced) meal was uncalled for. Our emphasis was on how to improve food value with certain modifications and practices to make it 'near square'. We also discussed the topics which appeared 'out of reach' for children, like inequitable distribution of food and water, price-rise, droughts and scarcities. Simple experiments with locally available foods which did not involve extra cost or fuel utilisation, were tried out in schools and with parents.

**(Contd. on page 6)**

(Contd. from page 3)
were proper controls (whether willingly or unwillingly unenforced). One can imagine what will be the position as a result of decontrolling, with a liberal New Drug Policy.

**Table 3**

**RATES OF DRUGS : GOVERNMENT-COMPANY DIFFERENTIALS**

| Company & Name of bulk | Govt. Fixed Rate Rs. per kg. | Company Rate Rs. per kg. |
|---|---|---|
| ***Glaxo*** | | |
| Betamethasone 17 valarate | 105850.00 | 220000.00 |
| Betamethasone Diasodium Phosphate | 126230.00 | 225000.00 |
| ***Hoechst*** | | |
| Baralgan Ketone | 1810.00 | 24735.00 |
| ***MSD*** | | |
| Dexamethasone 21 phosphate | 55100.00 | 195370.00 |
| Dexamethasone pure | 51300.00 | 92620.00 |

***Source*** : VHAI document.

Multinationals, along with leading Indian drug companies, succeeded in scuttling the important provisions of the 1978 Drug Policy by creating artificial scarcity of life saving and essential drugs and obtaining a stay order from High Courts against abolition of brand names, for over-pricing drugs, and against banning of harmful drugs. No proper provision has been made for such eventualities and we may have to face the same situation again.

Dr. Amit Sen Gupta says (in the earlier quoted article) that one of the main election planks of President Bill Clinton was a promise to bring a semblance of order in the US drug industry. The World Bank, in a recent document, has also voiced fears that in many Third World countries structural adjustment programmes (SAP) have been set in motion without having a 'safety net' for the poorest sections. Is it not ironic that we wish to initiate changes that are under question in the same countries and by the same agencies at whose behest India's ecomomic liberalisation programmes are being carried out?

There are an estimated 60 to 80 thousand brands and various formulations available in India. It may sound strange, but the Drug Controller of India has no detailed list of available products and brands in the Indian market. At least 60 per cent of these products are either irrational, unessential or hazardous, and the drug manufacturers have ably proved that given a chance they can dump these products at the cost of availability of essential drugs. Table 2 shows the magnitude of the irrationality of our pharmaceutical business. Irrational drug combinations not only make the quality control work more complicated, but even pricing becomes problematic. In the New Drug Policy no mention has been made about control of such irrationalities. It is high time that all such irrational formulations and combinations be immediately withdrawn from the market.

### R & D : A Farce

Steps to encourage Research and Development (R & D) in the industry, mentioned in the New Drug Policy, are welcome. But merely charging 2 per cent of the turnover and passing on the responsibility of R & D to National Chemical Laboratories will not solve the problem. This 2 per cent will be coolly passed on to the consumers and the pharmaceutical firms will wash off their hands from R & D efforts. The present R & D expenditure is mainly spent on sales promotional conferences and drug trials, manipulation of molecular structure (under the glorious name of high technology) to evolve a so-called new product and thus justify higher prices. Instead, the government should claim a hefty percentage on the profits (so that the burden is not passed on to the consumer). The drug companies doing original research may be exempted from this tax.

It is essential to view the drug industry separately from other consumer goods industries. Market demand of pharmaceuticals is not regulated by prices of drugs, but such demand primarily depends on prescription habits of doctors, the disease profile, drug resistance, etc. So, the market cannot ever be a proper mediator of prices of drugs. This is further compounded by the oligopolistic nature of the industry where few companies have monopoly within various therapeutic groups. In such a situation, abandoning price and production controls will only lead to shortages of essential drugs and an unjustified rise in prices.

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1. **National Health Policy**, 1983, Min. of Health and Family Welfare, Govt. of India, New Delhi, Pg. 3.
2. **Ibid**, Pg. 15.
3. **Letter to the Editor**, Dr. Debabar Banerjee, *Economic and Political Weekly*, Bombay, Oct. 1 1994, Pg. 2568.
4. **Kelkar Committee Report**, Oct 1988, Min. of Industries, GOI, New Delhi.


(Contd. from page 5)

* In the concluding section, we came back to the study of the environment/our surroundings but in a different context. This section was meant to reinforce the messages already covered in the preceding sections. It deserved a separate section as we felt that health education should conclude with insights for attitudes (and practices wherever possible) with the profound reasoning developed in the preceding sections rather than in the form of precepts.

Though the sections appeared independent of each other, a certain "telescoping" between them was expected, so that the children could correlate various aspects of health in a more cohesive manner.

The curriculum was **(vertically)** divided into two parts, with both the 5th and 6th Standards having the sections and topics in a similar sequence but with a little more complexity introduced for the 6th standard. A certain amount of repetition was deliberately built in.

### Testing the Experiences : Looking Ahead

The whole curriculum was tried out with the teachers and children and evaluated in great detail over two years. As a significant outcome of this effort, we brought out a set of health manuals for teachers and children, which was extensively field-tested. The question, however, was how to integrate health education into the mainstream syllabus in a meaningful manner. This question is currently being examined in our new project which involves teacher training institutes in four districts of Maharashtra.

# The Scourge of Plague : A Viewpoint

*A friend of FRCH, Dr. Sham Ashtekar, who is a health activist, medical practitioner working in Nasik district (Maharashtra) and author of "Bharat Vaidhyak" (the Marathi text book for upgraded VHWs), sent us his comment on the recent plague outbreak. While the issue whether this, in fact, was plague or something akin to it is now steeped in controversy, we nevertheless carry his comment which bears a wider relevance to the problems of disease control and public health in India.*

***– Editor***

In the last week of September I found myself in the Mamla village of Beed district in Maharashtra where the all-important plague made its first appearance. Some of my friends wanted me to give a firsthand account of the plague outbreak there and suggest a possible plan of action for some development workers in the area. Initially, I was a little reluctant to go since most of the facts had already been reported to the press and there was little, I thought, that was left to be covered in that area. This area is close to the region affected by the earthquake and the main centre of damage is farther south. Theories have been floating that it is the earthquake that has caused the rats to come out and invite the menace. But there is, at present, no plague in the Killari belt which was worst hit by the earthquake.

**The Antecedents**

Since the key factors in plague are : a) rat-human contact and b) *Y Pestis* introduced by the wild rodents or from the burrows, the causation must be investigated in the light of these two factors. The latter factor involves long-term surveillance of rodents and sylvatic plague so I cannot, offhand, speculate on how the spark (or 'sparks' to be more correct) was provided. It is known that plague bacilli survive and even multiply in rodent burrows for years. But the area is not on the hitherto known map of sylvatic plague, though, of course, the last case of human plague was reported in 1966. What we can only say is that there must have been widespread upheavals in the *Y Pestis* distribution in recent years.

The other factor, the rat-human contact, is perhaps the more important factor providing the inflammable conditions for the *Y Pestis* sparks (though some authors prefer to close in on the flea-human factor). Tackling this factor is the only long-term solution to the problem of plague. I would like to mainly dwell on this issue.

**Sharing Houses with Rats**

Mamla village, like thousands of other surrounding villages and hamlets, is an ideal ground for close encounters between humans and rats. The houses are no more than rat holes, just big enough to accommodate *homo sapiens*. Mud balls heaped layer upon layer make the walls, while a layer of saplings plastered with mud makes the roof. Some houses have not even as much dignity. The *tar* (Bengal gram) shrubs serve as both walls and roof. There is little by way of a plinth or foundation. Doors hardly shut off rats who are ubiquitous in all seasons in all houses. Last year's earthquake forced the villagers to seek shelter in temporary hutments with tin roofs, in the vicinity of the old houses which now lie abandoned. The floor, walls, roof and surroundings of these old houses are teeming with rats. The new homes are not much different. As a peasant woman aptly puts it, rats would not allow the humans to eat even a *roti* in peace.

Rats are natural inhabitants of farms and fields. Till harvest time they are busy devouring the standing crop; but after harvests they literally invade human habitations, in search of food. The fault lies with us humans that, even in the last decade of the twentieth century, we have most of 'Bharat" living in inhuman conditions. But for this ignominy of having to live among rats, there would have been no plague epidemic of this size.

The problem of pneumonic plague stalking our cities and capitals is mainly that of overcrowding and non-availability of adequate breathing space. Bubonic plague is well-anchored, not so the pneumonic variety, which is likely to burn out rapidly.

Most of the peasantry and agricultural labour more or less inhabit the same homes and hearths as their forefathers used to in the last century; the only additional facility being electricity to illuminate their plight now. I read an excerpt of Mahatma Jyotiba Phule's description of such inhuman conditions in his famous book titled ***Shetkaryacha Asud*** (The Farmer's Whip) - it befits this decade no less. Plague is merely a symptom of our pauperised peasantry exploited to the hilt. Incidentally, it is also bad for 'India', the favoured nation.

**Under Control ?**

The panic has spread to other cities and nations, resulting in the blockading of Indian movement. The fear of a possible economic blockade has probably forced us to underplay the epidemic and also give periodic assurances of it being 'under control'. Unfortunately, plague is not an illness that can be controlled by merely stamping it out wherever it breaks out. For instance, plague cases are not only reported from the villages under surveillance but more and more new villages are catching up. Distant states and cities are getting infected, as if like a fire fanned by winds. This certainly disproves our declarations of it being 'under control'. Let us grapple with the facts at this stage. Even if this particular phase of plague is under control, there is every chance that it will erupt again at other times and places. Indian Plague Commission studies conducted in the earlier part of the century state that the plague season is between September and April and hence this could just be a beginning. This should prove a sufficient warning for us.

However, it would be unfair to blame the health administration entirely for the outbreaks. This is not to say that our health system is any good. But the fact remains that the Beed outbreak had evoked a fairly adequate response from the state Health Department, despite the initial delays in recognising the danger. The point is that, the very nature of plague epidemiology is multifocal. Therefore, if anything is to be blamed for the outbreaks, it is our neglect and exploitation of our own people.

**What Next ?**

The only long-term immunity against plague lies in severing the rat-human link by providing good housing country-wide. Till then we have to rely on antibiotics to treat every new case of plague. The

**(Contd. on page 8)**

*FROM THE SENIOR LIBRARIAN'S DESK . . . .*

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**(Contd. from page 7)**

key to plague control is to handle rat falls rapidly and to ensure early antibiotic treatment to new cases and those in the 'definite risk' category. The rat fall job includes proper anti-flea measures. I wonder whether a general BHC spraying will ever be undertaken in the country, as was done for malaria earlier. Routine spray operations have been stated to be the undoing of plague by controlling the flea population. This is definitely advisable since it would lead to a significant reduction in the flea population for six months till May, when the plague bacillus finds it tough to survive.

An important lacuna in our already dubious health services is the lack of any village-level human power in this field. The Community Health Worker could have been a great asset at such times, apart from a lot of other services which s/he could have rendered to the village people. In lieu of this, we must institute real village units for fighting plague on its own grounds. No fake committees would do this time.

**– Sham Ashtekar, Dindori**
(Nasik Dist).

Due to unavoidable circumstances the concluding article in the series from the project **Social and Operational Constraints in Tuberculosis Control** could not be carried in this issue. The same will appear in a later issue of FRCH Newsletter.

- Editor

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