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Therapeutic Pluralism: Need for Encouragement

There are cases of unscrupulous doctors resorting to cross therapy, disregarding all norms of safety, simply to increase their earnings. A few such cases should not bring about a negative verdict for therapeutic pluralism though, says ***Prof. R.K. Mutatkar;*** *viewed against our socio-economic background, therapeutic pluralism would in fact be beneficial to our country.*

Recently, the Supreme Court passed a judgement holding a doctor guilty of malpractice on the grounds that though a homeopath, he had prescribed allopathic medicines to a patient, who ultimately died. The irony of the case is that according to the AIIMS, the allopathic prescription was right.

The Supreme Court judgement has brought into limelight the controversial issue of therapeutic pluralism and the ethics involved therein. The basic debate is : should therapeutic pluralism be curbed as it could lead to irrational treatment or should it be encouraged as being ultimately beneficial to the patient. This is too important an issue to be based on the outcome of a single case in the Supreme Court. It requires a debate on the national level among practitioners, professionals, administrators and researchers on whether the advantages outweigh the disadvantages.

The issue has to be judged on the basis of competency of doctors to do cross therapy, the advantages to patients, the involvement of vested interests, the possibility of malpractice and the changes required in allied systems like education and law to curb it, and most important, the role of therapeutic pluralism in providing good, affordable health care to the people.

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Therapeutic Pluralism

No medical systems are perfect. Partly they are science and largely faith. Each system has its own strengths and weaknesses in terms of therapeutic value, availability, acceptability, cost, suitability to the patient etc. We have to gauge in what way the different systems contribute to the health care of our people and how we can derive maximum benefits out of this plurality.

Given India's complex health care structure, and the equation between health and poverty, any health care issue needs to be addressed in relation to the country's socio-economic reality. About 70% of the practitioners belong to disciplines other than allopathy. We have the entire infrastructure in medical education and research for all systems of medicine. To disallow therapeutic pluralism would mean denying patients the benefit of integrated medical assistance, especially in rural India, where there are few allopathic doctors. Also, it would translate into a less than optimum utilisation of the existing human resources.

Taken to its logical conclusion, it would also mean abandoning the projects, including many supported by the government, that teach people about self-care and self-medication, to take care of basic health problems. This would have serious repercussions on basic health care.

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One of the biggest misconceptions is that therapeutic pluralism is indulged in only by non-allopathic doctors. The reality is that Zhandu, Chavanprash, Leve 52 - all essentially Ayurvedic medicines - are said to be freely prescribed by allopaths. The proof lies in the great volume of prescriptions inspite of the fact that generally, Ayurvedic practitioners do not prescribe medicines from outside as they prepare there own medicine.

Often, therapeutic pluralism becomes a way of providing supportive therapy - a patient could be recommended both therapies at one and the same time to speed up recovery. In increasing numbers, the modern medical practitioners are prescribing ayurvedic and homeopathic drugs to the patients as supportive therapy, especially in life-style based diseases. The use of spices, baths, packs, smokings, massage, physical exercises, monitoring nutirion intake and so many processes popularly practiced, knowingly or unknowingly, represent therapeutic pluralism, and often with good results. When we have such a store-house of information in India, not allowing allopathic practitioners to prescribe medicines based on other systems would amount to unncecessarily denying patients the benefits of supportive therapy. In many cases, for instance in maternal and child health, a lot of preventive care is done through traditional medicine whenever it is thought to be safer, easily available and self-administrable. Doctors prescribing these therapies would in fact be providing people with greater alternatives that can be more empowering.

The Government of India has already recognised medical pluralism by providing the required infrastructure. WHO too, has provided guidelines for use of traditional systems of medicine in health care delivery. It has come out with a new primary health care approach enshrining inter-sectoral development, easily affordable appropriate technology, community participation and use of grassroots level health workers with the basic skills of therapeutics and referrals. Imbibing traditional midwives with modern technological inputs to enhance their skills is one such instance.

As people are becoming more knowledgeable, they are developing their own ideas about the efficacy and weaknesses of various therapeutic systems. Patients are themselves seeking cross therapy from a person in whom they have faith. Even in the West, where the problem of cross therapy does not feature strongly as they do not have many parallel medical systems, three out of every ten people seem to be taking to alternate medicine. Such increasing global importance of traditional systems of medicine and herbal therapy should be viewed positively.

Though specialisation has its advantages, it is also in the interests of the patient to refer to one doctor who knows her/him over a period of time. At least for minor cross therapy then, it would be more convenient for the patient to take prescription from the same doctor.

Proficiency

The main aim of medical education, whatever system it is imparted in, is to develop the critical faculty. Real knowledge and development of skills comes only with experience and practice. With the explosion of knowledge and information, it has become necessary for all medical professionals, irrespective of the therapeutic system they belong to, to continuously update their knowledge and skills, making education an ongoing and self-learning process. Doctors from all systems need to keep themselves updated by referring to medical journals, publications, by attending conferences, by exchanging views and through experiment including those on human beings, albeit with their consent. In such a scenario, gaining knowledge about parallel systems as their importance is realised, should be seen more as an extension of the learning process.

There is an appalling ignorance about the duration and content of medical education in traditional Indian systems, leading to the general opinion that doctors from non-allopathic systems are not equipped to understand the basics of and hence give prescriptions for allopathic drugs. In fact, all disciplines have an intensive course of common duration and all disciplines are imparted basic knowledge of human anatomy and modern biology including dissection of the human body. The difference lies in diagnostic techniques and pharmacology. Hence, where the capability of doctors to do minor cross therapy is concerned, practitioners of all systems should be treated at par.

Vested Interests

It would not be wrong to say that those involved in making medical policy generally belong to the allopathic system and knowingly or unknowingly, would be biased against other medical systems. Our medical policy is generally equivalent to *fatwah's* from people in power that help them to retain their monopoly over the health system.

Another important factor is the pharmaceutical companies who would do their best to increase their profits and keep their monopoly intact. It would be in their interests to encourage policies that prevent their clientele from resorting to alternate therapy and thus create an exclusive demand for the particular drugs produced by them. Pharmaceutical companies of all medical systems are guilty of such monopolisation.

It is up to the people to support only those policies that are genuinely people-friendly rather than getting caught in the war of pharmaceutical companies or allowing policies that serve the vested interests of those in power.

Tackling Malpractice

Irrational practice and misuse exist even within particular systems - it is not necessarily a feature of cross therapy. There is already a law under the Consumer Act to take care of such malpractice. Hence, the focus should be on implementing the law diligently and seeing how we can use plural systems for preventive and promotive aspects of health care. Any lacunae in the law should be corrected by the government in the national interest.

Some safeguards and checks and balances do need to be evolved in cross therapy. While medical professionals should have the freedom to prescribe certain drugs, those drugs which require strict monitoring and could have dangerous side effects should be prescribed only by doctors from the particular system. Where a major switch-over of therapies is required, the referral system should be made compulsory.

However, the general consumer law to take care of malpractice and other safeguards is not enough. Knowledge has a tendency to get mystified under technical jargon and mystification leads to exploitation. Democratic values therefore call for demystification of knowledge and transmitting of correct information to the people so that they can make an informed choice.

Integrated Medical Education

While those speaking against therapeutic pluralism point to the lack of adequate formal learning in parallel systems as a reason for its disallowance, the fact is ignored that even if anybody wants to undergo such training it is not available at present. On the other hand, those graduating from non-allopathic systems have to do their internship in the PHCs where allopathy is the dominant therapy. Many of the traditional medical colleges do not have hospitals with exclusive traditional therapy. It is ridiculous to expect these doctors to suddenly switch over to prescribing drugs only within their system, once they start their own practice.

How does one address this issue of polarisation in education but integration in practice ? Can there be a single medical education structure incorporating all the systems ? Or would it be better to expose students of one medical system to the other? If yes, what could be the level of this exposure and in what manner could it be achieved? Can there be extension courses for mutual exchange of knowledge?

One suggestion is to introduce an integrated medicine course as a compulsory subject in the syllabus of every medical system.

Regarding provision of opportunities for inter-disciplinary and collaborative research, it is suggested that if clinical laboratories are developed as separate units in governmental and non-governmental areas, it would help to develop therapeutic pluralism.

Traditional medical systems have to interact with each other and have to evolve with changing times through a process of constant review and reinterpretation. To make it possible to interpret terms and principles of traditional medical systems correctly in terms of modern medicine, it is essential to initiate basic, pharmacological and clinical studies using inputs of modern science and technology.

For continuing education, it is necessary to organise basic training and workshops in all therapeutic systems open to practitioners of all systems. Therapeutic aids available from one system of medicine to another should be encouraged and it is desirable to create facilities or training in use of such tools as well as in essential drugs or traditional remedies.

Along with the introduction of these policies research will have to be done on the short as well as long term effects on research and industry due to polarisation or integration of medical education and practice.

To conclude, for optimum health care delivery, their is need to create greater awareness about therapeutic pluralism among the public and professionals alike. Professionals from all systems of medicine have to be involved in health care delivery. Rather than considering them as apposite systems, the correct approach would be to treat all systems as one stream of medical knowledge to be used for providing good, affordable health care to the people. ❑

As told to Vaijayanti Aphale

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A Plea for Pro-People Health Care

Planning for health care does not pertain to the health sector alone but is inter-linked with development in the socio-economic sector. This would require decentralisation initiatives within the state and strong support from the Centre explains ***Dr. Gouri Pada Dutta*** *using the example of West Bengal.*

No health care system, however perfect, can deliver the goods unless it is based on a socially just economy and polity, for health is only the final manifestation of the general quality of life. In a class stratified society the propensity of the dominant section is to use the resources, including human resources, for its own benefit. The common man is granted certain privileges but only to the extent that they do not destabilise the power structure of the society. As regards the health sector, this power is retained by the dominant section through:

a) Control over the institutions for medicare;

b) Control over the selection, training and employment of the medical and para medical personnel; and

c) Control over drugs and appliances for diagnostic as well as therapeutic purposes.

This politisisation of health care has resulted in the narrow approach of disease control, paving the path for commercialisation of medicare in the name of science. The phenomenal development of science has given us enormous scope for diagnosis and treatment of hitherto untreatable diseases, but blind dependence on such procedures ignoring the holistic approach to health has led to wrong indoctrinisation of both the recipients and the 'on counter' deliverers of health care. What is needed is a rational application of science keeping in view a more holistic definition of health. WHO itself has acknowledged a wider definition of health as stated in the Alma Ata declaration - 'Good health does not mean mere absence of disease. It is a sense of physical, mental, economic and social well being.' The health situation of our country has to be studied and planned for, keeping this perspective in mind.

Health Sector Planning Versus Health Planning

Creation of adequate health infrastructure is important but by no means the final answer for health care of the people. West Bengal is one such example. Right since independence, it has developed a strong infrastructure for health care of both the rural and the urban population. Unfortunately, the huge infrastructure could not yield the expected results. The health sector planning, imposed as it was from the top, was inevitably geared to suit the demands of those at the helm of affairs and could not provide the needed services to the people. It only stimulated a greater demand for curative services and led to the wrong indoctrinisation of health care personnel. Simultaneously, the non-planned expenditure, mostly for salaries and infrastructure, went on increasing. This necessitated a change towards a more holistic approach known as health planning.

Health planning is not merely concerned with the health sector but is linked to the economic and social upliftment of the people in the form of :

* Increased employment opportunities and viable self-employment.
* Increased productivity and equitable and remunerative distribution of the benefits of enhanced production.
* Provision of basic minimum needs viz. food, shelter, clean water and disposal of human and other wastes.
* Greater self-respect, self-confidence and social awareness through :

a) Total literacy movement and post literacy programmes, and integration of non-formal measures with formal education; and

b) Inclusion of neo-literates in vocational and production oriented training.

* Grassroots participation in health care delivery.

This social awareness has to be integrated with health consciousness, forging an effective health movement.

It is appreciated that an immediate radical change in the health sector planning cannot be instituted. However, West Bengal has made a start by already fulfilling about 70% of the Centre's target for the Minimum Needs Programme in the rural areas. As regards curative services, the infrastructure has exceeded the prescription of the Union Government.

West Bengal is now experimenting with the democratisation of departmental functions, and involvement of the people and their representatives in their own development.

Separate Advisory Committees have been set up for general education and drugs and Technical Committees set up for all other units up to the sub-centres. Management Boards have been instituted for teaching institutes and big hospitals.

The West Bengal Legislative Assembly has created a subject Committee of MLAs to increase their accountability to the

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peoples' representatives. At the district level, a powerful District Health Committee has been created to monitor the departmental activity under the Chairmanship of the *Savadhipati*. In Zilla Parishads and Panchayat Samitites there are standing committees for health and every Gram Panchayat consists of one member responsible for health care and health awareness.

Central Government Support

To optimise this endeavour towards decentralisation of the health sector and its greater integration with other services the states must be provided with the following facilities from the Centre:

* The states should be given the liberty to utilise the existing health units like sub-centre, Primary Health Centres and Community Health Centres according to the need of the community. For effective primary health care, greater participation of paramedical personnel like CHG, TBA, MPHV and their three-tier supervisors in collaboration with the three-tier panchayats/ municipalities and municipal corporation needs to be encouraged.

* All the vertical programmes sponsored, assisted or supplemented by the Centre should be implemented by the state in a manner that best suits the community and the region. The Centre should monitor only to the extent of assuring that the finances are not misused or diverted to other activities.

* For strengthening secondary health care, the states should modify the outline given for Community Health Centres according to their own requirements. The basic idea would be to offer secondary health care at the block/subdivision and district levels where the maximum responsibility is taken up by block/rural hospitals. Complicated cases may be treated at the state/general hospitals as well as upgraded district and sub-divisional hospitals. This will improve the function and turnover of these hospitals as well as that of the attached medical colleges.

* West Bengal is contemplating to decentralise and vest control in all health activities, including the functioning of various health units, to the three-tier panchayats and municipalities. For this, adequate infrastructure has to be provided to the institutions.

* To implement secondary health care at the block level and part of the tertiary health care at the sub-division and district level, greater resources are needed. Some of the financial support may be raised from the affluent sections either directly or through a suitable insurance scheme.

* Further financial support is needed from the centre to comply with the remaining needs for both the planned and non-planned budget. Recurrent support is also needed from the Centre to maintain and run the existing units created by the directives of the Centre, otherwise, the state exchequer will be drained out merely in the maintenance of infrastructure. At present about 87-90% of the budget is spent on this account.

* Higher education is a concurrent subject. Whereas for general and other technical education the centre provides reasonable support through bodies like UGC/DST/CSSR etc., similar support for medical education is absent. On the contrary, the Medical Council of India (MCI) imposes a levy on the medical colleges for affiliation, inspection and introduction of new courses that can only be called prohibitive. Presently, the MCI charges as much as Rs.1 lakh for opening a new course and Rs. 25,000 as inspection charges (to be further enhanced) from the medical colleges. This imposes a heavy financial burden on the state government and universities, retarding the prospects of government medical colleges. It is also one of the reasons for mushrooming of private medical colleges which have become a lucrative business indeed. Even in the face of this competition the West Bengal Government has not permitted a single private medical college and students are admitted only on merit basis. Adequate financial help from the Central Government is needed to stem this trade of medical education which is destroying the very spirit of medical service.

* It is now accepted even at the international level that medical education as it is practised today, is not serving the desired objective. For implementing integrated people-oriented need-based medical education, both the MCI and the Union Government should accept and support the new form of medical education proposed by the state.

* A survey to obtain relevant information about the functioning of the health institutes as well as the morbidity pattern is essential for any future planning. The Planning Commission should grant financial support to the State Planning Board for this purpose.

* A systematic pool of information from all the states is needed to draw up an acceptable pattern of health care and medical education. The importance of regional variation and objective situations of the state must be considered in the process of planning and implementation.

* Assessment of the Indian systems of medicine should be undertaken with Central help so as to retain and promote the useful practices within these sytems.

* The drug industry, particularly that pertaining to drugs of indigenous origin, has to be rationalised and promoted for better functioning and usage.

This process of decentralisation has to be properly understood and strengthened with sincerity. Only then will people be able to resist the undue commercialisation of health care and dominance of the privileged section and achieve a shift towards holistic pro-people health care. ❑

निर्जलीकरण का व्यावसायिक एवं घरेलू प्रबंध

यह जानकारी, 'डेविड वर्नर, डेविड सैन्डर्स' आदि की पुस्तक 'क्वेश्चनिंग द सल्यूशन : द पॉलिटिक्स ऑफ प्राइमरी हेल्थ केअर एण्ड चाइल्ड सरवाइवल' से ली गई है।

डाइरिया, जिसे चिकित्सीय विज्ञान में गैस्ट्रोएन्टेराइटिस के नाम से जाना जाता है, विश्व में वच्चों की मृत्यु का एक प्रमुख कारण है (वचपन में होने वाली प्रत्येक चार मृत्युओं में से एक) - केवल तीव्र श्वसन संक्रमण (एआरआई) का स्थान ही इसके ऊपर है। इन मृत्युओं में से 99.6 प्रतिशत तीसरे विश्व के देशों में होती हैं।

अधिकतर वच्चे जिनकी मृत्यु डाइरिया से होती है, वे शरीर से वहुत अधिक द्रव्य निकल जाने, अर्थात निर्जलीकरण के कारण मरते हैं। अतः यह वहुत समय से माना जाता रहा है कि पानी जैसे डाइरिया से पीड़ित वच्चे के लिए द्रव्य के पुनर्जलीकरण (एक ऐसा इलाज, जिसका प्रवंध आसानी से घर पर किया जा सकता है) से निर्जलीकरम से वचा जा सकता है या उसका इलाज किया जा सकता है और यह अक्सर जीवन-रक्षक सिद्ध होता है। वास्तव में, घर पर किए जाने वाले इलाज के रूप में, विशेष प्रकार के पेयों, जड़ी-वूटी की चाय, सब्ज़ियों आदि के रसों के माध्यम से, खोए हुए जल या द्रव्य को वापस करना (ओरल रीहाइड्रेशन थेरेपी) कई संस्कृतियों में, इलाज के एक स्थाई हिस्से के रूप में प्रचलित है।

दुर्भाग्यवश, वैज्ञानिक प्रमाण की ओर अत्यधिक रूझान, इस दृष्टिकोण (घरेलू इलाज) को अस्वीकृत करने का एक वहाना रहा है, जवकि यह दृष्टिकोण वीमारों को अपेक्षाकृत अधिक फ़ायदे परन्तु डाक्टरों को कम फ़ायदे उपलब्ध करा सकता है। 19 वीं शताब्दी में, निर्जलीकरण के इलाज के लिए नसों के माध्यम से द्रव्य पदार्थ दिए जाने के इलाज को प्रचलित किया गया, जवकि इलाज की इस पद्धति की वहुत सी सीमितताएँ थी, जैसे, रवर की नलियों को, जिससे दृव्य दिया जाता था, रोगाणु-रहित रखने में होने वाली कठिनाइयाँ; आवश्यकता से अधिक द्रव्य दिए जाने का ख़तरा, जिसके फलस्वरूप मृत्यु भी हो सकती है; तथा, इस इलाज को अधिक से अधिक लोगों तक पहुँचाने के लिए अपेक्षाकृत अधिक दक्षता एवं निधि की आवश्यकता।

पेशेवर डाक्टरों द्वारा आई वी इलाज के साथ-साथ दवाओं का गलत व अत्यधिक इस्तेमाल भी किया जाता है। डायरिया के इलाज के लिए जो दवाएँ लिखी जाती हैं वे विल्कुल भी प्रभावी नहीं होती हैं और अक्सर उनके दुष्परिणाम भी होते हैं। डब्लू. एच. ओ. ने भी कहा है, कि डायरिया के इलाज के लिए किसी भी दवा का इस्तेमाल नहीं करना चाहिए, क्योंकि किसी भी दवा का कोई व्यावहारिक मूल्य सिद्ध नहीं हुआ है और कुछ दवाएँ तो खतरनाक भी हैं। डब्लू. एच. ओ. के अनुसार, डाइरिया के इलाज की दवाओं पर वर्तमान में लगभग एक अरव डालर प्रतिवर्ष खर्च किए जाते हैं। इनमें से अधिकतर दवाएँ वेकार या खतरनाक हैं, जवकि अधिकतर मरीजों को सरल व सस्ती ओ.आर.टी. (मुख से द्रव देकर इलाज) ही चाहिए। प्रमुख पश्चिमी दवा उत्पादकों द्वारा ही लगभग 35 करोड़ डालर मूल्य की डाइरिया के इलाज की दवाओं की विक्री प्रत्येक वर्ष की जाती है, इनमें से एक तिहाई, तृतीय विश्व के देशों में जाती हैं। वहुत सी दवाएँ, गरीव किसानों को वेची जाती हैं जो अपने वच्चों को डायरिया से मरने से वचाने के लिए अपनी सारी पूँजी लगाने को तत्पर रहते हैं। यूनीसेफ के अनुसार, ऐसे डाक्टर, जिन्होंने ओ.आर.टी. अपनायी भी है, उनके लिए भी दवाएँ लिखने की आदत छोड़ पाना कठिन साबित हो रहा है. अतः एक अच्छे इलाज ने वुरे इलाज का स्थान नहीं लिया, वल्कि उसे वुरे इलाज के साथ जोड दिया गया है।

आदर्श ओ.आर.एस फार्मूला

1970 के दशक के अंतिम वर्षों में ओर.आर.टी. की पुनः खोज हुई। लानसेट द्वारा प्रस्तुत की गई एक रिपोर्ट से ओ.आर.टी. को अन्तिम अनुमोदन मिलने में मदद मिली। उन्होंने लिखा, 'नमक और पानी को आहार नली की कोशिकाओं के माध्यम से रक्त तक पहुँचाने में, साधारण शक्कर (ग्लूकोज़) वहुत महत्वपूर्ण है। अतः ग्लूकोज़ को घोल में मिलाने से पुनर्जलीकरण की प्रक्रिया में अत्यधिक तीव्रता आ जाती है।' इस इलाज का चीन में, नंगेपाँव (वेअरफुट) डाक्टरों ने 1955 में सफलतापूर्वक इस्तेमाल किया। हालाँकि, 1962 में वंगलादेश में आई, कालरा की भीषण महामारी, जिस पर मुख से पुनर्जलीकरण द्वारा ही नियंत्रण पाया गया था (इसके द्वारा मृत्यु-दर घट कर लगभग शून्य हो गई थी), द्वारा इस इलाज की संभाव्यता सिद्ध हुई। इसी इलाज को 1971 में भी सफलतापूर्वक प्रयोग में लाया गया। डब्लू.एच.ओ., यूनीसेफ, यू.एस.एड जैसी अन्तर्राष्ट्रीय संस्थाओं तथा व्यापारिक संस्थाओं के गहन सहयोग से, 1980 के दशक के अन्तिम वर्षों में, 90 देशों में राष्ट्रीय ओ.आर.टी. कार्यक्रम आरम्भ किया गया। हालाँकि, इन कार्यक्रमों में ओरल रीहाईड्रेशन सल्यूशन - ओ.आर.एस. (मुख से लेने वाला पुनर्जलीकरण घोल) के तैयार व्यापारिक पैकेटों के इस्तेमाल पर ज़ोर दिया गया, जिन्हें डब्लू.एच.ओ. के स्थापित फार्मूले द्वारा तैयार किया गया था। ओ.आर.टी. को प्रोत्साहन देने वाले कार्यक्रमों की प्रगति के आँकलन के लिए कई साधन प्रयोग में लाए गए हैं, जैसे :

1. पहुँच दर : जनसंख्या का एक प्रतिनिधिक हिस्सा, जिसकी ओ.आर.एस. उपलब्ध कराने वाली संस्थाओं तक सुगम पहुँच है।
2. प्रयोग दर : डायरिया से पीड़ित पाँच वर्ष से कम उम्र के वच्चों का एक प्रतिनिधिक हिस्सा जिसे अधिक मात्रा में द्रव्य उपलब्ध होता है व नियमित रूप से दिया जाता है।
3. प्रभावी प्रयोग दर : i) उपयुक्त विधि से तैयार किए गए या संतुलित पेय पदार्थ; ii) द्रव्य पदार्थों का अधिक मात्रा में लिया जाना तथा; iii) नियमित रूप से द्रव्य पदार्थों को दिया जाना।

हालाँकि प्राप्त लाभ का सही अनुमान लगाना कठिन है, परन्तु इन सभी सूचकाँकों का कुल प्रभाव, दवाओं या आई.वी. इलाज से कहीं अधिक था।

व्यावसायिक ओ.आर.एस. पैकेट वनाम् घरेलू पेय पदार्थ

हालाँकि स्वास्थ्य के लिए कार्य करने वाले अधिकतर समूह, अव ओ.आर.टी. या मुख द्वारा पुनर्जलीकरण द्वारा इलाज की श्रेष्ठता को मान्यता देते हैं, परन्तु अभी भी इस वात को लेकर विवाद है कि इस इलाज में घरेलू पेय पदार्थों

का प्रयोग किया जाना चाहिए अथवा व्यावसायिक ओ.आर.एस. पैकेटों का।

व्यावसायिक पैकेटों के सबसे अधिक उत्साही समर्थक, जैसा कि अनुमान लगाया जा सकता है, बड़े राष्ट्रीय एवं अन्तर्राष्ट्रीय संस्थान हैं। ओ.आर.एस के समर्थन में इनके द्वारा जो तर्क प्रस्तुत किए जाते हैं, उनमें से प्रमुख हैं :

1) ओ.आर.एस. पैकेटों में वैज्ञानिक रूप से फार्मूलाकृत किए गए पदार्थ होते हैं, जिन्हें परिशुद्ध रूप से मापा व नियंत्रित किया जाता है। यह आवश्यक था, जैसा कि विभिन्न अध्ययनों से प्रदर्शित हुआ कि लगभग 23 से 73 प्रतिशत महिलाओं ने शक्कर और नमक (आई.डी.डी.) के जो घोल बनाए उनमें नमक की मात्रा ख़तरनाक रूप से अधिक थी।

2) ओ.आर.एस. पैकेट सस्ते हैं और आई.वी.इलाज की अन्य दवाओं की अपेक्षा अधिक सरलता से उपलब्ध हैं।

3) इस दृष्टिकोण के अनुसार, माताएँ ओ.आर.एस. को उस दशा में अधिक स्वीकारेंगी, जब उसे दवा के रूप में प्रस्तुत किया गया हो, इसकी तुलना में, घरेलू पुर्नजलीकरण पेय पदार्थों के विषय में वे अक्सर यह शिकायत करती हैं, कि वह 'द्वितीय श्रेणी के नागरिकों के लिए, द्वितीय श्रेणी का घोल है' । ओ.आर.एस. की अनुपस्थिति में, ऐसी आशा है कि लोग अप्रभावी तथा/ अथवा ख़तरनाक प्रतिडायरिया की दवाओं या आई.वी इलाज की ओर जाने के लिए अधिक उन्मुख रहेंगें।

अन्तर्राष्ट्रीय संस्थानों को यह सुगम लगता है, क्योंकि वे गरीबी व कुपोषण जैसे मूलभूत कारणों का मुकाबला करने के इच्छुक नहीं हैं और सरल, स्पष्ट व गिनने योग्य साधन जैसे, टीके, विटामिन 'ए' और इस संदर्भ में, ओ.आर.एस. पैकेटों के आधार पर किए गए तकनीकी प्रयासों को अधिक पसन्द करते व महत्व देते हैं। इस नीति को यू.एस.एड द्वारा भी मान्यता दी जाती है, क्योंकि यह नीति, लोगों की इसका मूल्य देने की इच्छा पर आधारित है। यही दृष्टिकोण प्रशासन व नौकरशाही द्वारा भी अपनाया जाता है क्योंकि यह दृष्टिकोण, घरेलू घोल जो कि अधिक अस्पष्ट व अनुकूलनीय है, की तुलना में, केन्द्रीकृत योजनाओं से अधिक सरलता से मेल खाता है।

पैकेटों को प्रोत्साहन देने वाले की अपेक्षा, घरेलू पुनर्जलीकरण पेय पदार्थों की सर्वाधिक उत्साही प्रस्तावक छोटी सामुदायिक संस्थाएँ हैं। उनके अनुसार :

1) ओ.आर.एस. पैकेटों का भी अक्सर गलत उपयोग होता है। ऐसा आमतौर पर, इन पैकेट के पदार्थों में जल की अपर्याप्त मात्रा मिलाने के कारण होता है जिससे घोल में शक्कर व नमक की मात्रा ख़तरनाक रूप से अधिक हो जाती है, जो निर्जलीकरण को अधिक गम्भीर बना सकती है।

2) ग्रामीण क्षेत्रों में रहने वाले लाखों लोगों के लिए, पैकेट उपलब्ध हो पाना आसान नहीं है। कभी दूरी की वजह से, तो कभी अधिक दामों या पर्याप्त आपूर्ति न हो पाने के कारण ग्रामीण जनता तक उनकी पहुँच दुर्गम रहती है। यहाँ तक कि डब्लू.एच.ओ. ने भी यह माना है कि यूनीसेफ द्वारा आपूर्ति किए गए ओ.आर.एस. पैकेटों के अन्तर्राष्ट्रीय दामों की तुलना में, ओ.आर.एस. पैकेटों के स्थानीय दाम अक्सर अधिक रहते हैं, जिसके फलस्वरूप ये पैकेट गरीबों की पहुँच से बाहर हो जाते हैं। डायरिया, न सिर्फ बच्चों की मृत्यु का सबसे बड़ा कारण है, बल्कि यह एक ऐसी बीमारी भी है, जो गरीब परिवारों में अक्सर होती है। व्यावसायिक ओ.आर.एस. पैकेटों का औसत मूल्य 15 से 20 अमरीकी सेंट (100 सेंट = 1 डॉलर), है । खेतिहर मज़दूरों और अकुशल कारीगरों को मिलने वाली निम्न स्तर की मज़दूरी का अर्थ है कि बहुत से गरीब परिवारों की, जो वैसे भी अपने बच्चों को पर्याप्त भोजन देने में असमर्थ रहते हैं और फलस्वरूप, डायरिया से अधिक पीड़ित रहते हैं, अपनी एक दिन की मजदूरी का एक-चौथाई से तीन चौथाई हिस्सा, एकमात्र ओ.आर.एस. पैकेट पर ही खर्च कर देना पड़ता है।

3) क्योंकि ओ.आर.एस. पैकेटों का मूल्य अधिक है, अतः ओ.आर.एस.पैकेटों पर आधारित, किसी भी प्रकार के स्वास्थ्य कार्यक्रम को कार्यान्वित करने के लिए सरकार को लगातार अनुदान देते रहना पड़ता है। इसलिए यदि कार्यक्रमों को सफल होना है तो उसे सरकार पर निर्भर रहना पड़ता है। आपूर्ति लगातार बनाए रखने की भी समस्या है। इसकी अपेक्षा घरेलू-घोल सुगमता से उपलब्ध होता है और लगभग मुफ़्त में तैयार हो जाता है। साथ ही इससे गरीबों में आत्म-निर्भरता भी बढ़ेगी।

4) सामुदायिक स्वास्थ्य कार्यकर्ता यह महसूस करते हैं कि ओ.आर.एस. को दवा के रूप में बढ़ावा देने की नीति सही नहीं है क्योंकि यह, लोगों की जागरूकता बढ़ाने की बजाय उनकी ग़लतफहमी या भ्रान्तधारणा पर आधारित है। इसकी संभावना है कि व्यावसायिक पैकेटों का घरेलू इस्तेमाल के लिए उत्साही व ज़ोरदार प्रोत्साहन, परिवारों को भोजन की अपेक्षा पैकेटों पर खर्च करने को मज़बूर कर, संभवतः बच्चों की मृत्यु में अप्रत्यक्ष रूप से सहयोग दे रहा है। वास्तविक उद्देश्य, निर्जलीकरण आरम्भ होने से पहले ही पुनर्जलीकरण उपचार शुरू करना है, अर्थात, निर्जलीकरण के उपचार के लिए ओ.आर.एस. पैकेटों की आवश्यकता को घटाना है। माताएँ इसे अपने बच्चों को, अक्सर दवाओं की 'खुराक' के रूप में देती हैं, जो कि बहुत मात्रा में और अनियमित होने की वजह से प्रभावशाली नहीं होते हैं। हालाँकि, यदि ग़रीबों को तीव्र डायरिया से प्रभावित बच्चों की वास्तविक ज़रूरतों के विषय में समझा दिया जाए तो वे उन ज़रूरतों को अपने ही संसाधनों से, लगभग मुफ्त, पूरी करने में सक्षम होंगे। यह स्वास्थ्य कार्यकर्ताओं तथा संस्थाओं पर निर्भर है कि वे जागरूकता बढ़ाने को बढ़ावा देते हैं अथवा मत परिवर्तन की प्रक्रिया ही जारी रखते हैं। परन्तु जब तक व्यावसायिक शक्तियाँ अपना आधिपत्य जमाए रखेंगीं, तब तक वे गरीब जनता को पैकेटें उपलब्ध कराती रहेंगी।

आगे जारी.....

डाइरिया नियंत्रण

ओ आर एस का डब्लू.एच.ओ. मान्यता प्राप्त फार्मूला (सूत्र) :

शक्कर : 20.0 ग्राम, खाने का नमक : 3.5 ग्राम,
पोटैशियम क्लोराइड : 1.5 ग्राम, ट्राइसोडियम साइट्रेट : 2.8 ग्राम

इसके समानांतर, बराबर का घरेलू आईडीडी :

चाय के दो छोटे चम्मच शक्कर और आधा चम्मच नमक को एक लिटर पानी में घोले। खांडसारी शक्कर, शीरा या शहद का प्रयोग भी किया जा सकता हैं। खाने का सोडा भी मिलाया जा सकता है, परंतु यह अनिवार्य नहीं है।

जायके तथा पोटैशियम की पर्याप्त मात्रा के लिये (जो बच्चे को मूख खोलने में मदद कर सकते हैं), नीबू, मोसम्मी, टमाटर या अन्य फलों के रस को मिलाया जा सकता है अथवा बच्चे को केला खाने के लिये उत्साहित किया जा सकता है। चूल्हे की राख (पोटाश) से भी पोटैशियम उपलब्ध हो सकता है।

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NEWSLETTER

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The Body Image and Health-Seeking Behaviour

*This is an abridged version of a paper presented by **Dr. Hemant Apte** titled "Cultural Perceptions of Anatomy and Physiology as Barriers to Health-Seeking Behaviour", at a seminar on 'Women and Health' organised by FRCH on 5th December'97 at Pune. The paper focuses on how cultural perceptions of reproductive anatomy and physiology affect health-seeking behaviour among rural women.*

Health-seeking behaviour of individuals is influenced by a number of factors, both medical as well as nonmedical. A study was conducted in two villages from the Shirur block in Pune District, in 1995, to determine how rural women in Western Maharashtra perceive the construction and functioning of their reproductive system and how these perceptions affect health-seeking behaviour particularly, with regard to reproductive issues like menstruation, pregnancy, contraception etc.

Data Collection

The sample framework consisted of 150 married adolescent males and females each as well as 100 unmarried males and females each, i.e. total 500 adolescents. Though data collection was mainly done through the use of qualitative tools like key informant interviews, in-depth interviews, case-studies and several other participatory tools like body mapping and ethno-histories in the first phase of the study, a survey was also conducted during the second phase of the study. Though no direct enquiry was made with regard to health-seeking behaviour of women, several clues obtained during data collection were used to determine this behaviour. It was observed in our study that generally, reproductive health behaviour seems to fall in the purview of 'hard core' of culture, making it rather change resistant.

Health-seeking Behaviour

It was realised that the variation in health-seeking behaviour among rural women and their urban counterparts was chiefly a result of 1) the perception of what constitutes illness which, among rural women, is mainly guided by cultural notions and 2) the form of health care resorted to for treatment which, in this case, is largely the traditional or folk sector. It will be appreciated that resorting to home remedies or to medications in the folk/traditional sector does not cost money and advice is available at the doorstep, as against the professional sector, where the woman has to physically go to the provider, spend time and money (both of which may not be at her disposal) and get treatment. Only a failure to get cured may drive her to resort to the 'professional' sector of modern medicine. We therefore contend that we are looking at two entirely different sets of models of health and health care when we think of rural women's health-seeking behaviour with reference to the professional health sector.

Body Image

To all members of all societies, the human body is more than just a physical organism, fluctuating between health and

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illness. It is also the focus of a set of beliefs about its social and psychological significance, its structure and function. The term 'body image' has been used to describe all the ways that an individual conceptualises and experiences her/his body, whether consciously or not. This concept is important as it is the means through which sociocultural perceptions determine how we perceive and interpret the many changes that can occur over time in our own bodies, how we differentiate a 'sick' body from a healthy one and how we view some bodily functions as socially acceptable and others as morally unclean.

In general, concepts of body image can be divided into three main groups : 1) Beliefs about the optimal shape and size of the body; 2) Beliefs about the body's inner structure and 3) Beliefs about how it functions. Although beliefs about the body's structure can have clinical importance, those about how it functions are probably more significant in their effect on people's behaviour in reproductive health matters like menstruation, sexual intercourse, infertility, pregnancy and childbirth and finally, the use of contraceptives.

To most of the interviewees, the inner structure of the body and its functioning is a matter of speculation. Lack of scientific information on the subject leads to a reliance on inherited folklore, ethno-logic and theorising. Beliefs about functions usually deal with one or more interrelated aspects of the body like 1) Its inner workings; 2) The effect on these of outside influences, such as diet or environment and 3) The nature and disposal of the by-products of the body including menstrual blood.

The body is conceived of as a series of hollow cavities or chambers, connected to each other and with the body's orifice, by a series of pipes or tubes. The major cavity is the abdomen, which is thought to contain numerous organs including the heart and at times, the lungs, along with organs that belong to the digestive system and those that belong to the genitourinary system. The organs too are connected with tubes, to each other, and to the different orifices. Helman calls this model of conceptualisation of the human body as the 'Plumbing Model'. Central to this model is the belief that health is maintained by the uninterrupted flow of various substances including blood, air, food, urine and menstrual blood, between the various organs or between the cavity and the exterior, via one of the orifices. The 'blockage' of any of the connecting tubes results in illhealth.

There is an understanding that the body takes in substances like air, water and food and converts them into undesirable waste matter which is subsequently excreted out of the body through different orifices. There is a notion that 'good blood' which circulates in the body gets 'bad' in due course and is collected in a separate bag for subsequent disposal. This belief explains the presence of two bags in some of the body maps drawn by the respondents - one for menstrual blood and another one for the baby.

Menstruation

One rarely finds women seeking modern medical health care for menstrual disorders or other symptoms like cramps or low backache because menstruation is considered to be a curse of 'womanhood', an inevitable part of a woman's life, and she is expected to bear the discomfort without any complaint. Many perceive the uterus to be a hollow organ that is tightly closed between periods while it slowly fills up with tainted blood and then opens up to allow the blood to escape during menstruation. Hence, all the women, irrespective of their educational backgrounds, believe that a women is 'impure' during this phase as she passes impure blood. A menstruating woman is not only 'polluted' herself but can also pollute others around her. Cross-sexual pollution too is feared (it is even thought to lead to leprosy by some) and sexual intercourse is prohibited during this period. (Naturally, the rules of seclusion during menstruation apply more strictly to married rather than unmarried women.) At the same time, it is commonly believed that conception is most likely to take place at such times, i.e. a little prior to, during, or a little after menstruation, because the mouth of the uterus is open and can receive the sperms. Women reported that they prefer the menstrual flow to be profuse as a scanty flow is thought to adversely affect ones health. The 'good flushing', if obstructed, would result in a backward flow leading to ill-health and mental disorders. Most women see menstruation as a method of ridding the body of impurities that might otherwise cause illness or poison the system. The body is thought to be in a 'hot state' and women reported having consumed excessively hot and spicy food to commence the menstrual flow if it is delayed. On the other hand, excessive menstrual bleeding is sought to be curbed by consuming 'sour foods'. On the fourth day of menstruation women are expected to take a head-bath which is a symbolic act of ritual cleansing/ablution and is also expected to cool the body and stop any further bleeding.

Sexual Behaviour

This is one area where treatment is not sought easily and frequently because sex is supposed to be a very private and personal act. It is also thought to be a 'polluting' act and the woman is expected to have a bath immediately after she gets up the next morning before she begins her routine chores. This does not apply to the man, however, as according to our respondents, sex happens inside the body of the woman

but outside the body of the man'.

Sexual union is legitimised through the institution of marriage. Most girls reported not having any idea or a very limited knowledge about sexual intercourse before marriage. A woman from the rural community has no active role to play in sexual intercourse except passively giving in whenever the husband demanded sex. A man's sexual desire was compared to his appetite and women yielded to the demand of sex for fear of being deserted. Respondents who were educated upto the 10th grade, however, reported that they could deny sex if they did not want it on a particular day and that their husbands were most likely to listen to them.

Pain during intercourse is not looked at very seriously until it becomes unbearable. In fact, many miss out on bleeding during or after intercourse because intercourse is frequently carried out hurriedly in the dark, without much privacy. Women are thus likely to continue to suffer because of lack of privacy, their passive role in sexual intercourse and generally due to their secondary status within the family. Symptoms like white discharge are often neglected until the time they become severe, when some of them visit a doctor, because the cause of white discharge is thought to be 'excessive heat' in the body. White discharge is also believed to be something that happens to most women sometime or the other and hence, not worth taking any cognizance of.

Infertility

Infertility is a universal concern, whatever its cause. Most cultures include a series of rituals taking special precautions to help a woman conceive and have a safe delivery. Every married woman is expected to get pregnant at the earliest and preferably produce a male child. When a woman fails to conceive, a wide variety of explanations are offered blaming either the individual's behaviour, the malevolence of other people, natural or supernatural forces or gods. Infertility in most South-east Asian societies is primarily associated with women and not men. A barren woman is often marginalised by the society, and seen as someone both personally unfulfilled and socially incomplete.

According to some respondents, while marriage got consummated 16 days after the ceremony, in the previous generation, today, it may even happen on the same day in some cases. There are several days of ritual abstinence according to the religious rites but not many are observed by young couples. It was generally observed that a large majority of the younger generation believed that getting pregnant, or the sex of the child depended on both husband and wife. Despite this understanding, the treatment of infertility continues to fall in the domain of magico-religious, magico-medical remedies/therapies and women are saddled with various proscriptions/taboos. One could visibly see a large crowd of people in front of a temple situated in the premises of a rural hospital and not so much in the Gynaec-OPD because the priest is believed to be a powerful man who cures fertility.

Curiously, many of the women are seen to simultaneously resort to medical, magical and religious remedies for suspected infertility. The reason is that people do not mind spending money on the concerned woman because the desired result is in the interests of the entire family and the benefits are not enjoyed by the woman alone. If infertility is not cured in due time, the women are promptly deserted and men take new wives.

It may be noted that only a few couples see any specialist for suspected infertility. Of course, the services of such a specialist are not really required as most of the couples who see general practitioners are 'normal' cases, driven into seeking treatment by impatient mothers-in-law.

Pregnancy and Childbirth

Pregnancy is thought to be a vulnerable state and also a state of transition between two social roles for the women - from that of a wife to that of a mother. The rituals and taboos surrounding pregnancy therefore serve both to mark this transition and to protect the mother and foetus during this delicate period. There are several dietary and behavioural proscriptions for pregnant women. Like menstruation, pregnancy is thought to be a 'hot state' and consumption of hot foods is proscribed. Rest and work schedules are laid down and the pregnant women is expected to adhere to them. It was found that the elderly women in the community have a number of ethno-diagnostic criteria to judge whether the foetus is that of a male or a female. Depending on these perceptions, health care during pregnancy varies. If the foetus is thought to be that of a female then the level of health care is low. Many elderly women believe that a young pregnant woman should not eat a lot of food because it would not leave adequate space for the baby to grow, keeping it small in size. If an abnormal child is born it is blamed post hoc on the mother's behaviour during the antenatal period. For eg. a cleft lip or cleft palate is supposed to result from cutting tubular vegetables in pregnancy during a solar or lunar eclipse.

Behavioural and dietary rules continue in the postpartum period. The body that is supposed to have been in a hot state now requires to be kept hot and hot foods like jaggery, gum acacia, fenugreek, dry fruits and a lot of fatty foods

are prescribed. Aaleev, which is a proven galactogogue, is consumed by most women. The woman is given hot/warm water to drink and sour foods are disallowed because they are thought to be 'cold' and are believed to affect the health of the newborn as well as the mother. Fomentation and massage continues for quite a while afterwards to normalise the overstretched muscles.

Use of Contraceptives

The young as well as the old generation has realised the advantages of a small family, but it is found that in most cases the sex composition of children (preferably two sons and one daughter) overrides the advantages of a small family. Temporary methods, also called spacing methods, have not taken root in the rural community as 'Everyone eagerly waits to see the first flower on the plant s/he grows!' The terminal method of tubectomy is preferred over temporary methods for two reasons: fear of failure of a method and perceived complications. The prevalent thought is that a couple should have as many children as they want at the earliest and finally resort to tubectomy.

A common belief is that the birth interval between two children is hereditary (Paalna) and that it runs in the family. In reality, birth intervals could be attributed to factors like days of ritual abstinence which has a bearing on freqency of intercourse, lactational amenorrhoea, opportunities for sexual union over the agricultural season, etc.

Body image and concepts about construction of a woman's body guide the choice of contraceptive. There is a severe resistance to acceptance of CopperT (CuT) because in many cases women complained that it poked and pained during intercourse. Some women said that it poked and hurt their husbands. There were others who reported that there were cases of CuT migrating all the way to the chest while still others reported experiencing menstrual irregularities and white discharge on insertion of an IUD. Some medical treatment is thought necessary when white discharge after CuT insertion becomes excessive and unbearable and many women reported having discontinued the contraceptive with an idea that the white discharge will get cured. Similar notions were recorded regarding Oral Pills. They are thought to increase the body heat which subsequently results in white discharge. Such notions become an impediment to the acceptance of temporary methods. Mothers-in-law were generally against their daughters-in-law inserting IUDs. There are several instances where young women have, without the knowledge of the mother-in-law, gone to the health facility and got an IUD inserted and, also, cases where on suspecting that the daughter-in-law is using an IUD, the mother-in-law has accompanied her to the clinic and got the device removed. However, once the woman has had enough children of the desired sex composition the mother-in-law herself encourages the young woman to accept tubectomy.

Women were, however, unable to ask their husbands to use condoms because such decisions (regarding contraception or protection) are not supposed to be made by them. Counselling in this regard is largely done by peers, based on their own experiences as the elder women in the household were of practically no help in this matter. As mentioned earlier, there is a common belief among women that conception is most likely to take place a little prior to, during or a little after menstruation. All such notions together results in most of the pregnancies being unplanned.

Conclusion

We must keep in mind that even if doctors and patients come from the same cultural setting, they view ill-health very differently. Their viewpoints are based on different premises, they employ a different system of diagnosis, and judge the efficacy of treatment in a different way. The main premises of modern medicine are: 1. Scientific rationality 2. Emphasis on objective, mumerical measurement 3. Emphasis on physicochemical data 4. Mind-body dualism 5. The view of disease as entities 6. Emphasis on the individual patient, rather than on the family or community.

On the other hand, at the individual level, the process of defining oneself as being ill is based on one's own perceptions, on the perceptions of others, or on both. The premises are: 1. Perceived changes in body temperature 2. Changes in regular body functions 3. Unusual body emissions 4. Changes in the five senses 5. Unpleasant physical symptoms 6. Unusual emotional states etc.

The lay theories of illness causation take into account the individual in his/her entire setting, from where the cause of illness is located. Therefore, though from the perspective of modern medicine, it may be true that not many women seek health care and cultural perceptions could be thought of as barriers to health-seeking, in reality, most women seek health care from the traditional sector, if they perceive themselves or others perceive them as being ill. These cultural factors, where they can be identified, are often difficult to quantify and hence, less attractive for medical specialists. Also, there is no neat, measurable dose-repose relationship existing between a cultural factor and the condition of the patient. As a result most issues in the area of reproductive health of women continue to lie outside the domain of modern medicine. ❐

The Inverse Health Care Law

This information has been extracted from the article "Variations in use of cardiology services in a health authority: comparison of coronary artery revascularisation rates with prevalence of angina and coronary mortality" by ***Nick Payne and Carol Saul*** *in the 25 January'97 issue of BMJ*

Tudor Hart summarised the inverse health care law when he enunciated the sad fact that **'the availability of good medical care tends to vary inversely with the need for it in the population served'.**

A study was carried out at a small area level in the city of Sheffield, England with a population of 53,000, to assess whether use of health services reflects need or otherwise. This was done by comparing coronary artery revascularisation rates (symbolising advanced medical care) with prevalence of angina (heart ailment) and coronary mortality.

Data Collection

The health authority's database was used to examine hospital admission activity at electoral ward level - all these data were based on hospital admissions, not consultant episodes, which can be multiple even within a single admission. The sample frame consisted of residents registered with general practitioners, randomly stratified for age and sex. The sample was also stratified at the electoral ward level to reflect differences in socioeconomic development among the 29 electoral wards. A survey was conducted through a postal questionnaire of 16,750 persons aged between 18 to 94 years, to assess the prevalence of angina symptoms. The questionnaire was a highly simplified form of the World Health Organisation angina questionnaire. The survey revealed a total of 491 patients including, those admitted to the hospital for coronary heart disease; patients who died; and patients undergoing angiography, angioplasty, or coronary artery bypass graft. Overall, 4% experienced symptoms of pain or discomfort in the chest when walking at an ordinary pace on the level. This data was cross-checked with data on admissions and procedures in the Northern General Hospital where specialist cardiological investigation and treatment is carried out. Survey data were analysed with EpiInfo and plotted as scatter points, and Pearsons's product moment correlation coefficients were calculated.

The 1991 census was used to calculate the Townsend score for each electoral ward. This score is designed to be high in areas of increased deprivation. Thus the higher the Townsend score of an electoral ward, the greater the level of deprivation in that ward.

Results

It was seen that prevalence of disease varied widely between electoral wards but was positively associated with Townsend score, as was mortality. However, correlation between admission rates and Townsend score was less clear.

To determine whether utilisation of coronary artery revascularisation was related to need, we calculated the ratio of revascularisations to the number of people in the electoral ward estimated to have symptoms of angina. There was a clear variation between electoral wards in these ratios : deprived wards had only about half the number of revascularisations per head of population with angina symptoms than did affluent wards. A similar inverse relation was observed between revascularisations per premature death (5 years) from coronary heart disease and Townsend score and between revascularisations per myocardial infarction and Townsend score. Thus use of services was not commensurate with need and seemed to exhibit the inverse care law, even though the availability of care is the same.

Given that private sector activity is likely to be higher for more affluent wards, however, and indeed that private insurance coverage in professional groups is much higher than in unskilled manual groups, ***the differences in use in relation to need for these services between the affluent and deprived populations may be even greater than described.***

Likely Influence of Other Variables on the Result

The following variables which were likely to have interfered with the result have been explained and assessed to determine whether they could have had any influence on the rates of revascularisation treatment:

1) Need - epidemiology of disease, even after differences in age and structure are considered, varies substantially from place to place, at both national and local levels. However, in this case, both mortality and prevalence of symptoms were strongly correlated with material deprivation, as estimated by the Townsend score, at the electoral ward level.

2) Supply - the availability of cardiologists and centres carrying out revascularisation procedures has been shown to be a substantially important predictor of utilisation. The very location of the hospital which is situated closest to some of the worst suffering areas in terms of heart problems takes care of any influence of accessibility on the study results.

3) Demand - though the correlation between admission rates and Townsend score was not as strong as in the case of the above two variables, it was significant nonetheless.

Contd. on pg. 8

निर्जलीकरण का व्यावसायिक एवं घरेलू प्रबंध

यह जानकारी, 'डेविड वर्नर, डेविड सैन्डर्स' आदि की पुस्तक 'क्वेश्चनिंग द सल्यूशन : द पॉलिटिक्स ऑफ प्राइमरी हेल्थ केअर ऐण्ड चाइल्ड सरवाइवल' से ली गई है।

पिछले अंक में उपरोक्त शीर्षक के अन्तर्गत प्रकाशित लेख का यह दूसरा व अन्तिम भाग है।

खाद्यान्न-आधारित ओ.आर.टी. के पश में तर्क

खाद्यान्नों को अब, प्रभावी मुख पुनर्जलीकरण का एक महत्वपूर्ण हिस्सा माना जाता है। इस क्षेत्र में किये गए अनुमान यह दर्शाते हैं कि पारम्पारिक रूप से अधिकतर माताएँ डायरिया के दौरान अपने शिशुओं को भोजन देती हैं और लगभग सभी, अपने शिशुओं को स्तनपान कराना जारी रखती हैं। भोजन से पुनर्जलीकरण की प्रक्रिया को प्रोत्साहन मिलता है, पोषण का पर्याप्त स्तर बना रहता है तथा आंतों से जल के सोखे जाने की प्रक्रिया भी तेज हो जाती है। हर्सकॉन के अनुसार, पुर्नजलीकरण का एक महत्वपूर्ण कार्य, शिशु के स्वास्थ्य को बेहतर करना है, जिससे कि वह भोजन कर सके। भोजन से अन्य पोषक तत्व, जैसे विटामिन 'ए' भी प्राप्त होते हैं, जो कि डायरिया के साथ होने वाली संक्रामक बीमारियों के प्रति रोगप्रतिरोधक क्षमता बढ़ाते हैं।

हाल के वर्षों में, खाद्यान्नों पर आधारित ओ.आर.टी. पर परिक्षण किए जा रहे हैं। खाद्यान्न अथवा खाद्य-पदार्थों पर आधारित पेय (थोड़े नमक के साथ), डायरिया के इलाज व उससे बचाव में शक्कर-आधारित पेयों की अपेक्षा अधिक प्रभावी होते हैं। इस इलाज के, मात्र शक्कर-आधारित पुनर्जलीकरण पेयों की तुलना में रोग-विषयक व गैर-रोग विषयक, दोनों तरह के फ़ायदे हैं।

हालाँकि, रोग-विषयक फ़ायदे बहुत अधिक नहीं हैं, परन्तु गैर-रोग विषयक फ़ायदे बहुत अधिक हैं क्योंकि खाद्यान्न-आधारित पुनर्जलीकरण पेयों में उपस्थित स्टार्च, अपनी आणविक संरचना तथा रसापरासरण (ऑस्मोसिस) के कारण, शक्कर की अपेक्षा बेहतर कार्य करता है। अन्य प्रकार के गैर-रोग विषयक फ़ायदे निम्नलिखित हैं:

मनोवैज्ञानिक : ग्लूकोज (शक्कर) पर आधारित पेय पदार्थों की तुलना में, खाद्यान्न-आधारित पेयों के प्रयोग से, मल की मात्रा तथा शौच की अवधि व संख्या में ४० से ५० प्रतिशत की कमी लाने में मदद मिलती है।

पोषण - सम्बंधी : क्योंकि खाद्यान्न-आधारित पेयों में रसापरासरण की प्रक्रिया धीमी रहती है। अतः उन्हें, शक्कर या ग्लूकोज की तुलना में तीन गुने अधिक की कैलोरी तक का बनाया जा सकता है और इससे शिशुओं को कोई खतरा भी नहीं है। अब ऐसा माना जाने लगा है कि गरीब परिवारों के बच्चों में कुपोषण के कारणों में से एक कारण यह भी है कि उन्हें जो भोजन उपलब्ध होता है, उसमें पानी की मात्रा इतनी अधिक होती है कि पर्याप्त कैलोरी मिलने से पहले ही उनके पेट भर जाते हैं।

सुरक्षा-सम्बंधी : खाद्यान्न - आधारित ओ.आर.टी. को यदि आवश्यकता से अधिक गाढ़ा बनाया जाए तो भी वह सुरक्षित है। जबकि ओ.आर.एस. पैकेटों के साथ ऐसा नहीं किया जा सकता है।

सुविधाजनक : माताएँ व बच्चे इसे अधिक स्वीकार्य मानते हैं, क्योंकि वे खाद्य पदार्थों को माँ का दूध छोड़ने के बाद से खाते आए हैं। यह पेय अधिक सुविधाजनक व व्यवहार्य है, क्योंकि इसे स्थानीय परम्पराओं पर चलते हुए भी बनाया जा सकता है।

व्यवहार्यता व मूल्य : एक परिवार के लिए, जिसके पास अपने बच्चों को भर पेट भोजन उपलब्ध कराने के लिए भी पर्याप्त धन नहीं है, उसके लिए कुछ ओ.आर.एस. पैकेटों को खरीदने के दाम तथा उसको प्राप्त करने के लिए काम का हर्ज़ व आने-जाने के खर्च का भार, उस परिवार के लिए पोषण के संदर्भ में मँहगा साबित हो सकता है। डाएरिया का घर में ही इलाज करने की दृष्टि से देखा जाए तो यह आवश्यक है कि माताओं के सामने आने वाली कठिनाइयों पर अधिक ध्यान दिया जाए तथा उनकी व बच्चों की ज़रूरतों के लिए हल खोजे जाएँ। खाद्यान्नों पर आधारित ओ.आर.टी. को बनाने में बहुत कुशलता की आवश्यकता नहीं होती है तथा ओ.आर.एस. की अपेक्षा उनका स्वाद बेहतर होता है। अतः इन्हें बड़े भाई-बहन द्वारा भी बनाया व पिलाया जा सकता है। खाद्यान्न-आधारित ओ.आर.टी. का विरोध करने वाले उनके इस्तेमाल में होने वाली निम्नलिखित असुविधाओं व हानियों पर ज़ोर देते हैं: ईंधन पर अधिक खर्च, अधिक कार्य तथा मिश्रण को पकाने की जो आवश्यकता होती है, उसके कारण विलम्ब होना। अधिकतर माताएँ यह भूल जाती हैं कि उनके घर में ऐसा भोजन हमेशा ही तैयार करता है और माताओं को उसमें थोड़ा पानी मिलाकर केवल उसे अधिक पतला करने की आवश्यकता होती है, यदि वह अधिक गाढ़ा है या उसमें नमक की मात्रा अधिक है, तो उसे थोड़े-थोड़े समय पर देते रहना होता है। संभवतः सबसे बड़ी असुविधा या नुकसान यह है कि खाद्यान्न-आधारित पेय, शक्कर-आधारित पेयों की तुलना में जल्दी ख़राब होते हैं, परन्तु आमतौर पर परिवारों को यह पता रहता है कि उन्हें खराब होने से कैसे बचाया जा सकता है। कुछ स्वास्थ्य विशेषज्ञ इस

डायरिया नियंत्रण

डायरिया पीड़ित बच्चे को भोजन कराते रहना आवश्यक हैं। घरेलू पेच पदार्थों को, अधिकतर गरीब परिवारों में उपलब्ध पदार्थों की मदद से बनाया जा सकता हैं - सस्ती आमतौर पर खाई जाने वाली खाद्य पदार्थों को मापने के लिये पारम्पारिक तरिकों को अपना कर। उदाहरण के तौर पर, चावल, मक्का, आलू या आम तौर पर खाये जाने वाले उपलब्ध सस्ते खाद्य पदार्थों या परिवार के पास उस समय जो भी जड़ वाली सब्ज़ी उपलब्ध हो, उसका पतला घोल। जहां तक सम्भव हो, इस पेय पदार्थों में नमक होना चाहिए। बिना नमक के कुछ पेय पदार्थ जैसे हल्की चाय, चावल का पानी, दही से बनाये गये पेय तथा साधा पानी भी उपयोगी होते हैं। कुछ पेय पदार्थों को, जहाँ तक सम्भव हो, नही लेना चाहिये, जैसे बोतल बंद गैस-युक्त पेय, कॉफी या ऐसे पेय पदार्थ जिनका प्रभाव मूत्रल (अधिक मूत्र) या निरेचक (अधिक मल) का होता है।

बच्चे को माँ का दूध पिलाने या भोजन देने में कोई कमी नहीं करनी चाहिए व उसे पर्याप्त मात्रा में देते रहना चाहिये। पेय पदार्थों की मात्रा बढा देनी चाहिए और बच्चों को उनकी इच्छा के अनुसार, अधिक से अधिक दिया जाना चाहिए।

अंततः बच्चे को हर समय, पर्याप्त मात्रा मे भोजन की आवश्यकता होती है, न कि डायरिया क् दौरान, उससे तुरन्त पहले अथवा उसके तुरन्त बाद। दूध छुड़ाने के लिये स्वस्थ उपाय या साधन आवश्यकता है, ज़ब कोई भी बच्चा अल्प-पोषित हो सकता है और डायरिया से उसकी मृत्यु भी हो सकती है।

खतरे की ओर ध्यान दिलाते हैं कि माताएँ नियमित भोजन के स्थान पर खाद्यान्न-आधारित ओ.आर.टी. दे सकती हैं। सामुदायिक कार्यकर्ता यह महसूस करते हैं कि माताएँ अपने बच्चों का भला-बुरा समझने में सक्षम हों और कुछ विशेषज्ञों द्वारा संदेह करने के बावजूद, उन्हें ऐसी आशा नहीं हौ कि माताएँ बच्चों को नियमित भोजन देने की आवश्यकता को नहीं समझेगी और उसके स्थान पर खाद्यान्न-आधारित पेय देंगी, वे जानती हैं कि दोनो साथ-साथ दिए जाते हैं। ऐसा इस कारण से है, क्योंकि खाद्यान्न-आधारित पेयों में पानी अधिक मात्रा में होता है और उनमें बच्चों के लिए पर्याप्त मात्रा में कैलोरी या ऊर्जा नहीं होती है। विशेषज्ञ, पुनर्जलीकरण कै लिये आजकल इलाज के लिए खट्टा किया गया दलिया की संभाव्यता की जाँच कर रहे हैं, क्योंकि यह जल्दी खराब नहीं होता है, किण्वन (फर्मन्टेशन) प्रक्रिया, ऐसा माना जाता है, बच्चों के लिए अनाज को अधिक सुपाच्य बना देती है और अम्लीय दलिया में उपस्थित जीवाणु, डाएरिया पैदा करने वाले संक्रामक विषाणुओं से लड़ने में मदद करते हैं। माताओं ने भी इस बात की पुष्टि की है कि बीमार बच्चे, किसी अन्य खाद्य पदार्थ की तुलना में खट्टा किया हुआ दलिया अधिक पसन्द करते हैं और उनका यह भी मानना है कि इससे डाएरिया से लड़ने में मदद मिलती है। दूसरी महत्त्वपूर्ण बात यह है कि इससे दलिया का गाढ़ापन कम होता है, जिससे इसका पेय बनाने में सुविधा रहती है जो कि गाढ़ा न होते हुए अधिक ऊर्जा-दायक होता है। इससे अतिरिक्त, अंकुरित अनाज का आटा भी मिलाया जा सकता है, जो कि गाढ़ेपन को काफ़ी हद तक घटा देता है। यह मिश्रण यूगाण्डा तथा भारत जैसे देशों में पहले से ही प्रयोग में लाया जा रहा है तथा स्थानीय परम्पराओं पर आधारित 'सुपर.ओ.आर.टी.' मिश्रण बनाने की संभावनाएँ प्रदान करता है।

शिशुओं के लिए, डाएरिया से मृत्यु होने से बचने का सर्वोत्तम उपाय स्तनपान के माध्यम से है। अध्ययनों से पता चला है कि केवल स्तनपान पर रहने वाले शिशुओं की तुलना में बोतल से दूध पीने वाले शिशुओं को डाएरिया होने की संभावना पाँच-गुना अधिक हो जाती है तथा डाएरिया से मृत्यु, २५ गुना अधिक होती है। गरीब देशों में डाएरिया अधिकतर संक्रामक विषाणुओं के द्वारा होता है तथा ऐसे शिशु जो अल्प पोषित हैं या जिन्हें बोतल से दूध पिलाया जाता है, उनकी डाएरिया से मृत्यु होने का अधिक ख़तरा है।

भ्रांतिपूर्ण संदेश

सही इलाज को प्रोत्साहन देना मात्र पर्याप्त नहीं है। यह भी आवश्यक है कि लोगों को इस इलाज के बारे में भी उनकी ही भाषा में बतलाया जाए जिससे कि उसका अधिकतम लाभ हो। सरल इलाजों का, ओ.आर.टी., ओ.आर.एस., आई.डी.डी., सी.वी.-ओ.आर.टी. जैसे संक्षिप्त रूपों का प्रयोग करके, चिकित्सीकरण करना तथा उन्हें रहस्यवादी बना देना, स्वास्थ्य के क्षेत्र के पेशेवर लोगों तथा सम्बन्धित व्यावसायिकों के लाभ तथा व्यक्तिगत प्रतिष्ठा व शक्ति प्रदर्शन के लिए किया जाता है।

अक्सर जो स्वास्थ्य शिक्षा के संदशों को बनाते हैं, वे वास्तविकता से दूर रह जाते हैं, क्योंकि वे दूसरी ही दुनिया में रहते हैं और जिनके लिए ये संदेश बनाए जाते हैं, उनसे वे दूर-दूर तक भी सम्बन्धित नहीं रहते हैं। वे समस्या के हल के लिए एक संकीर्ण चिकित्सीय/तकनीकी/वैज्ञानिक दृष्टिकोण अपनाते हैं तथा आम जनता के जीवन की वास्तविक परिस्थितियों तथा उनके सामने आने वाली अत्यधिक गम्भीर परेशानियों को अनदेखा कर देते हैं। इसका एक आम उदाहरण, 'आ.आर.एस. घोल बनाने के लिए पानी को हमेशा उबाल कर लेना चाहिए' की सलाह देना है। वास्तविकता यह है कि पानी उबालने में काफ़ी समय लग सकता है, विशेषकर ऐसे परिवारों के लिए, जहाँ पर इस कार्य के लिए पहले ईंधन का इंतज़ाम करना पड़ता हो, जो कि एक अत्यधिक निर्जलीकृत बच्चे के लिए घातक सिद्ध हो सकता है। दूसरी ओर, डाएरिया से पीड़ित बच्चा, बिना उबाले पानी से होने वाले सभी संभावित संक्रमणों से पहले से ही प्रभावित रहता है। पानी को उबालने में रुपए-पैसे खर्च होते हैं - बेहतर तो यही होगा कि इस रकम को बच्चे के पोषण पर खर्च किया जाए। अतः संदेश यह होना चाहिए, 'अपने पास उपलब्ध शुद्धतम पानी का इस्तेमाल करें, पानी को उबालने में समय नष्ट न करें'।

एक और उदाहरण, ओ.आर.एस. पैकेटों का भ्रामक प्रोत्साहन है, जो लोगों को यह विश्वास दिलाता है कि ओ.आर.एस., डाएरिया होने से 'बचाता' है - अतः बहुत सी महिलाओं ने डाएरिया को होने से रोकने के लिए अपने स्वस्थ बच्चों को ओ आर एस दिया। दुर्भाग्यवश, ऐसी भ्रामक धारणाओं को सुधारने के स्थान पर, व्यावसायिक लाभ के लिए उनका फायदा उठाया जा रहा है।

दीर्घकालीन दृष्टिकोण

कुपोषण और डाएरिया के बीच का सम्बंध अब पूर्णतया स्थापित हो चुका है। अधिकतर गरीब बच्चे, जो आमतौर से, डाएरिया से अधिक संख्या में पीड़ित होते हैं, कुपोषण और डाएरिया के कुचक्र में फँस जाते हैं। डाएरिया की प्रत्येक घटना में उनका वजन कम होता है, बच्चा जैसे-जैसे पतला व कमज़ोर होता जाता है, बीमारियों के सिलसिले, डाएरिया समेत, और अधिक लम्बे और गम्भीर होते जाते हैं। इसके परिणामस्वरूप बच्चे का स्वास्थ्य धीरे-धीरे बिगड़ता जाता है।

विश्व स्वास्थ्य संगठन, गरीबी और कुपोषण के मूल कारणों की ओर ध्यान देने की बजाए, उनकी ओर आँख मूँद लेने के दृष्टिकोण को अपनाते हुए कुपोषण के लिए डाएरिया को दोषी ठहराता है। जिम्बाब्वे के ग्रामीण क्षेत्रों में हाल में किए गए एक अध्ययन ने हालाँकि, यह सिद्ध कर दिया है कि कुपोषण, बच्चों को डाएरिया होने के अधिक ख़तरे के लिए पूर्वप्रवत्त करता है, न कि डाएरिया के कारण कुपोषण होता है। बंगलादेश मे हुए एक अध्ययन द्वारा इस निष्कर्ष की पुष्टि होती है, जिससे यह प्रदर्शित हुआ कि बच्चों के वज़न में प्रति माह होने वाली बढ़ोतरी, पर्याप्त कैलोरी ग्रहण करने पर अधिक निर्भर थी। अतः डाएरिया के होने, उसकी गंभीरता तथा उससे मृत्यु होने की घटनाओं में वृद्धि होने का मुख्य कारण लम्बे समय तक होने वाला कुपोषण है।

क्यूबा तथा चीन (इन दोनों देशों में शिशु मृत्यू दर, विशेषकर डाएरिया से मृत्यु-दर का स्तर अपेक्षाकृत बहुत कम है) के तुलनात्मक अध्ययन से स्पष्ट होता है कि डाएरिया से होने वाली मृत्युओं को कम करने का सबसे प्रभावी कार्यक्रम, बच्चों की सभी पोषण-सम्बंधी आवश्यकताओं तथा मूलभूत ज़रूरतों को पूरी करना है, न कि ओ.आर.टी. पर योजनाएँ केन्द्रित करना। केवल ओ.आर.टी. का प्रचार करना तथा माताओं को इसके बारे में शिक्षा देना मृत्यु को टालना मात्र है। हमें माताओं को, पर्याप्त मज़दूरी प्राप्त करने, व उनके समुदायों में उनको उपयुक्त दर्जा दिलाने, जिससे कि वे अपने बच्चों को पर्याप्त भोजन दे सकें व स्वयं का स्वास्थ्य भी बेहतर रख सकें, के प्रयासों में उनकी मदद करने की भी आवश्यकता है। अन्ततः जब तक डाएरिया की रोकथाम के साथ-साथ, रहन-सहन की अस्वस्थ परिस्थितियों तथा गरीबी से लड़ने के प्रयास भी नहीं किए जाते है, तब तक मृत्यु-दर तथा सम्पूर्ण स्वास्थ्य पर कोई अपूर्व व चमत्कारिक प्रभाव नहीं पड़ेगा। ❐

हिन्दी अनुवाद : मीता श्रीवास्तव

Contd. from pg. 5

4) Response rates to questionnaires tended to be highest in the affluent wards (variation: 63-88%), and might have influenced the results. There is no cause for concern though, as long as deprived respondents are as representative of deprived population as affluent respondents of affluent populations.

5) Patients who smoke are known to have poorer results after revascularisation procedures, hence many clinicians are reluctant to perform these procedures unless patients have stopped smoking, and prevalence of smoking is known to be higher among less affluent groups. If we consider smoking rates to be twice as much in deprived areas it would account for only half the decrease in number of patients resorting to revascularisation. While angiography rate was 11% in affluent areas, in deprived areas it was only 4%. Even if only nonsmokers were included, angiography rates would still be twice as much in affluent areas.

Recommendation for Action

To redress this apparent inequity, firstly, an audit of referral of angina patients needs to be carried out. If consultation thresholds are higher in the less affluent areas it should be determined whether education of patients is required to encourage consultation by those with symptoms suggestive of angina. General practitioners should be aware of referral recommendations and potential benefits of treatment for those with angina. Detailed discussion of these results with cardiologists suggests that once patients have been referred for angiography those needing revascularisation are prioritised only on the basis of the severity of their disease. Finally, if cardiology services are expanded, steps should be taken to ensure that those in less affluent parts of the city receive a fairer share of these health services. These steps would to some extent ensure that health care is targeted where it will have the greatest effect. ❐

Of the total CT scans done in the private medical sector in Calcutta, only 5-10% give positive findings. A case study by the Medical Service Centre, Calcutta reports that only about 20% of the investigations advised have clear indications. The rest show rather vague indications.

Information Supplied by the Medical Service Centre, Calcutta

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NEWSLETTER

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The Indirect Path to Complementary Medicine

Anuprita Karyakarte had conducted a study in Pune city, Maharashtra in 1996 to determine the behavioural pattern of chronic patients in the utilisation of complementary medicine. Here we have highlighted the findings of this study concerning the reasons for and process of shifting therapies and practitioners by chronic patients in the course of their illness.

In 1985, a 48 year old women visited her family physician, a general practitioner, with complaints about pains in her knee joints. The practioner could not give any diagnosis but treated her for 3 months after which he referred her to an orthopedist.

After unsuccessfully trying out the orthopedist, followed by a stint with Accupressure and Magnetotherapy, in 1986 she visited her relative who was an Ayurvedic practitioner, where her condition was diagnosed as 'Arthritis'. After 1.5 months she shifted over to another Ayurvedic practitioner on the grounds of opting for a more professional practitioner. She spent Rs. 1300 for this treatment before discontinuing it.

In 1987, for 20 days, she tried out herbal treatment on an experimental basis costing Rs. 2,000; underwent the 'Panchakarma' treatment (a part of the Ayurvedic system) for 8 days; and also attended a camp for arthritis patients, all of which gave dissatisfactory results for one reason or the other. Meanwhile, the disease had advanced to severe proportions and she had to take emergency treatment of Allopathy for 8 months which cost her Rs. 8000 and caused a lot of side-effects.

The author, M.Sc. in Health Sciences, is a Documentor at FRCH

All this while she had been hearing of Homeopathy from her relatives and friends and in 1988 decided to give it a try. Her practitioner informed her right from the begining that she would not be totally cured of the disease, though within a year she did get satisfactory results. However, the death of her practitioner forced her to discontinue this treatment after a year. She had an almost similar experience with Acupunture which she tried out subsequently. After a brief unsatisfactory brush with Tabe treatment in 1992, she went back to Acupuncture with another practitioner only to be disillusioned by the high costs and severe side-effects.

In 1993 her condition became acute and she went to an Ayurvedic physician who prescribed a combination of Ayurveda and Allopathy. This, she discontinued after 2 years, when she found no improvement in her condition.

At the time of the interview, she had been following a combination of Homeopathy and Acupuncture for the previous 3 months. Her condition was so severe that she couldn't even stretch her legs. If she was unable to visit the homeopath her family members would get the medicines for her while the acupuncturist would visit her personally

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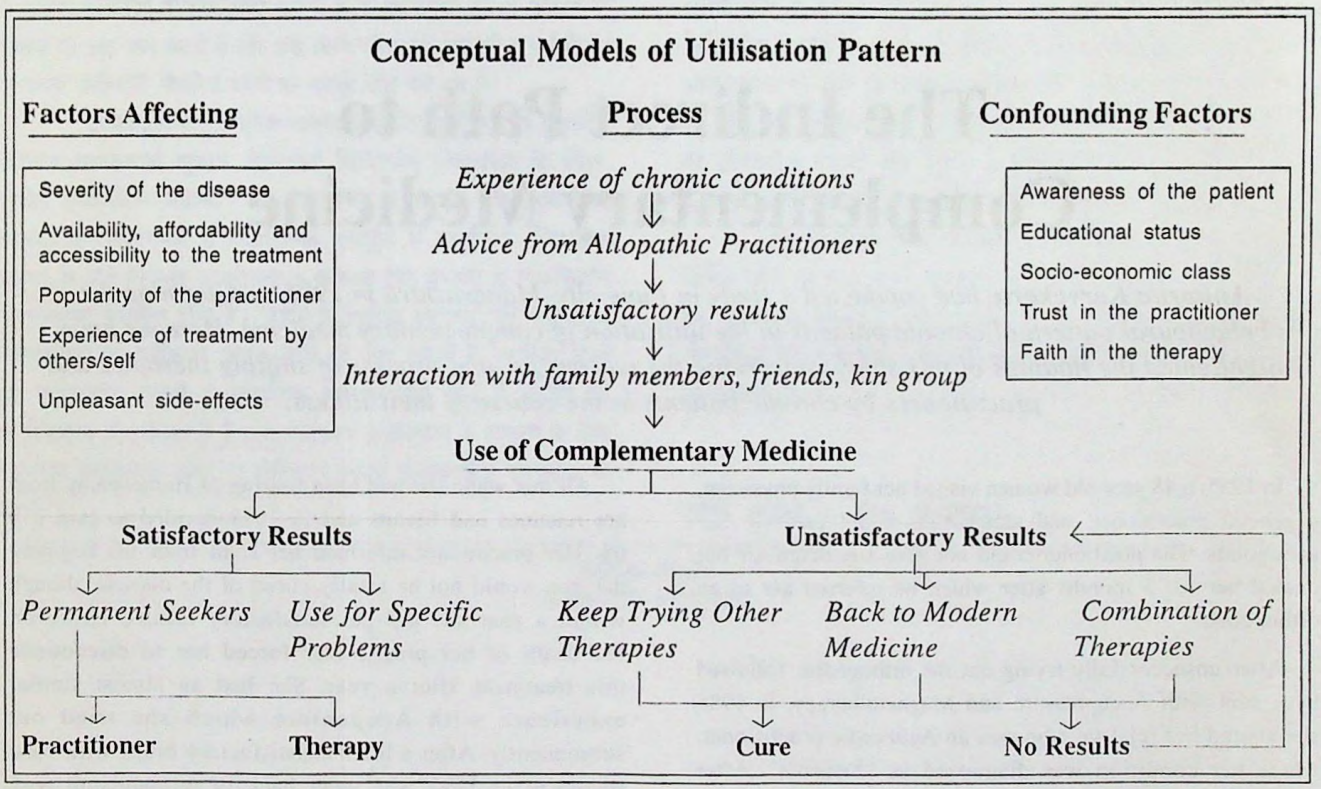
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for 20 days a month. This treatment combination was proving highly effective in her case and she claimed to have been cured by 50% since starting this treatment and looked forward to getting compleletely cured of the disease.

Though this is an extreme case, combined with the experiences of 102 other chronic patients interviewed in the study, it gives us a good inkling of the important and inevitable phenomena of 'shifting' in treatment seeking behaviour of chronic patients.

Duration of Illness - There is an exact relationship observed between number of shifts in therapies and duration of illness. The patients changing their therapies more than thrice are suffering from their illness for more than 6 months while those having their illness lasting for more than 2 years, show minimum 5 shifts in therapy. As mentioned above, the lady patient having maximum shifts in therapies (13), as well as maximum shifts in the practitioners (18), has been suffering from severe arthritis for the past 10 years.



The Phenomenon of 'Shifting'

A shift in this context can be defined as a change in treatment/practitioner by a patient, usually on an experimental basis, due to failure of or dissatisfaction with the previous treatment or practitioner. Both kinds of shifts have been analysed to determine the utilisation pattern of complementary medicine. If a patient come's back to her/his previous treatment/practitioner subsequently, it would still be considered as two shifts in therapy or practitioner, as the case may be.

Through our studies it was observed, not surprisingly, that greater the frequency of shifts the lesser the number of patients falling under that category. Out of the total 103 patients, 48 have shifted only once (although the number of practitioners changed might be more than that) while at the other end, there are only two cases with more than 7 shifts. The main factors affecting number of shifts are : Few patients had continued the same treatment for a duration of more than 5 years.

* *Socio-economic Class* - A higher number of shifts are observed in the middle income group. The Lower income categories do not show more than 2 shifts.

Sources of Information

Information about complementary medicine is generally gathered from the following sources in that order of importance : 1. Family members; 2. Relatives; 3. Friends; 4. Literature; 5. Communication media including advertisements; 6. A doctor friend or relative; 7. Lectures; 8. Previous doctor; 9. Occupational source; 10. Other.

The data suggests that literature is an important source of information regarding Naturopathy, Ayurveda, Magnetotherapy, Accupressure and Reikee. Generally,

efficacy of Ayurveda, Homeopathy, Yoga and Acupuncture and other therapies which include Tabe treatment, Bach flower remedies, Reikee, Diet therapy etc. is experienced by relatives, friends or family members and then suggested to the patient. The specialists are usually recommended by general allopathic practitioners. About 50% have used various combinations of therapies while the remaining half have not used any kind of combination. The most common combination observed is of Allopathy and Ayurveda.

It was observed that people from slum areas did not have the concept of 'pathy' or 'therapy' at all. They perceived only two categores - 'English' medicine which included tablets of all different kinds and injections. Thus, even Homeopathy and Acupuncture were perceived to be 'English' medicine. The other category was termed as 'Gavathi', meaning folk medicine.

On getting information about some complementary medicine, the patient does not go and consult the practitioner directly. S/he takes advice of either his family members, friends, relatives, neighbours or any medical practitioner and only then confirms her/his decision. Only 18.6% of the total patients had taken decisions on their own and consulted the practitioner directly.

Factors Affecting Shift in Therapy

When a patient decides to consult a complementary practitioner, it's not a sudden decision; there are certain factors operating which make the patient resort to shifting.

Reasons for shifting therapy in order of importance:

1. Treatment was not effective
2. Temporary relief
3. Expensive treatment
4. Dissatisfied with the practitioner
5. Wanted quick relief
6. Undesirable side-effects
7. Regimens not desired
8. Unable to follow the treatment
9. Unable to contact practitioner
10. Geographically inaccessible
11. Time consuming

These reasons influence both the choice of therapy and preference for a particular practitioner. 12.8% of the patients have shown trust in their practitioner and 8% patients have mentioned faith in the particular therapy. This factor is mentioned mostly for Ayurvedic treatment. Whereas, trust in the doctor is mentioned mostly for allopathic practitioners. Another reason for preferring them is their easy accessibility.

In the case of Allopathy, either the treatment did not produce any effect (38.2%) or it produced a temporary effect (31.7%) due to which patients were not satisfied. Perceived or actual side-effects of the drugs also seemed another reason for leaving the treatment (29.8%). The "unable to follow the treatment category" (10.2%) mainly included those who were recommended surgery by allopaths but feared to undergo it.. In case the problem became severe and treatment was needed in an emergency, 28.7% of the patients have sought advice from allopaths.

The main reason for leaving Ayurveda was ineffective treatment (29.7%), the other important reasons being high costs (14.3%), inaccessibility (11.9%) and dissatisfaction with the practitioner (11.9%).

In Homeopathy, ineffectiveness of the treatment (46.2%) appeared to be the main reason for shifting from the therapy.

After getting relief from the illness, the following preferences were given regarding future choice of therapies:

1. Depends on the family doctor - 19 patients
2. Depends on the illness - 12
3. Preferred Allopathy - 26
4. Preferred single complementary medicine - 32
5. Preferred combination of complementary medicines - 14

Out of 103 patients, 55 did not insist on any therapy. Thirty-nine patients insisted on some or other form of complementary medicine and only 9 insisted on Allopathy..

Time Duration for Following the New Therapy

About 30% continue treatment for 1 month and more or less the same number for 1 to 6 months. During this period they get information of a new therapy or different practitioner of the same therapy. About 12% continue the treatment for a year and around the same number for 2 years. Only 5% had continued treatment for 5 years or more.

First Shift in Therapy

The first shift in therapy refers to second preference of therapy in treatment-seeking behaviour. The shift usually occurs away from Allopathy as the latter is generally the first preference in therapy. However, 7 patients had given first preference to Ayurveda and 3 patients had chosen Homeopathy as the first therapy. The most common shift is from Allopathy to Ayurveda, though, 26 patients preferred Homeopathy. Others have preferred Naturopathy, Yoga, Herbal medicine, Acupuncture, Magnetotherapy and some other therapies like Bach flower or Sanjeevani. Those who have chosen Ayurveda first, have given second preference to either Allopathy, Homeopathy, Naturopathy or Yoga. Those who preferred Homeopathy first, gave second preference to either Allopathy or Ayurveda.

Second Shift in Therapy

Out of 51 patients who have shifted therapies more than once, 15 patients have listed Allopathy as their third preference. Those patients might suffer an acute attack of the illness or they might have lost trust in the complementary systems of medicine. Twelve patients have tried Homeopathy as their third choice. Other preferences include Ayurveda, Naturopathy, Yoga, Herbal medicine, Acupuncture, Accupressure, Magnetotherapy etc.

Shift in Practitioner

Knowledge about shift in practitioners is needed to see at what stage of the illness patients prefer to go to the complementary practitioner. If a practitioner is practising more than one therapy and if the patients have changed the therapy and not the practitioner, then it is not considered as a shift in the practitioner. Trying out 4 practitioners is not uncommon. For most patients, the first preference is the family doctor, second the general practitioner and third, direct consultation with the specialist. Out of 83 patients who have changed more than one practitioner, 52 have given third preference to the specialist. Once the patients have shifted to a complementary practitioner, all subsequent shifts are commonly towards other complementary practitioners.

Factors Creating Preference for Particular Practitioner

1) Popularity of doctor, 2) Others' experiences, 3) Easy access to the doctor, 4) Cost-effectiveness, 5) Trust in the doctor, 6) Faith in the therapy, 7) Failure of other therapies, 8) Efficacy of particular medicine, 9) No remedy for that illness, 10) No side-effects, 11) Emergency treatment, 12) Experimental basis, 13) Other. Some patients have mentioned multiple priority factors.

21% patients prefer the practitioner because s/he is famous for effective treatment. This category also includes preferences given to specialists. Whereas, 16% patients mentioned that they consulted the practitioner on experimental basis. They have heard about the treatment but do not have any guarantee of getting relief. These patients have tried many therapies but still have not been cured. A similar factor to this but mentioned separately is experience of others. As the people around the patient have told her/him about the effectiveness of the treatment, s/he also wants to try it. This factor has been listed by 13% of the patients.

Time Spent by Practitioners

Individualisation of treatment is the speciality of complementary practitioners. The amount of time spent by the practitioner with the patient plays an important role, as it helps create faith in the practitioner which has a lion's share in the curation of the disease. The time spent by the practitioner with the patients is usually about half an hour in the first meeting, successively reducing to about 15 mins More the time spent by the doctor in the first meeting, more the trust the patient develops in the doctor.

Reasons for Changing the Practitoner

1. Dissatisfaction with the treatment, 2) Treatment too expensive, 3) Dissatisfaction with the doctor, 4) Wanted quick relief, 5) Course duration was over 6) Side-effects 7)Tired of strict regiments, 8) Unable to follow treatment, 9) Clinic too crowded, 10) Unable to contact the doctor, 11) Clinic too far away, 12) Reference by previous practitioner, 13) Long duration of treatment, 14) Any other.

In the first category, while 16.5% patients mentioned the treatment as being totally ineffective, 10.8% mentioned that the treatment had only a temporary effect.

Consultation With Earlier Practitioner Before Shifting

It has generally been observed that patients leave the treatment without consulting the earlier practitioner. The most common reason given was that it would cause a misunderstanding between the practitioner and the patient while others felt that it was not necessary as it would make no difference to the treatment. Other reasons mentioned were 'Course duration of the treatment was over', 'Unable to contact the doctor' and 'Lost trust in the doctor'. However, a considerable number of patients (43%) have consulted their earlier practitioner before leaving the treatment. In case of 15 patients, the practitioner had referred the patient to another practitioner while 13 practitioners had asked patients to experiment with other treatments. Eight practitioners had welcomed the decision of the patients to change therapy, while 7 had said nothing, indicating their displeasure.

Conclusion

One of the most common behavioural patterns in treatment seeking by chronic patients is "shifting" in therapy. Generally the longer the duration of the illness, the greater the number of shifts. Factors including availability, accessibility and affordability of therapies, information about practitioners, severity of symptoms, chronicity of the disease, cost-benefit perceptions, perceived efficacy, reports of other patients or acquaintances, side-effects etc. play an important role in the shifting of a treatment. The reasons may differ in case of different therapies. A shift in the practitioner depends upon the popularity of the practitioner, his/her relationship with the patients including amount of personal attention given etc. Generally, the patients fail to inform their earlier practitioners when they shift to another. The most common shift is from modern medicine to Ayurveda, the second choice being Homeopathy. ❑

Book Review

Participatory Research in Health : Issues and Experiences

Ed. by Kornie de Konig and Marion Martin

Participatory research (PR) and associated methodologies like Participatory Rural Appraisal (PRA), Rapid Rural Appraisal (RRA), and Rapid Assessment Procedures (RAP) are increasingly becoming popular in the field of health. Participatory Research has gained importance both as a research strategy and as an educative process. The book is divided into five parts dealing with various aspects like historical perspective, training and practice, methodological aspects, and the planning and evaluation of PR. The various topics are illustrated with case studies from Asia, Africa, Latin America, and also from U.S.A, U.K, and Europe.

The book begins with a note by the editors which helps to 'set the context'. According to the authors, PR enables the consideration of non-measurable factors like cultural, historical, socio-economic, and political factors which have an impact on outcomes of interventions for health improvement. PR also helps to bridge the gap between perceptions of health professionals and those of the community. **Local needs and priorities can be identified and placed in the context of people's lives.**

In Participatory Research, the researchers and the research community design the research together, or the researchers design the study, and then collect data with the help of the community. This leads to greater sensitisation of the researchers to the needs of the community. The community is also made to play a more active role and work in close facilitation with the NGO. The community itself becomes an active component in generating information. The quality of participation in PR can be evaluated by checking whether community participation occurs at all the stages of the research and whether all groups in the community are represented in each of the processes.

The authors point out that in PR the process of knowledge production is as important as the actual information gathered. On the one hand this would help the deprived to gain self-confidence and on the other hand build respect about the community amongst professionals. PR involves developing interventions that take into account local specifications.

Part I of the book deals with the historical perspective. The essay by Rajesh Tandon delineates the evolution of PR as it is understood today. PR first became visible in the early 1970s. The distance between the researcher and the researched came under sharp critique, and the Subaltern studies presented a view of society, human order, and human history from the position of the marginalised. Simultaneously, adult educators in Africa, Asia, and the Latin American countries evolved methodologies of learning that helped to establish the **control of the learner over the learning process.** All these developments along with the growth of action research contributed to the building up of the concept of 'Participatory Research'. In the late and mid 1970s, the debate on the development paradigm raised the question of people's participation, women's participation, community participation, and participation of those whose development is being attempted. This was re-inforced by the failure of the top-down, blue-print approach to development.

According to Tandon, tendencies that have expanded the original scope of PR include the acceptance of the fact that rational sciences have been a basic tool of hegemony (the power to rule), that alternative education systems can lead to social transformation, that male biases with patriarchal roots need to be challenged, and that indigenous knowledge systems ensure sustainable human life with ecological balance. PR has now come up with new methodological formulations.

Due to increased specialisation, health had come to be narrowly defined in terms of disease/ill health, and the focus was on nurses, doctors, treatment, medicines, hospitals, and surgery, rather than on the people whose health was the purpose of any health care programme. PR in health is a redefinition of health as a part of life and as a dimension of lifestyle, where a sustainable lifestyle becomes a key variable. PR aims at finding out relevant indigenous practices and knowledge systems and giving them their due value and place. PR in health expresses the need for demystification of and popular access to knowledge and technology in health care. It recognises people's right to know in general, and in the context of health in particular.

Patricia Maguire's essay on the historical perspective relates to Gender and PR. She states that feminism involves a commitment to uncover the forces that cause and sustain all forms of oppression against women, and to work individually or collectively in everyday life, to end all forms of oppression. Hence, PR and feminism share emancipatory and transformative intentions. In practice however, PR has often ignored the gender factor and women have been excluded from much of the earlier PR literature work. **The author highlights that making PR more feminist cannot merely involve a given set of techniques, rather it means a new and more gender sensitive attitude or perception.**

There are two essays on training in PR in Part II of the book, one by Ineke Meulenbery Buskens, and the other by

Elizabeth Tolley and Margaret Bentley. The essays discuss what the participatory researchers need to know, be, and do. Both content as well as training methodologies to be used for orienting participatory researchers in terms of attitude and knowledge are discussed. **Like the research methodologies** that participatory researchers are expected to use, **the training methodologies also need to be essentially participatory and experential.** Issues like the value of local knowledge, interactive versus extractive approach, and qualitative versus quantitative research are discussed. The training hosted by MYRADA, India is used as a case study to illustrate effective training methodologies.

The essays on PR processes for empowerment included in Part III, highlight that **PR is "much more than the application of PR methods"**. It includes education, pain and struggle, and results in empowerment. Through case studies set in India, Uganda, and the UK, the essays portray the capacity building and awareness raising aspects of PR.

PR methodologies form the content of Part IV of the book. The four essays in this part highlight methodological approaches used in the specific PR processes like the `Drama in Education' exercise in South Africa, an ethnographic study on sexuality in Bombay (India), and a needs assessment study in Gujarat (India). Apart from focussing on methodological aspects like focus group discussions, triangulation for cross-checking, and sharing with the community, the case studies also analyse problems faced, and impact in terms of confidence, behaviour change, and awareness creation. With respect to insights relating to effective methodologies, this section has nothing new to offer.

Part V of the book deals with Planning and Evaluation methods in PR. People's Participatory Planning (PPP), Auto-diagnosis (identification of one's own problems), community level problem solving, and other empowering social processes are discussed as mechanisms for participatory planning, monitoring, and evaluation, using case studies from Bangladesh, Bolivia, and the U.K.. While the philosophy of people's development in their own hands is unanimously accepted, what is notable is the identification of constraints These include increased burden on facilitators because they can only facilitate and not impose their views on the people, and doubts about whether the people can analyse the macro situation. To overcome these constraints, proper communication is suggested as the answer. Similarly the view is expressed that the Participatory Planning process would be more effective if specific methodologies and practical planning frameworks are developed. The U.K. case study includes a planning framework which was introduced in the training of health professionals.

An interesting and not too commonly dealt with topic, especially in association with PR, namely, **community based information systems**, is dealt with in Part VI of the book. Well illustrated using Zimbabwean and Kenyan case studies, it highlights the importance of indigenous knowledge, and the need for community based information systems in demographic studies. The methods used include participatory modelling, setting up local community registers for births and deaths, and using local human resources for collecting information.

The topic PR in the workplace which is not too relevant to the context of rural India is included in Part VII. Part VIII deals with Universities, Government health systems and PR. PR in Universities is essential because Universities are 'strategically vital' in providing professionals trained in PR. Implementing organisations (NGOs and the Government) are the ones which will put PR into action. Introducing PR systems in Government functioning would, according to the authors, require a change of the system, and 'phased introduction' of PR methods like participatory mapping, monitoring, and development strategies. The authors are honest to state that the acceptance and spread of PR in Government and Universities has been 'slow and hesitant', and a change in the work culture is required.

The book is useful in establishing that PR is not merely an instrument of gathering information, but is rather a whole approach, attitude, and process, that is empowering, enabling, and educational. Possibly, since a lot of literature is available on practical aspects of PR, do's and dont's, and methodology, the authors have chosen to keep methodological aspects to a minimum, and to focus on the true philosophy of PR. The final conclusion is that **`....none of us in applied health and allied disciplines can afford to isolate ourselves from the people. PR can bring us closer to them.'** ❑

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दक्षिण एशिया में प्राथमिक स्वास्थ्य देखरेख की चिंताजनक स्थिति पर सार्वजनिक स्वास्थ्य विद्वानों तथा सक्रिय कार्यकर्ताओं की एक टिप्पणी

अमीर तथा उच्च-मध्यम वर्गीय लोगों में उच्च - तकनीकि स्वास्थ्य देखरेख की लोकप्रियता बढ़ती जा रही है, फलस्वरूप इन वर्गों के लोग संक्रामक बीमारियों की बजाए अब गैर-संक्रामक बीमारियों, जैसे, हृदय रोग, उच्च रक्त दाब, मधुमेह तथा बुढ़ापे की अन्य बीमारियों से अधिक प्रमाण में पीड़ित होने लगे हैं। परन्तु, इसके साथ-साथ, दूसरी ओर निचले वर्ग तथा मजदूर वर्ग के लोगों में, डाएरिया, निमोनिया, अल्प-पोषण, तपेदिक, मलेरिया तथा अन्य संक्रामक बीमारियाँ अभी भी विद्यमान हैं। इस परिप्रेक्ष्य में, अवसंरचनात्मक समायोजन की नीतियों के सम्पूर्ण ढाँचे के अंतर्गत प्रस्तावित, स्वास्थ्य क्षेत्र के सुधारों का क्या प्रभाव रहा है? स्वास्थ्य क्षेत्र के सुधारों का वास्तविक अर्थ, सार्वजनिक क्षेत्र के निवेशों में कटौती, स्वास्थ्य देखरेख का निजीकरण, सार्वजनिक क्षेत्र को निजी निवेशों के लिए खोलना, प्रयोक्ताओं के लिए शुल्क तथा सार्वजनिक क्षेत्र द्वारा निजी क्षेत्र का भारी अनुदानीकरण रहा है।

क्या यह अधिक प्रभावी स्वास्थ्य देखरेख उपलब्ध कराता है ? क्या यह दक्षिणी एशिया के अल्प- सुविधा प्राप्त कमज़ोर क्षेत्रों तक पहुँचता है? वर्तमान प्राथमिक स्वास्थ्य देखरेख (पी.एच.सी.) नीतियों की क्या सीमाएँ हैं और इनके लिए क्या किया जा सकता है? ये कुछ मुद्दे थे जिन पर, दि.२४ से २६ सितम्बर १९९७ को जवाहरलाल नेहरु विश्व विद्यालय में ' दक्षिण एशिया में प्राथमिक स्वास्थ्य देखरेख पर अवसंरचनात्मक समायोजन की नीतियों के प्रभाव', पर आयोजित एक अन्तर्राष्ट्रीय सेमीनार में विचार - विमर्श किया गया। इस सेमीनार को सेंटर ऑफ सोशल मेडिसिन एण्ड कम्यूनिटी हेल्थ तथा कैम्ब्रिज विश्वविद्यालय, यू. के. के सामुदायिक चिकित्सा विभाग के सदस्यों द्वारा आयोजित किया गया। इसमें बंगलादेश, नेपाल, पाकिस्तान, श्री लंका, भारत, फिनलैंड, इंगलैंड तथा बेल्जियम के सार्वजनिक स्वास्थ्य, सामाजिक विज्ञानों, रोग विषयक चिकित्सा जैसे विभिन्न क्षेत्रों के विद्वानों तथा सार्वजनिक स्वास्थ्य के सक्रिय कार्यकर्ताओं, नीति निर्धारकों, स्वास्थ्य सेवा प्रबंधकों तथा स्वास्थ्य देखरेख के कार्यकर्ताओं ने भाग लिया तथा उपरोक्त तथा दक्षिण एशिया क्षेत्र में पीएचसी से सम्बन्धित अन्य मुद्दों पर विचार विमर्श किया। उन्होंने इस क्षेत्र के पीएचसी तथा यूरोपीय व अफ्रीका के क्षेत्रों सम्बन्धी के अनुभवों का तुलनात्मक अध्ययन भी किया।

सार्वजनिक स्वास्थ्य क्षेत्र एवं परिवार कल्याण योजनाओं व सुविधाओं वर्तमान एवं भविष्य की समस्याओं, स्वास्थ्य क्षेत्र के किए जा रहे सुधारों, तथा उच्च-तकनीकि पर, चिकित्सा सम्बन्धी उपयोगिताओं को विना ध्यान में रखते हुए, बढ़ती हुई निर्भरता पर तीन दिनों तक गहन विचार- विमर्श हुए। इसके साथ-साथ, पंचायतों को सक्रिय बनाने की दिशा में किए गए प्रयासों तथा गरीब मज़दूर वर्ग के लोगों को स्वास्थ्य देखरेख उपलब्ध कराने में स्वास्थ्य कार्यकर्ताओं के मूलभूत अनुभवों पर भी चर्चा हुई। यह सर्वसम्मति से माना गया कि सार्वजनिक स्वास्थ्य के दायरे में रोगनाशक चिकित्सीय देखरेख के साथ-साथ निरोधक एवं प्रोत्साहक सेवाएँ भी सम्मिलित हैं। यह किसी विशेष समूह, वर्ग या जनसंख्या के लिए नहीं, वरन् सम्पूर्ण जनसंख्या के लिए है तथा प्रशासन या सरकार, विकेन्द्रीकरण या जन-साधारण की भागीदारी के नाम पर अपने आप को इस उत्तरदायित्व से मुक्त नहीं कर सकती है।

इन चर्चाओं के आधार पर, समूह ने निम्नलिखित मुद्दों पर गम्भीर चिंता व्यक्त की -

जहाँ एक ओर विकसित विश्व, अपनी राष्ट्रीय अर्थव्यवस्थाओं के अवसंरचनात्मक समायोजनों के बावजूद, सामाजिक कल्याण के क्षेत्रों, विशेषकर स्वास्थ्य, में अपने निवेशों को संरक्षित करने के प्रयास कर रहा है, वहीं दूसरी ओर, इस उपमहाद्वीप को स्वास्थ्य क्षेत्र के सुधारों को स्वीकार करने पर मजबूर किया जा रहा है, जबकि ये सुधार अक्सर गरीबों के हित के विरुध्द होते हैं और इस उपमहाद्वीप में ऐसे गरीब ही बहुतायत में हैं। सेमीनार में सम्मिलित लोगों ने इस पर सहमति व्यक्त की, कि अफ्रीका, यूरोप तथा ब्रिटेन के अनुभव यह दर्शाते हैं कि स्वास्थ्य क्षेत्र के सुधार कमजोर वर्ग व मज़दूर वर्ग के लोगों को अधिक प्रभावित करते हैं, तथा इनके द्वारा उपलब्ध सुविधाओं का विखण्डन हो जाता है, जिससे स्वास्थ्य देखरेख अत्यधिक महँगी हो जाती है तथा रोगनाशक तथा रोग-प्रतिरोधक नीतियों के बीच की कृत्रिम दूरी के परिणामस्वरूप, प्रतिरोधक सेवाओं पर पर्याप्त ध्यान नहीं दिया जाता है। द्वितीय व तृतीय स्तर की अपर्याप्त देखरेख सुविधाओं वाली स्वास्थ्य प्रणाली के कारण परिधीय संस्थाओं द्वारा निम्न-स्तर की प्राथमिक स्वास्थ्य देखरेख (पीएचसी) सुविधाएँ उपलब्ध हो पाती हैं। शासन या सरकार द्वारा अनुप्रवर्तन प्रणालियों पर पर्याप्त ध्यान न दिये जाने के कारण पीएचसी सेवाओं के स्तर में और अधिक गिरावट होती है।

सम्मिलित लोगों ने यह महसूस किया कि दक्षिण एशिया के पीएचसी की समस्याओं के हल, स्वास्थ्य बीमा, सार्वजनिक चिकित्सालयों की सुविधाओं के इस्तेमाल पर शुल्क लगाने, स्वास्थ्य कार्यकर्ताओं की संख्याओं को कम करने, या औषधि निर्माण तथा उपकरणों के उद्योगों को अनुदान देकर, निजी क्षेत्र को अधिक महत्व देने में नहीं हैं। यदि आवश्यकता है तो वह साम्यता के साथ भारी आर्थिक विकास सुनिश्चित करने, खाद्य सुरक्षा प्रणालियों को वरकरार रखने तथा कल्याण सुविधाओं, जिसमें स्वास्थ्य में सार्वजनिक क्षेत्र सम्मिलित है, को संरक्षित रखने की है।

समूह ने उस एकत्रिक प्रमाण की समीक्षा की, जो ऊपर से थोपे गए रोग नियंत्रण कार्यक्रमों की निहित कमज़ोरी, उनके एकीकृत होने के अपर्याप्त स्वरूप, तथां जनसंख्या नियंत्रण के लिए परिवार कल्याण व व्यापक अन्तर-क्षेत्रीय विकास की वजाए, तकनीकि - केन्द्रित नीतियों को आवश्यकता

से अधिक प्राथमिकता देने की ओर संकेत करता है। इस समूह ने मनुष्यों विशेषकर महिलाओं पर, बिना उनकी जानकारी के तथा उनके सामान्य स्वास्थ्य के मूल्य पर, जनसंख्या नियंत्रण के लिए नए तरीकों सम्बन्धी अनैतिक प्रयोगों तथा क्वीनाक्रीन तथा नॉरप्लॉट जैसे असुरक्षित व खतरनाक गर्भ निरोधकों के इस्तेमाल पर चिंता व्यक्त की।

प्रमाण दर्शाते हैं कि समायोजन का कार्यक्रम विश्व के अधिकतर गरीबों के स्वास्थ्य व कल्याण के लिए आवश्यक आजीविका पर उचित ध्यान न देकर उसे नष्ट कर रहे हैं। कल्याण के क्षेत्र में कटौती का कुप्रभाव सब से अधिक महिलाओं पर पड़ता है, क्योंकि वे ही पारम्परिक रूप से परिवार की देखरेख का भार वहन करती हैं और उन्हें अपने पतियों की आमदनी में कटौती होने के कारण छोटी-मोटी नौकरियाँ करने पर मजबूर होना पड़ रहा है।

उपमहाद्वीप में सार्वजनिक स्वास्थ्य के वर्तमान दृष्टिकोण से सम्बन्धित वैचारिक पक्षपातपूर्ण झुकाव, विशेषकर चिकित्सीय नौकरशाही के भीतर, 'नवीन सार्वजनिक स्वास्थ्य' की अवधारणा के उद्‌गम तथा सार्वजनिक स्वास्थ्य के सकारात्मक व नकारात्मक पहलुओं से सम्बन्धित ऐतिहासिक प्रमाणों के प्रति निरन्तर उदासीनता व स्वास्थ्य सेवा प्रणाली के विघटीकरण में स्पष्टतया प्रमाणित होता है। 'नवीन सार्वजनिक स्वास्थ्य', की अवधारणा उत्तरदायित्व को व्यक्तिगत जीवन शैली की ओर मोड़ती है, लगातार बढ़ते हुए पर्यावरणीय ख़तरों व सामाजिक क्षेत्र के लिए खर्च में कटौती की अपरिहार्यता को स्वीकारती है तथा पर्यावरण व कल्याण के संरक्षण के लिए शासकीय हस्तक्षेप के स्थान पर व्यक्तिगत प्रयासों व व्यावारिक परिवर्तनों को चुनती है।

संयुक्त राष्ट्र के संकायों के दृष्टिकोणों में वर्तमान परिवर्तन भी इसी पक्षपातपूर्ण झुकाव को प्रतिबिम्बित करता है, जिसमें स्वास्थ्य के प्रति दृष्टिकोण अधिकाधिक संकुचित होता जा रहा है तथा जो अक्सर गरीबों व कमजोर वर्ग के लोगों के हित के विरूध्द होता है।

यह सर्वसम्मति से स्वीकार किया गया कि स्वास्थ्य देखरेख सुविधाओं को उपलब्ध कराने से सम्बन्धित सकारात्मक प्रयोगों व अनुभवों को स्वीकारने व समेकित करने की आवश्यकता है; पंचायत जैसी लोकताँत्रिक संस्थाओं के माध्यम से, सुविधाओं के लोकताँत्रीकरण की प्रक्रिया को बढ़ावा देने की आवश्यकता है तथा प्रौद्योगिकी की 'दक्षता' की अवधारणा को, उपयुक्त चिकित्सीय साधनों के चयन के परिप्रेक्ष्य में पुनः परिभाषित करने की भी आवश्यकता है; साथ ही समुदाय पर आधारित विकल्पों को, जो पीएचसी की सुविधाओं को उन लोगों तक पहुँचाते हैं, जिनके पास स्वास्थ्य देखरेख की औपचारिक प्रणाली तक पहुँचने के लिए कोई अवसर उपलब्ध नहीं हैं, पीएचसी की परिकल्पना करते समय अवश्य ध्यान में रखा जाना चाहिए।

यह भी सर्वसम्मति से स्वीकारा गया कि समाज के परस्पर सहयोगी, विभिन्न स्तरों पर काम करके पीएचसी से सम्बन्धित अधिक प्रभावी नीतियों को, बनाया जा सकता है; तथा उपमहाद्वीप के भीतर ही, स्वयं के विकास की नीतियाँ बनाने के लिए असंख्य विचार व दूरदृष्टि है तथा पर्याप्त अनुभव भी उपलब्ध है।

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NEWSLETTER

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Influence of Local Environment on Perception of Health Problems

The following information has been taken from the executive summaries on progress reports prepared and presented by the Centre for Social Studies, Surat at a National Workshop in Ethnography of Malaria in Surat District conducted by them.

It is often incorrectly assumed that villagers are ignorant and passive in terms of health assessment and treatment methods. Empirical evidence through our various studies in rural areas reveals that people are aware of what is normal health and what are the deviations from this state of health; they know what is fever and the ways of identifying and treating it. Generally, women are found to have greater awareness and knowledge of illnesses then men. The point to note is that the people have developed their own local terminology and system regarding the various health problems. Their perception and identification of illnesses are governed by the nature of their community organisation and other related dialectics.

Three villages in Surat district were identified by us representing three ecological zones namely, Karanj which is a coastal village, Sathavav which is located on an inland plain, and Khogalgam which is a hilly area. Each of them shows a notable difference in their physical, social and cultural landscape and each village was found to have its own definition of health based on particular environmental and economical considerations. Metaphors and similies used to describe health are from the immediate surroundings. In Sathvav and Khogalgam, the ability to plough, lift weights and have a good appetite are considered to be signs of good health. In hilly Khogalgam, the ability to run and capture hares and climb hills without getting tired are some of the criteria of good health. In coastal Karanj, health is linked to *hava* and *ujas* (fresh air and light). Sleeping in the open is associated with the danger of catching malaria, especially by the poor Halpatis.* Vulnerability to malaria is considered to be heightened when people participate in night-long religious gatherings such as singing religious songs, dancing etc. Karanj is a multi-caste village with proximity to Surat city with its own PHC. Hence it shows a greater awareness of fever, compared to the other two villages of Khogalgam and Sathvav. Within each village the socio-economic status makes a difference in health perceptions. For the poor Halpatis in Karanj, which is a costal village, health is a state in which one can move, eat and work. For the rich Koli Patels it is the absence of pain and lethargy, and a general exuberance of mind and body.

Knowledge about malaria is quite widespread (94%) in the population and this knowledge is largely rooted in their own experience. Either the respondents themselves or some of their family members had fallen ill due to malaria within the last two years. The Halpatis have their own local vocabulary to express the complex and wide range of malarial types and symptoms. Many

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of them (66%) had heard about what is called *Zeri* (poisonous) Malaria. A large section (67%) identified it with *Tadhiyo/ Kapro/Dhrujarino Tav* (fever). While awareness of *Zeri* Malaria was more pronounced in the coastal zone, the knowledge of *Tadhiyo* or *Kapro* fever was more widespread in the hilly zone. One out of every 6 persons expressed that malaria could be fatal, while one out of 7 persons feared physical disability or weakness as a major fallout of such an ailment. A greater proportion of the population considered malaria to be a serious disease in Khogalgam than in Karanj or Sathvav. Apart from that, quite a sizeable population from each zone (45% Halpatis) viewed malaria as a major problem. Nearly 7 out of every 10 persons attributed this to high costs or expenses associated with the malarial treatment. Malaria was perceived to be a cost-intensive ailment by all social groups of all the three villages. Indeed, computation of economic loss from malarial patients shows that people spend on doctors and drugs as much as they lose in earnings during the illness episode. The population in Karanj spends more on medical treatment as well as on travel as compared to the other two villages, probably because it has better health facilities.

The people do not know the precise and scientific causes of fever, though we do witness some efforts by villagers to establish links between effects and causes of fever in general and malaria in particular. For instance, fevers are attributed to natural, supernatural or both causes. Their knowledge on symptoms of fever, however, is quite extensive.

A majority knew that malaria owes its emergence to the strong presence of mosquitoes though the knowledge that a mosquito bite causes malaria was known to relatively smaller segments of our study population (34%). They also noted that lesser incidence of malaria is associated with relatively lesser filth and a cleaner environment. They overwhelmingly rated the monsoon season to be the most 'malaria-intensive' period. A significantly large number (60%) was not sure about the cause of malarial fever. The coastal region population seemed to be the best informed in these respects.

There is considerable awareness among the population of all three zones about the factors stimulating mosquito growth, and they attribute the menace to waterlogging, filth, foliage, and also cropping patterns like rice and sugarcane cultivation. The villagers point towards abandoned wells and shrubby dark places within the village as habitat for mosquito proliferation but they do not seem to be greatly aware about the exact locations leading to profuse mosquito-breeding.. This community knowledge of mosquito breeding places and ways to counter them needs to be documented thoroughly especially since it also gives an inkling into their perceptions on water management and control. Such inputs can then be effectively used in designing a comprehensive strategy for malaria prevention and control.

Sleeping Habits

Sleeping involves occupation of space, and the logistics of access to and utilisation of domestic physical space are governed by a set of social values and cultural traditions. These norms or social codes address not only to individual needs but also to social traditions related to the role and status of individuals in terms of their gender, age, occupation etc. For instance, the aged members in the household are found sleeping mostly on the verandah or (outer portion) of the house. This is not only for the functional reasons like easy access to the toilet or clearing phlegm during the night or even keeping a watch over any intruders etc. but also for cultural reasons like keeping a distance from the grown-up daughters and daughters-in-law in the family. Infants and children in the younger age group have specific spaces reserved for them for sleeping. Such arrangements are meticulously observed; and altered only in contingencies.

We also notice some distinct variations with regard to rising and sleeping timetables of the people within and across the zone. These timings vary depending upon the location, gender, occupational specificity and other such sociological factors. It is difficult to capture them all through a questionnaire on a single-visit encounter. But we have been able to establish some broad differentials with regard to timings, location (within and outside the house) and status (whether on the floor or on a cot etc.) concerning sleeping. Do these practices reveal any gender or age-specific health risks including malaria? Answers to these questions can be sought through future investigations to help us in deciphering their life style with a view to suggest appropriate interventions to counter malaria.

Mosquito Net

Seven out of every ten persons in our study did not possess the mosquito net. Only 30 per cent had such nets. Interestingly, nearly half of the Halpatis possessing the mosquito nets did not utilise the nets while sleeping. It should be noted that there is a strong desire among the study population to acquire and use the mosquito net. Lack of money is stated to be the major reason for not possessing a mosquito net by 76 per cent of the population. The Halpatis from the hilly zone were in absolute majority in this regard (80%).

It is also revealing to note that a majority (62%) still rely on traditional methods for repelling the mosquitoes and insulating themselves from them. These methods cover making smoke by using cow dung, neem leaves, etc. or simply covering their body. Use of modern electronic gadgets exists at a much smaller scale (less than 40%). Mosquito net usage is even lesser in extent (17%). In the hilly zone where the tribal Halpatis predominate, the use of modern methods of mosquito repellents is very restricted and possibly limited to those with higher education and better economic background.

Treatment Seeking

Availability of treatments varies in villages. The coastal village has the greatest variety and availability of treatments and hilly Khogalgam the least.

Our study reveals that the health phenomenon subsumes under it deeper socio-cultural complexities. They cover complex realities governing relations between society and its health profile. The health profile of a community is not necessarily exhausted by formal systems of health delivery and management, i.e. the presence of formal health institutions like the PHCs, government hospitals and dispensaries and their medical and paramedical outfits. Rather, it covers a wider ensemble of traditional knowledge (within and across individual households/community), customary practices and a whole range of faith-healing institutions and their representatives (called *Bhuvas*, *Bhagats*, etc. in local parlance). At the cultural level, one finds traditional ways of coping with fevers and information seeking from neighbours during illness. This is evident in all the three villages in varying degrees. Some groups like Halpatis show preference for traditional healers. Women too seek traditional healers for they feel inhibited to speak to a male doctor especially about their gyneac problems.

At times, these traditions or reactions appear to be contradictory and confusing. Our study underscores this convergence and divergence of the health traditions and practices at the community level. We observe that if a person falls sick, especially in cases of cough, cold or fever, they do not rush to the doctor. They may first wait for some definite assessment of impending illness; then, most probably, seek home remedies; and if everything else fails, consult the elderly persons around and finally consult a doctor.

It is also found that despite having some knowledge about how to identify fevers, their causes and treatment choices, some people fail to take timely preventive action. There seems to be a general hesitation in seeking prompt treatment, more so among the old, the relatively uneducated and the low-skilled. Some are afraid of drugs and injections. Yet others seem to be indecisive about whether they should go to the traditional healer or to a modern doctor. Those looking for speedy healing may shuttle between healers of different types including religious/supernatural healers.

Some may not wait that long, and may approach a health functionary as a first response, depending upon their sense of illness-comprehension or other factors like necessity of wage labour, pressure from the employers etc. These need to be examined further in the context of their socio-economic position in a village. Also, their socialisation and exposure to urban medicine need to be investigated in depth.

At the other end, their persist a lot of superstitions among the people about the illnesses and their treatment, driving them towards taking wrong decisions and physically harmful treatment methods. This is also true in the case of malaria. This problem needs to be tackled carefully by locating the sources of these beliefs and reasons for their persistence. We need to reassess our peoples' health practices within present day society and economy to identify which practices relate to peoples' own world views and which among the practices are beneficial, harmless or outright harmful. Educating people in this regard would lead to their empowerment by giving them access to critical knowledge about malaria and ways of dealing with it.

There is no definite pattern in seeking treatment. However, in all zones, irrespective of their social or ecological character, it is the head of the household, who is mostly a male, who makes decisions regarding taking a treatment. Only 11% women were found to make such decisions. In other words, the decision making sphere concerning health care and management within the community is very much under male dominance and control. The head of the household makes a decision depending upon the gravity of the situation, length of illness, age, sex and earning status of the ill person and availability of transport, money and healers.

Treatment strategies adopted by the people concerning malaria reveal that their is quite an overwhelming dependence on Allopathy in all three zones; though in the hilly zone, it is somewhat less. Here, it is worth noting that among the Halpatis with background of malaria episode, 78% chose Allopathy as the preferred treatment; while in the non-patient group, over 90% Halpatis hailed Allopathy as the only method for treatment.

Health Care Providers

Health care providers include medical officers,

paramedical staff and field workers of PHCs, as most of them are involved in providing health services to the people. Critical variables like communication, distance, accessibility to health services, perceptions on treatment methods, gender issues and modern versus traditional healer-patient relationship need to be identified and discussed.

The villagers have developed a preferences for certain methods of diagnosis and treatment while seeking medical aid from the modern healer. For instance, people prefer to be asked a number of questions by the doctor and attach greater value to injections. A village patient expects things from the health care providers which may not be really necessary in the process of treatment. However, the health care providers can serve the village folk better if they try to understand rural life and culture, and the way in which patients can be helped in their fight against illness. Similarly, effective communication between the health care provider and the health seeker is very important for improving the health services for the people. Empathic understanding of patients, listening to what people have to say (sometimes the discussion may be irrelevant in terms of diagnosis), appreciation of cultural values and norms could help in building up a better healer-patient relationship and lead to better health care.

PHCs provide health services to a large proportion of village communities. Hence, the ethnography of PHC personnel and their beneficiaries in the three ecological zones of tribal areas are important. Interestingly, the perceptions of PHC staff on the sleeping habits, water disposal, use of mosquito nets and environmental concerns are not different from the perceptions of the villages, and hence health awareness is needed for both health providers and seekers. Though most of the PHCs present a picture of not being able to provide good health services to people, some of the PHCs like those in Karanj and Varad stand out distinctively in their effective delivery of services despite limited facilities and equipment. This shows that there is scope improving the functioning of the public health system, provided changes in attitude are brought about among the health personnel.

Communication Network

The strategy for health communication or mobilisation has to take into account the existing networks, whether economic, political, religious or medical, in which we have identified people, places, events, meetings and mediums. The different communication networks tend to overlap - persons, places and mediums in economic, political and religious networks are to some extent the same as in the health networks. Even if they are not overlapping with the health network they can be potentially used for health communication and community mobilisation.

The strategy for communication or mobilisation in a nucleated village as opposed to a dispersed village; in a caste based heterogeneous village as compared to a fairly homogenous tribal village; in a village with more modern means of communication as against a village with lesser facilities, has to be worked out differently. Karanj has a larger number of people, places and mediums in different networks; Sathvav in the irrigated plain zone has less and Khogalgam in the hilly zone has least. There is greater heterogeneity in a nucleated Karanj caste village than in the dispersed tribal Khogalgam. Karanj is closer to the major urban centre in the district viz. Surat than Sathvav or Khogalgam. Amongst the three villages, Karanj has more modern means of communication and Khogalgam the least. Thus, the intensity or density of communication networks is seen to vary from village to village and from zone to zone.

Conclusion

* The findings reveal that the issue of gender is an obstacle in treatment seeking. Therefore, a gender balance needs to be built within the PHC structure for effective treatment.
* Not just the prescription but the approach of the doctor is also important in choosing a particular treatment.
* Perceptions of the people are more important than the effectiveness of the treatment offered.
* Companionship, faith etc. matter a lot in getting the illness cured, be it from a doctor, pastor, elderly respected person or through kinship network.
* Despite having faith in the modern healer, they simultaneously have faith in traditional medicine too. The case indicates the intensity of faith on factors other than medicines.
* A broad trend emerges in the treatment seeking behaviour. A relatively rich socio-economic group (Parsis, Chaudharis etc.) approach private clinics. The deprived castes and the poorest of the poor (Halpatis) seem to have more faith in Bhagats and Bhuvas, whereas, the others visit PHCs for treatment.
* PHC structure and functioning need critical reorganisation and thorough revamping to provide better health care.
* We need to address to the particular community's way of accessing different health services and the factors governing these decisions to provide better health care.

Note

* Halpatis are a local tribe in Surat District ❐

Role of Peoples' Representatives in Poverty Eradication for Stabilisation of Population Growth

Dr. Gouri Pada Dutta

Introduction

For about five decades after independence various attempts to limit population explosion have been made by Governments at the Centre and State levels. This urgent problem has been approached through various terms like Population Control, Family Planning, Birth Control, Family Welfare etc., with limited success. The enormous expenditure on this account could bring only marginal benefits to the target section, the major blame for which can be put on the socio-political milieu in which the programme has to operate.

It took a long time for the administrative echelons and policy makers to understand that birth control is not the panacea of all the social evils or the principal cause of poverty. Rather, failure to optimise the growth rate was itself the result of the social injustice perpetuated on the vast number of deprived sections of the population, especially women. The other dampening factor is the lack of commitment on part of the peoples representatives and the people themselves. The participation by the latter was not spontaneous, and sometimes even made under compulsion.

It must be remembered that the need for procreation is part of the survival instinct and needs to be considered along with the problems created by over/under growth of population, in formulation of measures for population control. Thus total family welfare needs to be emphasised rather than population control alone.

The acceptance of voluntary population control is preceded by a state of social and personal security which can be interpreted as general physical, mental, economic and social well being. The strategy of population stabilization has to be developed and implemented with this basic understanding. Those formulating and implementing the policies as well as the people at large need to be educated on the pros and cons of the situation.

Dr. Gouri Pada Dutta is MLA, West Bengal Legislative Assembly, and Member, State Planning Board, Government of West Bengal.

The Situation

The demographic scenario of India in respect of population is as follows:

Table 1.

Year	Population in million	C.B.R.	C.D.R.
1951-1961	683.3	41.7	22.8
1981	683.3	39.7	15.0
1991	846.3	29.7	12.0
1995 (Estimated)	911.0	28.0	9.3
Growth Rate	+227.7	-13.7	-13.5

Table 1. shows comparable reduction in both birth and death rates but it does not reveal the situation prevailing in the target section of the population. For this, the variation of birth rate between the affluent and deprived sections needs to be considered.

The growth rate of our population is as follows:

Table 2.

Year	Growth Rate
1941-1951	1.25
1951-1961	2.20
1961-1971	2.22
1981-1991	2.14*
2000 A.D. (Desired)	1.20

* Reduction from 1951 to 1991 is only 6%.

This reduction in growth rate is much below the desired level. The incongruity is heightened when juxtaposed against the expenditure on Family Planning from the First to the Seventh Five Year Plan.

The total expenditure by the Family Welfare Department alone from 1951 to 1991 was Rs.6433.83 crores and the reduction in birth rate was from 41.7 in 1951-1961 to 29.7 in 1991 i.e. 12%. In effect, it means that to bring down birth rate by 1% the department has to spend Rs. 536.2 crores.

The cost-benefit ratio becomes higher when one considers the expenditure on maternal and child health care (M.C.H.) which should be the focus of reduction in birth-rate. The said expenditure was only 11% of the total for all these years, and increased to a mere 28% after criticism from relevant quarters.

That denial of social justice is one important factor in population growth will be evident from the following statistics.

Table 3.

States	I.M.R.	C.D.R.	C.B.R.	C.P.R.
Assam	81	10.2	29.5	22.6
Bihar	70	10.6	32.0	22.4
M.P.	106	12.6	34.9	48.0
Rajasthan	82	9.1	34.0	37.1
U.P.	94	11.6	36.2	30.2
Kerala	13	6.0	17.4	50.7
W.B.	58	7.4	25.7	35.7

Table 3. shows an interesting analysis. The low birth rate is directly proportionate to low I.M.R. & C.D.R. and not to the couple protection rate.

It is evident that in those states where the feudal structure is dominant and social justice is denied to the target section of the population, the birth rate is remarkably high. The high birth rate is also directly proportional to female illiteracy which gets translated into social insecurity for women.

New Approach

It has been observed by various surveys that poor i.e. food-insecure families tend to be larger. Food insecurity is higher among landless and marginal farmers' households. Hence their birth-rate is high because their only tangible capital is their children. The surveys also point out that the women's income is spent more on food. High social position of women is thus a positive contributing factor in the small family norm.

These observations are of supreme importance. They indicate that population stabilisation can be achieved by:

* Eradication of poverty ;
* Women's empowerment ;
* Prevention of infant and maternal mortality ;

All these factors are interrelated and demand special attention.

Food security implies access by all people at all times to the food needed for inactive and healthy life. It is the ability of the household to secure, either from its own production or through purchase, of adequate food for meeting the dietary needs of its members.

Poverty eradication demands overall development strategy and macro economic policies to achieve it. This is being done in developed countries. **Rather than blindly copying these strategies, alternative development strategies suitable to the situation in the developing countries can have a strikingly different impact on poverty alleviation** whose basis can be food security. Such strategies should be implemented with the help of the community (local self Government) and have the following features :

* Policies for growth with equity, developed and implemented in a bottom-up manner.
* Accelerated growth in the food and agricultural sector through promotion of rural development which can be achieved through three-tier Panchayats.
* Stabilisation of food supply by cooperatives
* Credit to poor households for self-employment.
* An increase in the employment opportunities by introduction of labour intensive agricultural and industrial (SSI) projects. Minor Irrigation and construction of roads are examples.
* Income transfer schemes. This is difficult to implement but may be attempted through introduction of target feeding programmes, food stamps etc.

Role of Peoples Representatives

It has been stated that peoples representatives were not taken into confidence while formulating the strategies of population control. The situation demands that members of Parliament and State Assemblies be appraised of the situation. Since the peoples representatives are controlled by the political parties; these political parties and their frontal organisations must be made aware of the situation. Unless the political parties are convinced and motivated, little progress will permeate through isolated approaches.

Most important, the functionaries of three-tier Panchayats are the best vehicles to carry the message to the people and involve the community in its implementation. For instance, in West Bengal, the three-tier Panchayats, through decentralisation of administration, have been able to achieve a fair amount of success. Their role in poverty alleviation and food security has played an important role. This can be integrated with the programme for population stabilisation. To achieve this, a continuous dialogue needs to be initiated with the peoples representatives at the three-tier Panchayat, Nagar Palika, State Assembly as well as Parliament level. Only such an approach can effectively stabilise the population growth. ❐

पश्चिम बंगाल में आर्सेनियोसिस (संखिया विषाक्तता) का प्रबंध

डा. के. सी. साहा द्वारा लिखा गया यह लेख 'ब्रेकथ्रू' की मार्च १९९८ की प्रति में प्रकाशित हुआ

पश्चिम बंगाल में, कृषि में सिंचाई तथा मानव उपभोग के लिए प्रयोग में लाए जाने वाले भूमिगत जल में संखिया संदूषण ने अब महामारी का स्वरूप ले लिया है। पश्चिम बंगाल - बंगलादेश के सीमावर्ती क्षेत्रों में, गंगा - भागीरथी पठार में रहने वाले लाखों लोग संखिया के मिश्रणों से लम्बे समय से प्रभावित होते रहे हैं, जिसके फलस्वरूप वे भिन्न - भिन्न स्तर की संखिया विषक्तता (आर्सेनिक डर्मेटोसिस या एएसडी) से रोग ग्रस्त हैं। संखिया से सम्बन्धित रोगों से पहले ही सैकड़ों लोग मर चुके हैं व दस लाख से भी अधिक धीमी व दर्दनाक मौत की ओर बढ़ रहे हैं - दुर्भाग्यवश इनमें से बहुतों को इनके पीछे छुपे कारणों का भी पता नहीं है।

विषाक्तता के स्रोत का पता लगाना

संखिया के प्रवेश के लिए नलकूप से निकले जल पर शक किया जाता रहा है - क्योंकि ऐसा देखा गया कि संखिया से प्रभावित लोगों ने संखिया-युक्त कोई दवा नहीं ली थी, न ही उन्होंने कीटनाशक या चूहा मारने की दवाओं का ही इस्तेमाल किया था; दूसरी ओर गाँव के सामान्य नलकूप से जल पीने वाले लोगों में संखिया की विषाक्तता देखी गई तथा यह भी देखा गया कि जिन लोगों के पास व्यक्तिगत नलकूप थे, उनमें यह रोग नहीं था। नलकूप के जल में संखिया के संदूषण की एक अध्ययन द्वारा पुष्टि भी हुई, जब यह पाया गया कि नलकूप के जल में संखिया की मात्रा बहुत अधिक थी - विश्व स्वास्थ्य संगठन द्वारा संस्तुत ०.०५ मिली ग्राम प्रति लीटर की अनुज्ञेय सर्वाधिक सीमा से दस गुना अधिक। सामान्यतया छिछले नलकूपों (५० - १५० फिट गहरे) के जल से संखिया शरीर के भीतर प्रवेश करता है। गहरे नलकूपों (४०० फिट से अधिक गहरे) का जल संखिया से मुक्त पाया गया।

पश्चिम बंगाल में संखिया विषाक्तता की वर्तमान स्थिति

प्रभावित जिले : पूर्वी व दक्षिणी २४ परगना, नायदा, मुर्शीराबाद, वर्धमान, मालदा, हुगली, हावड़ा व कलकत्ता = कुल ९

कुल प्रभावित क्षेत्र : ३७,४९३ वर्ग किमी

कुल प्रभावित जनसंख्या : ३४, ६३२,०२४ (लगभग साढ़े तीन करोड़)

संखिया विषाक्तता की विशेषताएँ

१. रोग-पूर्व की स्थिति

इस चरण को दो उप-चरणों में बाँटा जा सकता है :

(i) अस्थायी, रासायनिक अथवा रक्त चरण

संखिया - संदूषित जल ग्रहण के बाद लिए गए रक्त व मूत्र के परीक्षणों में संखिया के पदार्थ प्रदर्शित होते हैं, परन्तु ऐसे जल को हटा लेने के उपरान्त मूत्र संखिया-मुक्त हो जाता है।

(ii) स्थायी, उप-रोगीय अथवा उतक चरण -

त्वचा या शरीर के अन्य ऊतकों के परीक्षणों में उच्च मात्रा में संखिया प्रदर्शित होती है, यद्यपि संखिया विषाक्तता के अन्य रोग सम्बन्धी लक्षण उपस्थित नहीं होते हैं। रोग से प्रभावित रोगी के परिवार के अन्य गैर-प्रभावित सदस्य अक्सर इसी अवस्था में होते हैं।

२. रोगी अवस्था (लक्षण-सम्बन्धी या प्रकट अवस्था)

संखिया विषाक्तता के लक्षण समय के साथ धीरे-धीरे प्रकट होते हैं। रोग सम्बन्धी लक्षणों के विकसित होने के लिए छह महीने से १० वर्ष (औसत २ वर्ष) तक लग सकते हैं। यदि ग्रहण किए गए जल में संखिया की मात्रा बहुत अधिक नहीं है, प्रति दिन ग्रहण किए जाने वाले जल की मात्रा कम है, रोगी अपना अधिकाधिक समय संखिया से गैर-प्रभावित क्षेत्रों में व्यतीत करता है या उसके पोषण का स्तर अच्छा है, तो यदि लक्षण विकसित हुए भी, तो ऐसा भी हो सकता है कि रोग- सम्बन्धी लक्षण विकसित न हों और कई वर्षों तक यदि लक्षण विकसित हुए भी, तो वे बहुत हल्के हों।

३. आंतरिक जटिलताओं की स्थिति

इस स्थिति में त्वचा-संबन्धी विषाक्त लक्षणों के साथ-साथ गैर - त्वचा - सम्बंधी विषाक्त लक्षण भी प्रकट होते हैं। सामान्य आन्तरिक जटिलताएँ, फेफड़ों (श्वासनली - शोथ व हल्का दमा, इत्यादि), यकृत (यकृत का कड़ा हो जाना, कभी-कभी पीलिया हो जाना, इत्यादि) तथा प्लीहा (प्लीहा सम्बंधी शोध) में होती हैं। कुछ रोगियों में होने वाली जटिलताओं में रक्तहीनता तथा सामान्य कमज़ोरी, माँसपेशियों में दर्द, आवाज़ का फट जाना, इत्यादि भी शामिल हैं, परन्तु ऐसी जटिलताएँ बहुत कम देखी जाती हैं।

४. विषाणु स्थिति

विषाणु स्थिति, संखिया से लगातार दस वर्षों तक प्रभावित रहने से पहले नहीं आती है। आमतौर पर, पहले लक्षण के आरम्भ होने के १५-२० वर्षों के बाद कैन्सर विकसित हो जाता है।

प्रमुख त्वचा - सम्बंधी लक्षण

काला - सरतान (मेलैनोसिस)

पहले हथेलियों में विकीर्ण कालापन पैदा होता है जो कि धीरे-धीरे सारे शरीर में फैल जाता है। यह सबसे पहला लक्षण है और शत-प्रतिशत रोगियों में पाया जाता है।

धब्बा-युक्त काला सरतान

लगभग पचास प्रतिशत रोगियों में सीने, पीठ तथा कमी-कमी हाथों व पैरों पर धब्बा-युक्त रंजकता प्रकट होती है।

केराटोसिस

इसमें ५ से १० वर्षों बाद हथेलियों व पाँवों में खुरदुरी व सूखी गाँठें प्रकट होती हैं। बाद में वहाँ की खाल मोटी हो जाती है जिससे खाल में चटकने व दरार पड़ने की शिकायत पैदा हो सकती है।

मेलानोसिस - केराटोसिस

इसे गाढ़े रंग की रंजकता के साथ-साथ हथेलियों व / या पैर के तलुवों पर सूखी व खुरदुरी धब्बा-युक्त गाँठें पढ़ जाती है। इन लक्षणों से संखिया विषाक्तता डर्मेटोसिस की उपस्थिति प्रदर्शित होती है।

ल्यूकोमेलानोसिस

लगभग एक-तिहाई रोगियों में पैरों तथा उदर पर रंजित तथा गैर-रंजित धब्बे पैदा हो जाते हैं। ऐसा, रोग की अति-विकसित अवस्था में होता है।

संखिया से पीड़ित जनसंख्या का उपचार

जिन इलाकों में संखिया से पीड़ित जनसंख्या होने का शक हो, वहाँ के सभी, लोगों के नाखूनों, बालों तथा खाल के नमूनों को परीक्षण के लिए, 'द स्कूल ऑफ ट्रापिकल मेडिसिन (एसटीएम) या ऑल इण्डिया हेल्थ (ए आई एच पी एच) में भेजा जाना चाहिए। यदि समय रहते उपचार उपलब्ध नहीं कराया गया तो यकृत या

डा. साहा कलकत्ता के 'द स्कूल ऑफ मेडिसिन' से प्रोफैसर व डर्मेटोलॉजी विभाग प्रमुख (हेड ऑफ डिपार्टमेंट) के पद से सेवा निवृत्त हुए ।

फेफड़ों के संक्रामण तथा कैंसर जैसी जटिलताओं के होने का खतरा होता है।

ऐसे रोगियों के लिए जो पहले से ही संखिया-सम्बन्धी बीमारियों से पीड़ित हैं, चिकित्सीय सहायता उपलब्ध कराई जा सकती है। रोग की अवस्था में, जब त्वचा पर मेलानोसिस तथा केराटोसिस के लक्षण प्रकट हों तो बी ए एल, पेनसिलामाइन, डी एम एस ए / डी एम पी एस जैसे कारकों के माध्यमों से मेलानोसिस से छुटकारा पाने में मदद मिलती है। केराटोसिस से होने वाली तकलीफ को कम करने के लिए पैरों तथा पैर के तलुओं के खुरदुरे व सूखे हिस्सों को हाथों से खुरचा भी जा सकता है। यूरिया और सैलीसिलेट मरमहों का प्रयोग भी किया जा सकता है। आंतरिक जटिलताओं के समय, परिजीवी (एंटीबायोटिक्स) दवाओं का इस्तेमाल कर, लक्षण-आधारित इलाज करना आवश्यक हो जाता है। यकृत को हानि पहुँचने की अवस्था में ग्लूकोज़ मेथिओनाइन का प्रयोग करना पड़ता है।

विषाणु होने की अवस्था में,

कारक प्रभावी नहीं रहते हैं, यद्यपि प्रभावित हिस्सों को रोग की पूर्वावस्था में सर्जरी के माध्यम से निकालने (यदि मेटास्टेसिस या गाँठों का फैलाव नहीं है) और कीमोथेरेपी से रोगी की उम्र बढ़ सकती है।

संखिया विषाक्तता (आर्सेनियोसिस) के प्रबंधन के सिध्दान्त

स्थानीय नलकूपों के जल में संखिया की मात्रा ज्ञात करने के उद्देश्य से उक्त जल का परीक्षण किया जाना चाहिए। ऐसे नलकूपों को, जिनके जल में संखिया की मात्रा ०.०५ मिलीग्राम प्रति लिटर से अधिक है, सरकार द्वारा बंद करवा देना चाहिए। संखिया की मात्रा विभिन्न नलकूपों में भिन्न - भिन्न होती है तथा यह सम्भव है कि स्थानीय नलकूपों में से कुछ ऐसे नलकूपों को पहचाना जा सके जिनमें संखिया की मात्रा अपेक्षाकृत कम हो। साथ-साथ संखिया की मात्रा को सही रूप से ज्ञात करने के लिए उपयुक्त परीक्षणों को समय-समय पर दोहराया जाना चाहिए।

गहरे नलकूप अपेक्षाकृत संखिया से मुक्त होते हैं तथा प्रभावित क्षेत्रों में गहरे नलकूपों को स्थापित किया जाना चाहिए।

बहुत से भूगर्भशास्त्रियों का हालाँकि यह मानना है कि गहरे नलकूपों का बड़े स्तर पर इस्तेमाल करने से संदूषण को और गहरे तक पहुँचने में मदद मिलेगी, अतः इस उपाय का, एक लम्बे समय में, उल्टा प्रभाव पड़ सकता है क्योंकि इससे भूमिगत जल का अनियंत्रित प्रयोग होगा, जिससे सतही जल स्रोतों में भी धीरे-धीरे विषाक्तता फैल सकती है। अतः किसी भी स्थायी हल के लिए तालाबों, झीलों तथा नदियों के सतही जलों पर अधिकाधिक निर्भर रहना होगा, क्योंकि ये जल संखिया से पूर्णतया मुक्त पाए गए हैं।

पश्चिम बंगाल में, वर्षा के तथा नदियों के जल की उपलब्धता, सभी प्रयोगों के लिए आवश्यक जल की माँग से अधिक है। अतः जो कार्य किया जाना है, वह है क्षेत्रीय - आधार पर जल शुध्दिकरण कर उसके वितरण के कार्यक्रम का कार्यान्वयन। पाइपों के माध्यम से, शुध्द किए गए सतही जल को गाँवों तक पहुँचाने के लिए वितरण प्रणाली स्थापित करने की भी आवश्यकता है।

मानसून के दौरान, वर्षा के जल को बड़े-बड़े बरतनों में एकत्र कर, उसे उबालकर, पीने व खाने पकाने के कार्यों के लिए इस्तेमाल किया जा सकता है। ❐

(हिंन्दी अनुवाद - मीता श्रीवास्तव)

FREEABSTRACTING

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