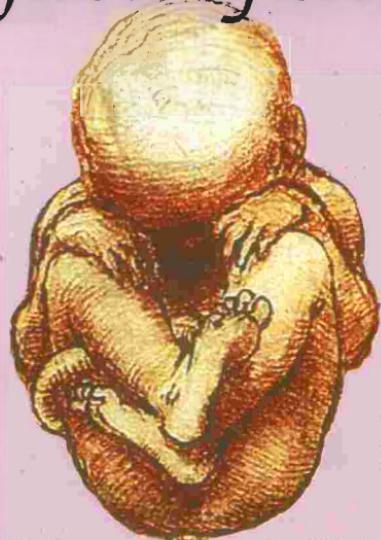


Whatever Happened to Health for All by 2000 AD?



Towards the People's Health Assembly Book-2

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Prepared and Published by

The National Coordination Committee

for the

Jan Swasthiya Sabha



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Whatever Happened to Health for All by 2000 AD ?

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- All India People's Science Network (AIPSN)
- All India Drug Action Network (AIDAN)
- Asian Community Health Action Network (ACHAN)
- All India Democratic Women's Association (AIDWA)
- Bharat Gyan Vigyan Samithi (BGVS)
- Catholic Health Association of India (CHAI)
- Christian Medical Association of India (CMAI)
- Forum for Creche & Child Care Services (FORCES)
- Federation of Medical Representatives Association of India (FMRAI)
- Medico Friends Circle (MFC)
- National Alliance of People's Movements (NAPM)
- National Federation of Indian Women (NFIW)
- National Association of Women's Organizations (NAWO)
- Society for Community Health Awareness, Research and Action (SOCHARA)

Participating Organizations:

Over 1000 organizations concerned with health care and health policy from both within and outside the above networks have joined the Jan Swasthya Sabha campaign as participating organizations.

Acknowledgement: Some of the illustrations have been taken from *Taking Sides* and from *The River of Stories*.

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About the Jan Swasthya Sabha

Governments & international agencies have forgotten the goal of **Health for All by 2000 A.D.** But we, the people, cannot forget it. It is time to strengthen & expand people centered initiatives - to find innovative solutions & to put pressure on decision makers, governments and the private sector.

There is a need to reiterate that attaining **Health for All** means ensuring everyone has access to affordable quality medicare, safe drinking water and sanitation, adequate nutrition, clothing, shelter and employment and no one is discriminated against on the basis of class, caste, race or gender. People need to be made aware of the links between globalization and the worsening health of the people. When structural adjustment policies work to undermine the vision of Alma Ata, renewing the **Health for All** call is an imperative.

With this understanding a large number of people's movements across the country have jointly initiated a national campaign called the **Jan Swasthya Sabha**. This has three broad objectives:

- ☛ To re-establish health and equitable development as top priorities in policy making with primary health care as the strategy.
- ☛ To forge a local, national and global unity of all democratic forces to work towards building long term sustainable solutions to health.
- ☛ Reinforce the principle of health as a broad inter-sectoral issue

The campaign has a four-tier structure. 2000-3000 blocks in 200-300 districts mobilize people on **Health For ALL – Now!** and conduct block level enquiries into the state of health services. These enquiries culminate in block seminars highlighting the findings & helping formulate people's initiatives for primary health care. Then, each district has a district level mobilization culminating in a District Seminar. All this builds up to the **Jan Swasthya Sabha** to be held in Calcutta from Nov 30th – Dec 1st 2000. Four trains with representatives from various parts of the country will arrive at the National Assembly. The **Jan Swasthya Sabha** – with over 2000 representatives – will call for a reversal of structural adjustment policies and a renewal of the **Health for All** pledge. The assembly will also send its representatives to the international People's Health Assembly being held at Dhaka from Dec 4th-8th, 2000 where similar representatives from other countries will gather. Following the **Jan Swasthya Sabha**, each interested block or district follows up with health intervention and advocacy.

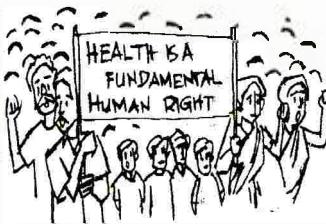
The **Jan Swasthya Sabha** is being coordinated by a National Coordination Committee consisting of 15 major all India networks of peoples movements and NGOs. This book is the second book in a 5 book series brought out by the NCC for guiding the block, district and state seminars.

Chapter I

Understanding Primary Health

Health is a state of complete physical mental and social well being and **not** merely the absence of disease.

-Alma Ata Declaration, 1978



What causes ill-health?



1. Malnutrition is the most important cause of ill-health!

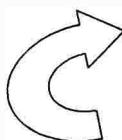


The major cause of malnutrition is Hunger.



Hunger is the result of poverty.

(Lack of food is not the problem – the ability to buy it is !)



Malnutrition leads to frequent infections

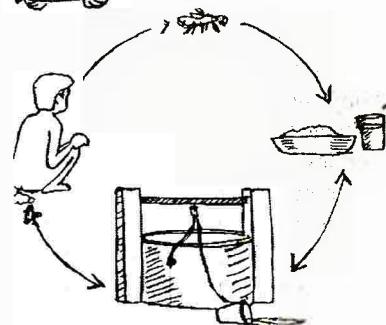


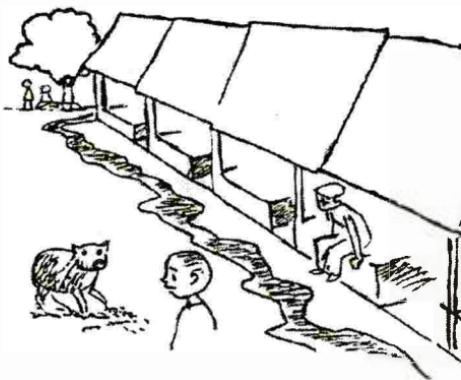
Frequent infections lead to Malnutrition

2. Unsafe drinking water & sanitation is another important cause

Most infectious diseases spread through water.

Water gets infected due to poor sanitation.





3. Poor living conditions and ecological changes affect health

Overcrowded homes, damp leaky poorly built houses, smoky environs increase TB and respiratory infection.

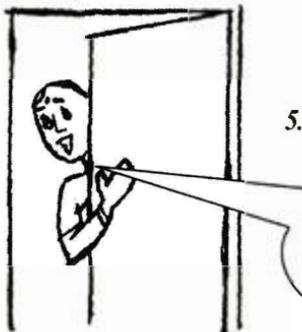
Migration & Squatter settlements are major sites of disease.

Poorly designed development projects with water logging spread malaria.



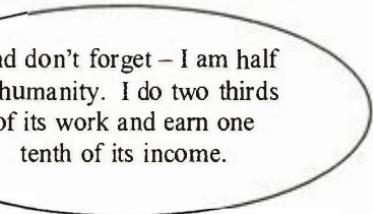
4. Poor Working Conditions!

Hey! I work 12 hrs a day and at the end, am more dead than alive!



Exhaustion due to long hours of work, continuous exposure to dust and dangerous chemicals, unprotected machinery and crowded & ill-ventilated workplace is a major cause of ill-health.

5. Patriarchy is a cause for ill health!



And don't forget – I am half of humanity. I do two thirds of its work and earn one tenth of its income.

A woman eats last and least, is acculturated to feel ashamed of her own body, suffers in silence, treats her health as last priority, is overworked and low-paid. She is also beaten, abused and sexually harassed.

Women are always in danger of death – from infanticide, foeticide, dowry death, destitution and desertion.

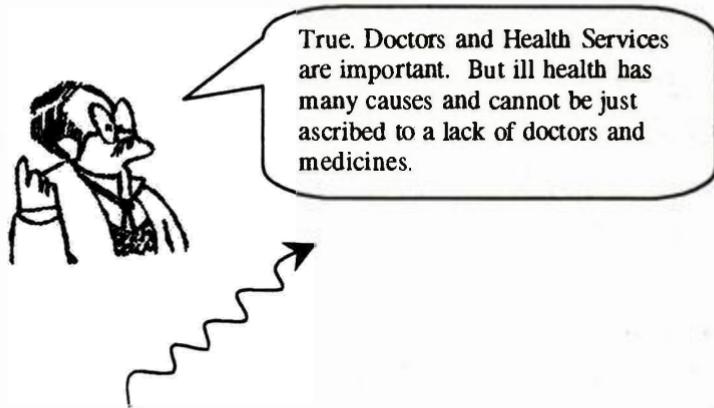


6. Stress is also a cause of ill health

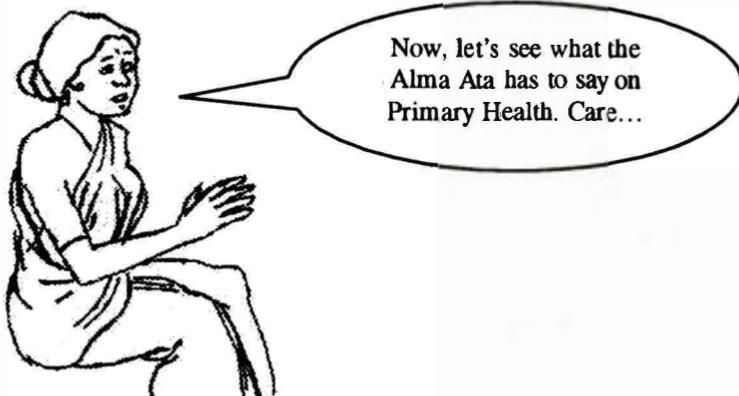
Stress results from an individual's inability to cope physically and mentally with social and personal adverse conditions. The breakdown of collective institutions, unemployment, lack of leisure, lack of security, consumerist culture and high competitiveness is leading to an increase in stress related diseases and suicides.



7. Lack of access to good health services is a problem.

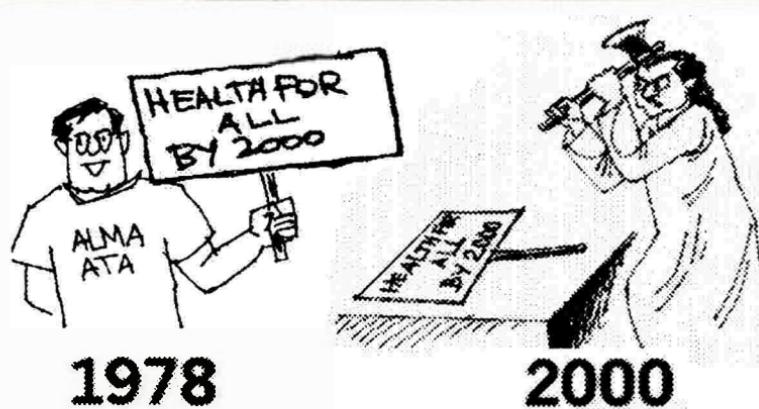


It was this broad understanding of health that guided the Alma Ata Declaration in 1978 on Primary Health Care.

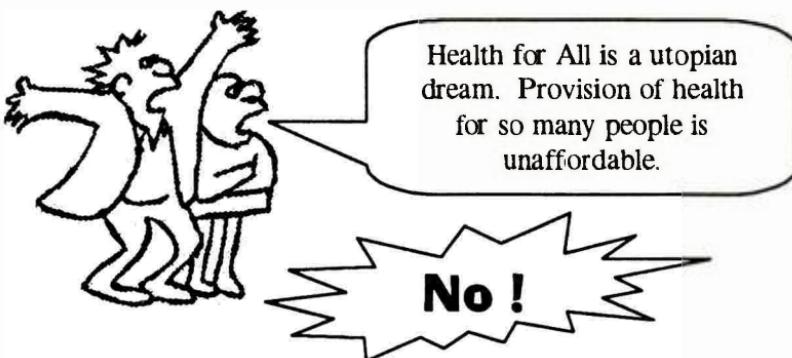


The Alma Ata Declaration...

Primary health care is essential health care... based on methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part, both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process.



By Health for All was meant the provision of primary health care for everyone, irrespective of the ability to pay for it. The declaration further clarified... **Primary health care included in the least health education, promotion of food supply and proper nutrition, an adequate supply of safe water and basic sanitation, maternal and child health care, including family planning, immunization against the major infectious diseases, prevention and control of locally endemic diseases, appropriate treatment of common diseases and provision of essential drugs.**



95% of all the useful remedies that science and human experience has discovered, whether in curing or prevention, can be provided at a cost that even the poorest countries can afford for their entire population. **Health for All was not a pipe-dream in 1978 and is not so now in 2000.** Primary health care for all was clearly achievable aim if only governments and people could have generated the political will for it.



Chapter II

The evolution of the Alma Ata Declaration

The Alma Ata declaration did not just accept that Health for All is something that can be achieved. It also accepted that Health is a fundamental human right. It accepted that the gross inequality in health status is unacceptable. It declared that people have a right and duty to participate individually and collectively in the planning and implementation of their health care.

All this was not being said for the first time in 1978. But this was the first time all the governments of the world –democracies or dictatorships, communist or capitalist - accepted these principles of primary health care officially and promised to bring this into being in all nations within the next 22 years.

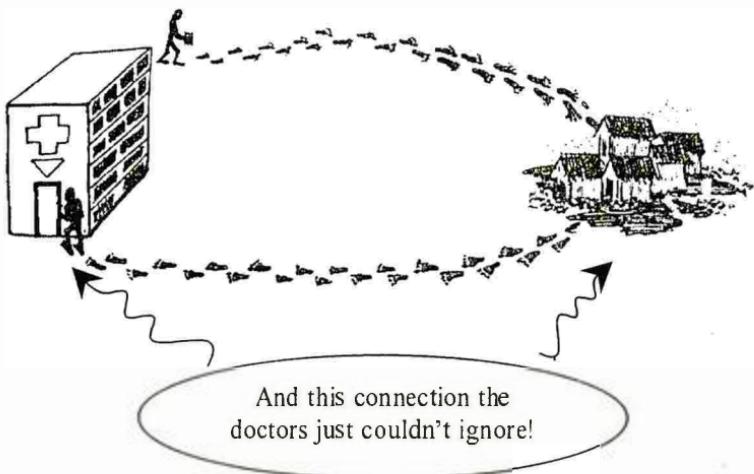


Wow ! All countries agreed on this common slogan. How did that happen ?

There are four major reasons why Alma Ata happened. One reason is in medical science the other three are in politics.

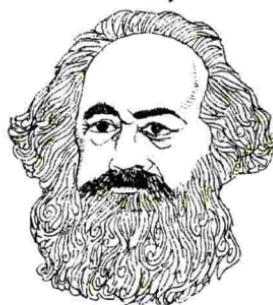
Medical science realized that poverty & related social conditions like poor sanitation was the major cause of ill-health. Studies showed that irrespective of medical interventions health status improved remarkably when the basic requisites of good health became available.

In the 50's to the 70's important technical advances in medicine were being made - for example, vaccines against a number of important diseases. Good chemotherapy had become available for almost all infectious diseases, especially bacterial diseases. The mechanism of spread of all major infectious diseases was worked out. The technical means for disease control were available. The challenge was primarily a question of equal access to all. In the 60's and 70's examples like the barefoot doctors of China, the Mexican health workers programme under David Werner, the Jamkhed programme in India and a number of mission inspired programmes were showing how much could be done in primary health care. These experiments proved that if there was adequate political will, then at affordable costs, the technology available was sufficient for achieving a remarkable improvement!



One political factor that came into play was the rise of socialism in almost one third of the world. These countries were committed to state funded healthcare for all. This was an old demand of left parties dating back to the French revolution when the more radical section - the Jacobins - raised this demand. So deep was this commitment that the first intervention after a socialist change was in most countries providing state supported health care. Also by giving rights to women, education to all, by actively addressing poverty, dramatic improvements were shown in the health status.

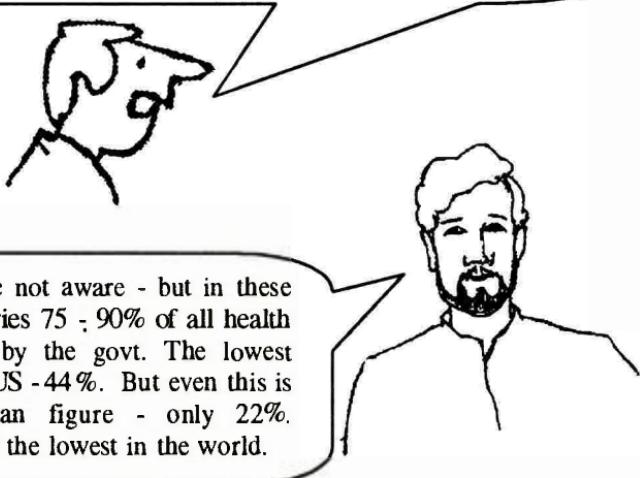
Socialism! Equality!
Rights to women!
Health for All !
Education for All !



There are many differing views about the achievements of socialist countries. But even the worst detractors had to accept that in health status they marked tremendous improvements. After what a poor country like Cuba, completely isolated from trade or Vietnam, totally racked by war or, China with almost no health infrastructure at the time of liberation could show, it was obvious to the world, that indeed health for all was an achievable goal.

Simultaneously, in the West all the developed countries undertook to guarantee the health of the poor. The defeat of fascism had required the complete support of people. The emergence of a strong socialist camp also made it essential for these governments to win over their workers. Moreover the experience of the great economic depression in the twenties and the turn to Keynesian economics brought these countries to accept the need for state intervention. In such a political context the governments of almost all the developed nations undertook healthcare as a state responsibility. The US was relatively the least, but even here almost all the poor and the old are provided health cover by the state.

What ! Are you saying US and other capitalist countries have a big state health care system ??? But I thought they love to privatize industry, health, education, love, life, happiness...



Most people are not aware - but in these capitalist countries 75 - 90% of all health expenditure is by the govt. The lowest figure is in the US - 44%. But even this is twice the Indian figure - only 22%. India's is one of the lowest in the world.

Countries like India that had recently thrown off the colonial yoke evolved their health policies in the 50's and 60's inspired by these two models. These countries, most of which came into being due to anti-colonial movements where millions participated, also promised their people complete health coverage.

It was this coming together of various factors which gave the context for the Alma Ata Declaration. Whether it was welfarist, socialist or a post colonial nation, there was a commitment to state supported universal health care. **It was only under such a situation that the WHO could propose the Health for all by 2000AD declaration and all governments of the world could accept it.**

Alma Ata and the National Health Policy of 1983!

India's commitment to universal health care precedes the Alma Ata declaration by at least three decades. The Bhore committee report, which was independent India's charter on health begins with the opening statement - no citizen should be denied an adequate quality of health care merely because of his or her inability to pay for it.



Indian Health Charter

However like most of the newly emerged colonial countries India did not follow the socialist path in eradicating poverty or redistributing wealth. In the absence of such measures the resulting system was more in the nature of a welfare measure like in the West. But unlike the west India was a poor country, and further it had to spend to develop its own industrial base. So the health delivery system that developed had a relatively low priority and was totally inadequate for the needs. Also it remained concentrated in urban areas.

The Alma Ata commitment did lead to some renewed attempts at achieving these goals. Soon after this, the Indian government passed in Parliament a national health policy in 1983. In this policy all the process elements of primary health care as understood at Alma Ata was highlighted. The National Health Policy went further to talk of large scale of transfer of knowledge and skills to health volunteers. It talked of a nationwide chain of sanitary cum epidemiological stations. It also talked of decentralization in health care and a referral system. It talked of inter-sectoral cooperation and even a better utilization of traditional Indian medicine. It even explicitly promised to phase out private practice by medicos in government.

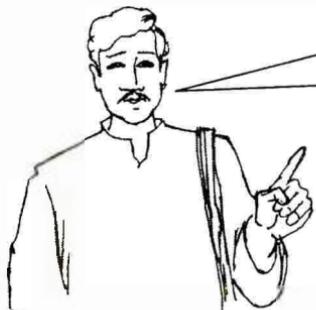


Unfortunately, even the senior health administrators did not read the health policy. World over the Alma Ata declaration was gradually marginalized and forgotten.

What we actually need is a Campaign for Policy Literacy. Educate the Administrators!



Why was the Alma Ata declaration scuttled?



The main reason was the change in the economic and political climate all over the world in the 80's – for the worse.

Under the leadership of Reagan in the US and Thatcher in the UK the welfare state came under attack. The reason for this attack on welfarism was the economic problem in these countries. This forced the ruling sections of these countries to reduce expense on welfare in their countries. Of the welfare expenses the burgeoning costs of health care provision was the largest and therefore there was pressure to cutback on this. The transnational companies were also keen to enter the third world markets and health care was a major area in which they could enter and make super-profits.

Meanwhile, the Soviet Union and the socialist bloc had fallen. The example of state supported health care was no longer in focus. Also with that the third world's ability to bargain and resist pressures of the west was severely curtailed.

The World Bank & the IMF now became the main institutions through which the US and the West operated to secure their interests. Unlike the WHO and the UN, these are not political forums of world nations. They are US dominated bureaucracies. The World Bank's pressures were to cut back public funding for health & shift as much curative care as possible to the private sector. The World Bank at no time had any stated commitment to Alma Ata declaration. It had its own agenda for health care.

The Result

The state retreated from its commitment to provide comprehensive health care!

The Story in India

1946-1983

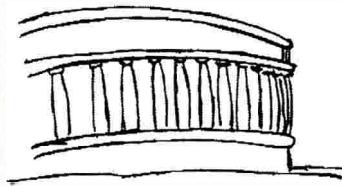
Vision of the Bhore Committee report. Maintaining, reiterating this through other committees.



Sshhh... Committee at work!!

1983

The National Health Policy



1990

What 'Health for All'?
Don't waste our time talking about all this nonsense!



The guiding vision since independence is no longer even a statement of intent.

The WB document of 1993 - "Investing in Health" set the new agenda and this becomes the new Indian Health Policy. This new policy calls for focussing on a small set of public interventions that technocrats feel can show the maximum improvement in indices for the minimum expense. For the rest, the private sector should provide the answer.



Not enough!
We need more profits.
Set up the WTO !

The discussions leading to the WTO tries to abandon even this already compromised position. The goal is now to declare that health is just like any other service and should be traded without restriction. Privatization becomes the answer and government documents actually start talking of increasing the profitability of health and related industries as the main goal.

Other
Changes



Delicensed Pharmaceuticals and soaring drug prices. Proliferation of Corporate hospitals and entry of foreign players. This is encouraged to attract foreign exchange!



Don't forget why the Alma Ata declaration was scuttled!

Primarily it is a retreat from the goals of health & drug policies as part of an overall social policy - a direct consequence of Globalization and the Structural Adjustment Programme

One way in which this retreat manifests, is the decline in budgetary allocations. But another even more dangerous consequence is the shift in values away from seeing health as a fundamental right guaranteed by the state.

Whereas earlier the fundamental purpose of government intervention was to reduce inequality in health status and provide access to all especially the poorest, now a new set of values is emerging where profitability of the health industry and the medical professional is the central concern. Illustrative of this is the sudden increase in





private medical colleges where fees of about 30 lakh rupees per seat is being charged!

The World Bank is pushing the idea of health care as a safety net. By this they mean that the economic reforms they are forcing on the country will cause an increase in poverty and therefore in sickness and death. Such setbacks can jeopardize the economic reform itself. Their solution is to invest in health such that by careful planning they can with the least possible

expenditure keep the poor from dying and spoiling the reforms. This safety net approach to health care means that a state supported intervention is essential but this must be limited to a very select role. This revolting idea is now fast replacing the earlier notion that Health is

Health Care is a Fundamental Right

Comprehensive health care 'addresses the main problems in the community, providing promotive, preventive, curative and rehabilitative services.'

National Health System bringing health care close to the people.

Emphasis on process: Intersectoral linkages, equality, basic needs & participation.

People have a right & duty to take part in planning & implementing health care.

The aim of health care is to find the best way to ensure a good quality of life.

Motivation – a genuine concern for people's health.

Health Care as a Safety Net

Selective primary health care: tackles only six areas identified at the national centers as important.

Most curative services provided by private sector. (And they prefer towns!)

Emphasis on elimination of disease by targeted technological means. Efficiency measured in terms of number of deaths averted at unit cost.

State will decide which diseases can be tackled at least cost and focus only on these (to keep expenses limited)

Aim of state's health care is to find the least cost approach to ensure survival. Quality of life does not matter.

Motivation – fear that too many deaths will question the basis of profit-driven structural adjustment programmes.

Chapter III

The Tale of Two PHCs

There is a vast difference between the existing primary health center network and the concept of Primary Health Care. This difference is the reason for the Jan Swasthya Sabha and for this book. We should understand this difference clearly.

What is all this about forgetting our Primary Health Care commitment? We have opened so many primary health centers. We have deployed so many health workers, increased health care budgets year after year. There is so much foreign aid from the World Bank. There is a large decline in infant mortality, in maternal mortality and gains in fertility control. And you say we have scuttled the Alma Ata promises! Are you mad?



No doubt the Alma Ata call was useful and some gains have been made. But the question is – is it adequate and does it conform to the promise? Let's see each claim closely.

Yes, there has indeed been a tremendous expansion of the PHC network – thanks to Alma Ata.

Sub Center	PHC
1980	47,112
1998	1,36,818

It's Trebled. 1985-90 PHCs Doubled. Little further increase.

So the claim about the PHC network was correct. What about the Health Budget? Has it also increased as claimed?

Increase in health budget: OK. Health budgets have increased, but let's adjust for inflation and see what percent of the total budget is allocated to health. Total health expense **went up** from Rs. 11.89 billion in 1980 to Rs. 78.67 billion in 1994-95. But as a percent of the total govt. expenditure it **went down** from 3.2% to 2.6%. **The recommended minimum is 5%.** The annual per capita growth rate of state health expenditure has fallen from 15% in 1980-81 to 7% with the fall in disease control programmes and in capital expenditure being much sharper than in other components.

Ref: Dug gal, et al 'CEHAT database special statistics: Health expenditure across states-Part I', EPW.

Let's look at some data now!



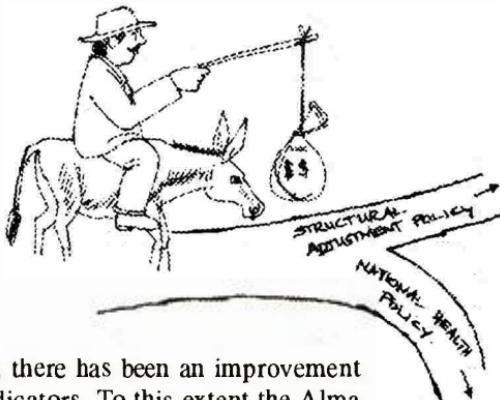
Health Infrastructure and Manpower - Coverage and Gaps

	Popn. covered	No. existing & in position	No. needed for 100% coverage (for 2002 popn)	% vacant or uncovered
Sub center	5000	136818	23190	14.91%
PHC	30,000	22991	4212	16.25%
CHC	100000	2712	3776	58.28%
ANM	5000	133567	27501	5.12%
MPWM	5000	72869	64860	16.39%
LHV	30000	19364	4224	13.76%
Doctor	30000	24648	1531	-15.11%

No. of ANMs, MPWM, LHV needed figures include both vacancies in current requirements & posts to be created. The uncovered areas for Sub center, PHC and CHC relate to infrastructure that needs to be created for meeting 2002 requirement. For all three institutions the shortfall is not even within states. HP, JK, Kar., Kerala, Orissa, Raj., Sikkim, TN & all union territories except Delhi have adequate or excess to requirement. At the other end Bihar & UP together account for 1649 PHCs shortfall, which is 39% of the entire shortfall. AP, MP & WB account for 12% each and Assam & Mah. for another 6% each. Tripura's 75 PHCs shortfall is 56.39% of its requirement - the poorest performance for any state. Bihar's shortfall is about 30% and the other states have shortfalls of 25% or much less. Thus UP needs 774 PHCs which is only 17% of its requirement.

Source: Bulletin of Rural Health Statistics in India: June 1998, Rural health division, DGHS, MOHFW, GOI

Foreign aid: It has come in but is only 9% of the total govt. expenditure on health. Despite that, this aid has been used to bargain with the govt. and win substantial alterations in the health programmes – away from the national health policy and more in tune with World Bank dictates!



Increase in health status: Yes, there has been an improvement in a number of health status indicators. To this extent the Alma Ata declaration was useful. But these achievements are far less than what is acceptable or could have been achieved. Let's examine this improvement in some detail.



There has been a definite decline in infant mortality & under 5 mortality. But our infant mortality is still very high - higher than many comparable countries. We have not reached even the modest target we set ourselves in mid-80's.

Under 5 mortality fell from 236 in 1960 to 105 in 1998. But this only takes India to the 49th rank (from the bottom) amongst 189 countries. Only some of the poorest African and Asian countries are below this level. Compare India's 105 figure with Sri Lanka's 18, Malaysia's 10, China's 47, Vietnam's 42 or Mexico's 34! Even poorer African & Asian countries like Namibia or Guyana, have figures of 74 & 79 respectively.

The Indian government had set itself a target of 70 as part of the national health policy and even this was not achieved. The current figure implies a total of 25,90,000 child deaths per year, most of which are preventable.

Source: State of the World's Children-UNICEF, 2000. Figures for 1998

The maternal mortality case is even worse !!



The government maternal mortality target of 200 per 100,000 is itself impermissibly high. At 1976 the maternal mortality stood at 450 per 100000. At present it is 410- only a marginal decline. In contrast almost all developed countries have a maternal mortality of less than 25 per 100,000.

(Source: same as above)

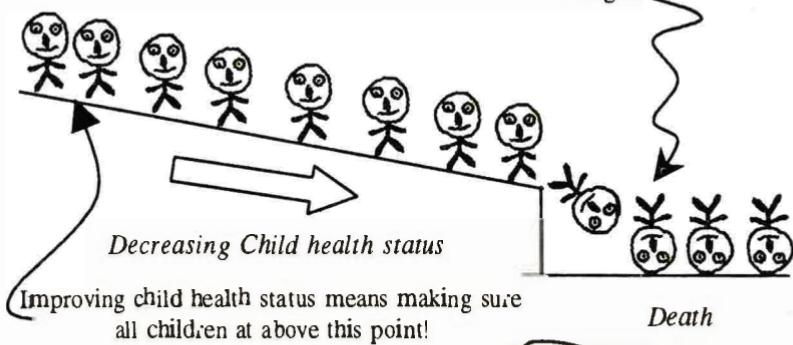
Why are we limiting ourselves to the government's targets? Primary health care is not about achieving targets – it is about establishing a set of processes.

But don't we need targets to measure our progress?

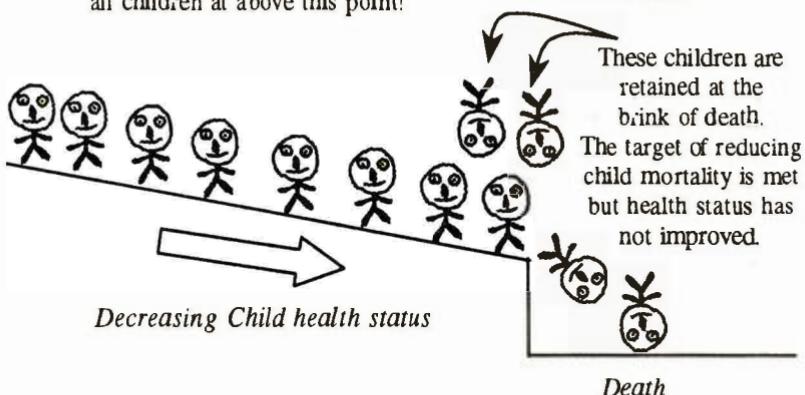
No! We need indices to measure outcomes, not targets to direct our work. And there is a difference – if these indices become 'targets' then there is a false feeling of improvement.



Child mortality as an index of child health is fine until you make it a target.



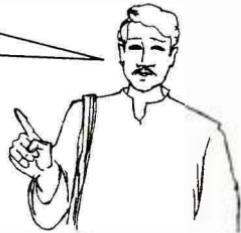
Improving child health status means making sure all children are above this point!



Moral

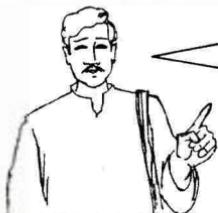
An index is an index only when it is not a target.
Using the index as target gives a false picture.

The government has used IMR and MMR as targets. Let's look at other indices to see how good the achievements really are.



Morbidity indices are difficult to collect and even more difficult to interpret. An educated person may seek help for measles whereas people in many rural cultures may not. In one culture white discharge would be reported in a survey as a sickness, but in another culture may just not be mentioned. We need some other index of health.

Malnutrition levels in children are a good index of health. It is easily measured. One just needs to take the weight of the child. Malnutrition occurs due to lack of food. But it also occurs due repeated sickness. Malnutrition also means a stunted child, a child who will never reach its full physical and possibly mental potential. If we take the definition of health as the fullest physical mental and social wellbeing, then malnutrition is a good index for that.



If the processes of primary health care were in place this should have come down dramatically. IMR would also have fallen as a by-product. How have we actually fared?

India: 53% children are malnourished. 22% very severely.

Brazil: Only 6% children malnourished !!

When malnutrition is adjusted for per capita income –India and Bangladesh have the worst figures in the entire world!

We have fared very very badly!!

Let me add – we are quite consistent! Not just in malnutrition but also in malaria and TB we have shown no improvement.



Tuberculosis

1947: 5 Lakh deaths

2000: 5 Lakh deaths!

1947: 20 Lakh cases.

2000: 120 Lakh cases!

TB does not lend itself to a single strategy. It needs comprehensive health care. But that was just not available.

In malaria we had 700 lakh cases annually and a single intervention - DDT spraying was to bring about a dramatic decrease to less than a lakh cases per year by the mid sixties. But this gain was fragile and soon it shot up to 70 lakh cases from which by early nineties it had stabilized at 20 lakh cases per year. However during the nineties it is rising again and the current malaria strain is resistant to treatment. Malaria again needs comprehensive primary health care for its control.

With all this infrastructure, why is the health status so poor? Are PHCs not supplied with enough drugs? Don't the nurses and doctors do their jobs?



This only true to some extent!

In most states the vacancy accounts for less than 15%. Even if we accept over reporting by the government, at least one third of PHCs must be adequately staffed.

Drugs supply is inadequate & erratic. This explains TB but not low performance in antenatal care, diarrhea management & other dimensions.

Moreover even in villages where the PHC and sub-center is functional only a small percent of people resort to it for their curative needs. Many public health targets are usually not met even in such villages where the infrastructure is adequate

I tell you it's not our fault. We do our best. The people are ignorant and don't know what is good. There already is enough primary health care. We just need to persuade people to use it.



↑ This is a very convenient explanation – and equates the network of Primary Health Centers with Primary Health Care. But there is a world of difference between these two PHCs! Let's see what the differences are...

1. The Primary Health Center aims to deliver *Selective Health Care*, NOT *Comprehensive Primary Health Care*.
2. Selection of health priorities is by distant bureaucracies not by local planning.
3. There is no community participation – in fact a fear of it.
4. There are no effective referral systems.
5. The focus is on fragmented health sector inputs – not an integrated inter-sectoral approach. The focus is on *targets* as different from *processes*.



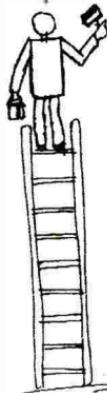
The above differences are very important. The difference between the two PHCs is the difference between health and sickness. So let's understand each of the 5 differences in more detail...

The First Difference

Selective

Comprehensive Health Care

- Alma-Ata
- World Bank



Yes! Yes! That's right! Change that and that. Those Alma Ata fellows were fools. There is just no money to provide everything to everyone.

Even before the ink dried on the signatures to the Alma Ata Declaration the World Bank helped by institutions of the rich like the Rockefeller institute, got into action. By 1985 they managed to push selective primary health care instead of comprehensive primary health care.

We can't do everything. So we focus only on cost-effective interventions. The important thing is that you keep your expense low.

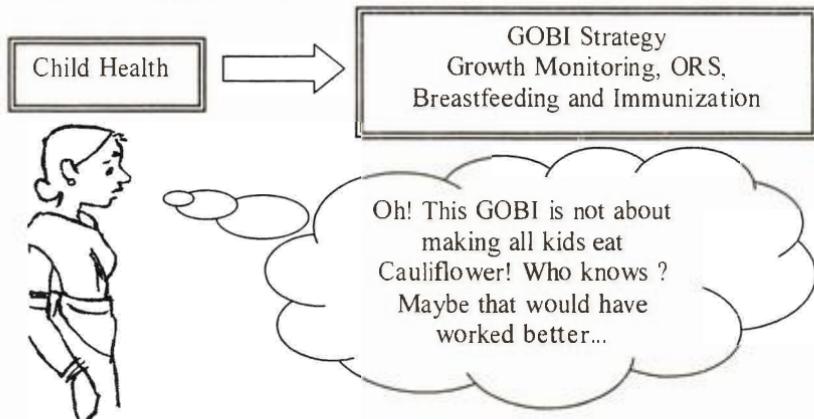
Hey! But we also need to show progress in health indicators!



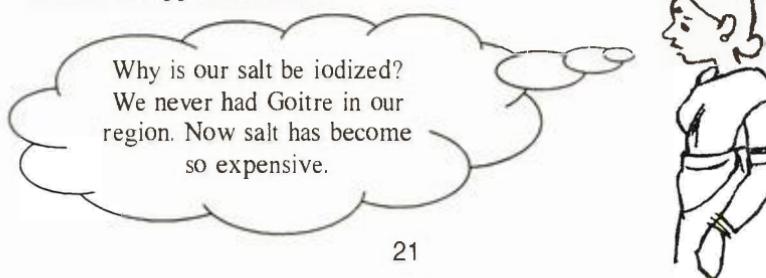
Just trust me! I have done this in country after country. I have the entire package worked out. Categorize all diseases as high, medium or low priority based on the cost and then you only address the high priority ones. If someone asks, just tell them you are addressing high priority disease first. And who can have problems with that !



And then they decided that India's priority in health was Family Planning, Women and Child Care, Nutrition, TB and sexually transmitted diseases. Next within this they decided to focus further:



On the field GOBI became further focussed on distribution of ORS packets and immunization. In women's health, the focus was antenatal care –particularly registering of pregnancies - as this was important for family planning. Nutrition - the focus was iodination of salt, iron and vitamin A supplementation.



The Second Difference

Who selects the priorities?

Hey! It was not WHO!
We did all of it.



Instead of communities deciding their health priorities, as envisaged in the declaration, the priorities are set in a distant capital or at the world bank and just thrust on the entire population. So it is not just selective health care. It is selection of health priorities by a distant medical bureaucracy – not even by local health officials, let alone the people. If a particular area has a major snakebite problem or a disease like anthrax or hepatitis is spreading there is no mechanism by which the PHC can respond to these problems. Often they would not even be aware of it.

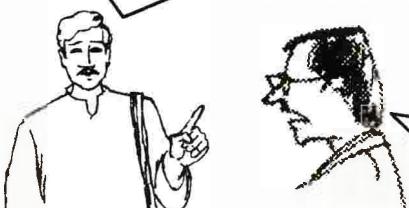
Doctor! Doctor! I have been bitten by a snake.

Sorry. It is not on this PHC list.



So, why don't you find out what the health problems in your area are?

How? Even our senior district officers don't have a way to find this! Even if I do, nothing will happen until the fellow at Delhi recognizes it as a major problem and allocates funds for it!



Local planning needs an effective health information system !

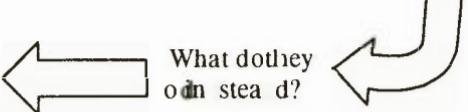
Most districts claim that immunization is complete. Only 14% of the ill go to govt. centers. How does one know that the very same diseases like measles or whooping cough are not prevalent in the district in some villages? No district for example, will be able to tell the extent of jaundice in their area. Till the distant authority wakes up to it, major health problems in an area remain unattended to.

Why is a functional health information system to guide health planning non-existent?



Because decentralized district level planning is never envisaged! So no pressure to build a system that can assess the local health needs on a continuous basis.

Conduct sample surveys periodically or sporadically and pray it is enough for central planning.



And don't think this new talk of building up an information system is going to help decentralized planning!! They are very clear - it is only aimed at improving central planning.



The Third Difference



Should we ask the village leaders and mothers to identify all children with malnutrition and night blindness and give these children vitamin A?

Be Practical! Asking them will lead to unnecessary trouble and we can't check if it was effective. Let us give it to all children. Our VHN can keep a register and make sure it is done.



All programmes are designed so that the health bureaucracy can use its junior staff to apply the remedy with no participation what so ever from the community. But such an administration driven approach is neither easy to implement nor even effective.

Success! We have reached 70% Vit. A coverage with our method.

Look carefully! That 30% left out has all the night blindness!



DOTS: Directly Observed Treatment Short Course!

Take the current DOTS approach to tuberculosis control as an example. Ensuring that the patients take drugs regularly by calling for direct observation by health staff is not just impractical, it also means limiting the programme's coverage. The option of involving the community in case detection and monitoring compliance is just not considered though there is much better demonstration of the success of such an approach.

What you say is not true.
We strongly believe in
community participation.
In fact it is our ideal.

All these critics! They just
can't understand that the
community is unreliable...



This poor experience with community participation is because of three reasons...

First



Community help is sought only to implement pre-decided programmes without bothering about their needs. This is community manipulation not participation.

Second



There is neither resource nor a planned process for capability building. Without it, community participation becomes an excuse for transferring the blame to the community. This is particularly true where panchayat involvement is proposed.

Third



Community participation needs to be catalyzed by elected panchayats, people's movements and NGOs. It is not something that can be nor *should be* secured by the bureaucracy acting alone. Mechanically naming some committee or group as representative of the community is paying lip service to community participation.

Real community participation needs community organization. Such an organization will not be limited to the mandate set by the bureaucracy. It will evolve demands and actions on many of its local concerns. This is the true test for the genuineness of community participation.

But the local bureaucracy-politician-contractor axis finds this threatening and prefers to keep the initiative at Delhi.



And don't forget...
There is no effective
Referral System!

The Fourth
Difference

It is true that PHCs can refer cases to the district hospital even now. But does not mean a referral system exists! Only when the PHC, the secondary hospital and the district hospital function as a single team, we can say we have an effective referral system.

This is what effective referral means: Team Work

High risk pregnancy → First seen at local level → Referred to and seen at secondary level

Admitted and managed at the secondary hospital ← Followed up at local level till child birth ← Referred back to the PHC

Similarly, a person with diabetes seen in a PHC can be referred to a secondary hospital for blood tests and expert advice and is then referred back to the PHC for follow up daily at the PHC as if the entire structure was a single unit.

Such a referral system extends the capacity of the PHC to manage a wide number of felt needs largely of a curative nature, which otherwise it cannot cater to.



The community health centers, planned at one per 100000 population, was to fill this gap. The FRU - First Referral Unit - was a referral specifically meant to reduce maternal mortality. Not even 50% of the required number has been established. And even those that have been, don't have the minimum staff and provisions needed.

Why did this happen?

Because of the conflicting desire and mandate to privatize at this secondary level !



Thus though we have a reasonably extensive antenatal care, in most of the country through the ANMs, we can offer very little to the high-risk cases.

In the absence of such a referral back up the main purpose of antenatal care is lost. Except to an extent, treating anemia & preventing tetanus, antenatal care mainly serves to identify family planning beneficiaries!

Wherever awareness of risks at childbirth has risen, it is private institution based delivery that has benefited. The almost complete neglect of secondary level health care and the understanding that one should encourage private provision for it is a complete misunderstanding of the primary health care concept.

This misunderstanding is there even in the national health policy document.

We still rely on
Fragmented Interventions !

The Fifth Difference

Without addressing malnutrition, diarrhea cannot be prevented. Without preventing diarrhea, malnutrition cannot be addressed. Claiming one intervention is more cost-effective, focusing on it and ignoring the other is absurd!

Another example: Separate malaria and filaria control programmes make no sense. In both mosquito control is the key! And mosquito control requires the coordination of several sectors, not just the health sector. Unfortunately, almost all national disease control programmes are examples of such completely fragmented vertical interventions.

There are 16 vertical disease control programmes. Each disease is assumed to have one most effective technical solution. Apply this solution (often a marketable commodity) widely and the problem will be solved.

This top-down, technology-oriented view of health is a serious limitation to our disease control efforts.



The Alma Ata declaration and the National Health Policy emphasize the necessity for inter-sectoral coordination of over 10 sectors. But in practice and even in programme design reliance on a single technology bullet precludes such a coordinated effort.



Medical professionals who contribute to health planning understand technical interventions but have no experience of multi-sectoral developmental processes.

The marketable commodity has its lobby but there would be no lobby for a multi-sector process. (The promotion of the Hepatitis B vaccine amongst children is an example of this. This has not yet built up enough support to become a government programme. Once it does, like iodination of salt or impregnated mosquito nets or universal vitamin A administration, there is no stopping it.)

Almost all vertical disease control programmes are seen as being implemented by the PHC. In the PHC it is only the Multipurpose Health Worker who is involved in public health concerns. Their priorities are already fixed as family planning, a bit of care at pregnancy and immunization. This is what is monitored, and this is what happens. Therefore the vertical disease control programmes remain largely on paper.



The family planning programme swallowed up the entire primary health center !

The Net Result

The primary health center (as it exists today) is unable to enthuse the public. It seems irrelevant to their needs. Because of the resulting apathy even the demand for a better primary health care goes.

This becomes a convenient excuse for:

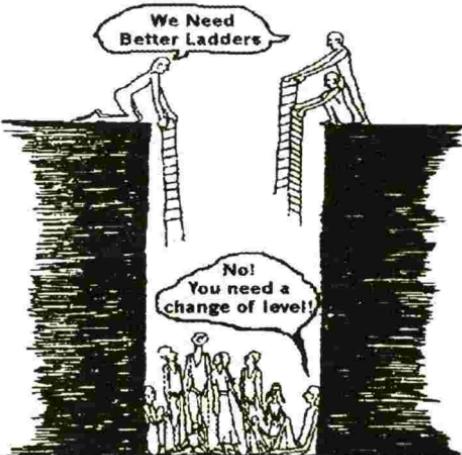
1. Expanding private health care and further curtailing public health care.
2. Talk of handing over PHCs to the industry, to NGOs etc.
3. A new world bank move to limit primary health centers to first contact care and use the private sector for other dimensions of primary health care.



There is no protest over these moves not because people like these new plans, but because people have no confidence in the ability of the PHC system to deliver what they want in health care.

A perception is growing that 'state supported primary health care was built up but has failed and therefore we have to rely only on the private health sector.' But this is just another way of justifying the abolition of the Public Health Sector. Primary health care as a set of desirable processes was never really given the chance. It lost out to the growth needs of the health industry right from the beginning. This 'failure' argument is therefore wrong and totally misleading.

A selective, administration driven, fragmented approach fails to address not just people's problems - it even fails to deliver these very selective targets on which it is focused!!



Unable to win people's confidence, the PHC is forced to thrust all the packages - be it vitamin A or immunization or family planning - on them. And there are limits to thrusting such health care on passive beneficiaries...

The Gap Between Health for All Targets and the Performance

Indicator	Status 1983	Target set	Status 1998
Infant Mortality Rate	104	<60	69
Under 5 Mortality Rate	140	<70	105
Crude Death Rate	12.5	9.0	9.0
Life expectancy	54	64	63
Maternal Mortality Rate	450	200	410
Crude Birth Rate	33.8	21.0	25
Total Fertility Rate	3.8		3.1
Immunization (BCG)		100%	79%
Immunization (DPT)		100%	73%
Immunization (Measles)		100%	66%
Pregnancy-TT		100%	80%
Trained Dai or Inst. deliveries		100%	34%

Note: The figures for the status in 1983 and the target set are taken from Park's textbook of Preventive and Social Medicine. The status achieved in 1998 is taken from the UNICEF publication "Status of the World's Children 2000" - which is the latest update on these figures available. The figures in this source are based on UNICEF surveys and may differ from the governments' figures.

Lack of resources

One cannot forget that in large areas across the country one of the main reasons the PHC fails to enthuse is simply the lack of adequate personnel or facilities or funds. The question of the correct processes can arise only after this minimum is made available.

And you guessed right!

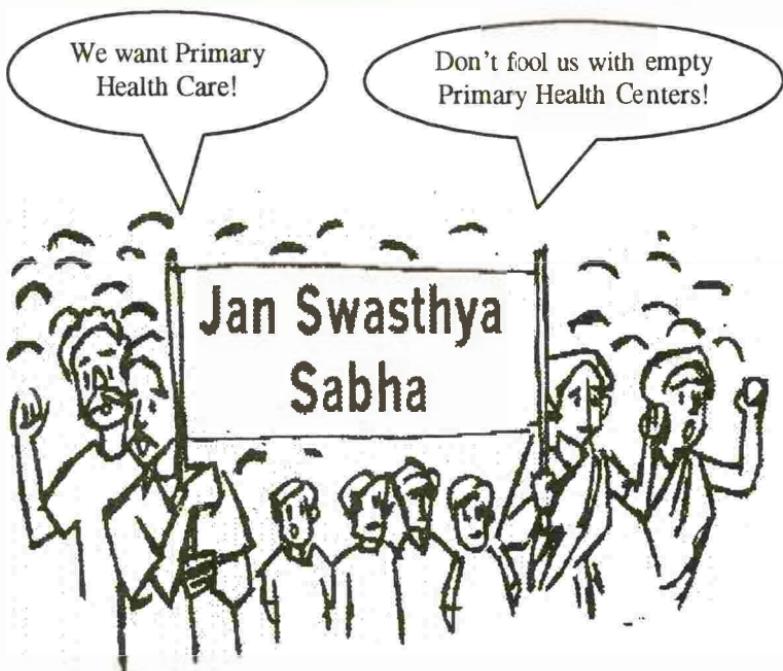
The situation is worst in those very states and within states in those very areas where the health status is worst.



The Minimum Requirements !!

1. **PHC:** 2 Doctors, at least one resident. In most states it is still the one doctor system.
2. **Sub center:** 2 Multipurpose workers 12 MPWs/PHC. In most places the male worker is not sanctioned, or not functional.
3. **Facilities:** To conduct delivery at any time of the day & manage the entire range of diseases that a general practitioner manages routinely.
4. **Drugs:** 50 essential drugs at the PHC and 25 at the sub center available without a break.
5. Adequate transport and communication facilities to enable the PHC and sub centers to function as part of the district team.

**Dismissing the primary health center as a failure
without ensuring these basic provisions for
it's functioning cannot be accepted!**



Chapter IV

What is to be done?

Health is a fundamental right. Good health is as essential as life itself. The nature of economic and social systems must flow from this premise.

It is not for economic systems to decide how much health is affordable or permissible!

Change this Economic System!



If today economics decides how much health is affordable, it is only because this is an unequal world where a few have the power to control the lives of the majority. It is now time for the people to assert themselves, to force decision making to reflect the will of the majority. **Health for All by 2000 AD** is not a programme that can be quietly forgotten once its period is over. Governments may do so. But people cannot allow that.

But how can we change policies made by bureaucrats sitting at distant capitals?

And often, even our own desibureaucrats are powerless. Decisions are already made by supra-government bodies. We live in a world ruled by a sole super power!



One weak chink in the armoury of the powerful is the constraint that wielding power in a democracy imposes on them!

And What's this Constraint?

In a democracy, the rulers are forced to win the consent of the people for their policies. When most nations are democracies, even international bodies recognize certain limits beyond which they cannot push governments.

Otherwise why would they talk of a safety net?



What are they doing

Defeating the Alma Ata and removing it from public consciousness.

What should we do

Build a public consciousness of this erasure – make people remember how they were conned into forgetting.

We must also challenge the false reasons that are created to explain the failure of the public health sector and manufacture consent for the health policies that flow out of structural adjustment and globalization.

We must fight this at the level of academics and policy statements, right?

Yes. But not only at that level! Remember – govt. strategy has always conceded radical positions in health policy documents. It is economic policy statements and health policy implementation that reflect the anti-people agenda.



Building up public consciousness also means that collective action must win immediate relief in health care, for health is an urgent and pressing need for the poor. It is in the course of such action that most of the poor will be able to enter and intervene in the decision making process. It is largely through such action that a genuine public consciousness can be shaped and the manufactured consensus for privatization questioned.

Collective action? What should that focus on? What policy changes do we want?

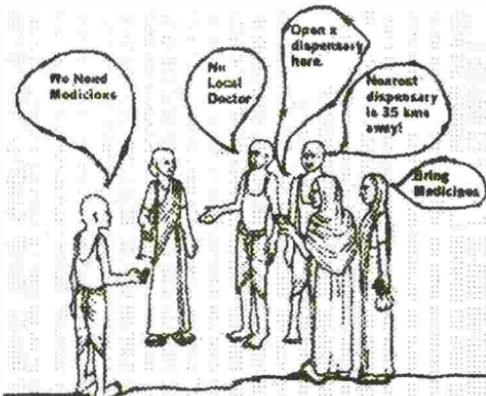


The Policy Changes We Want !

Ensuring Minimum Infrastructure

The Hardware: Cover every habitation, rural or urban, with a PHC. Gaps that need mending include:

- ☛ Opening PHCs in areas where they don't exist.
- ☛ Covering villages that get left out because of falling in between areas or being remotely located.
- ☛ Covering urban areas, especially slums and hutments – legal or illegal – particularly in district towns.



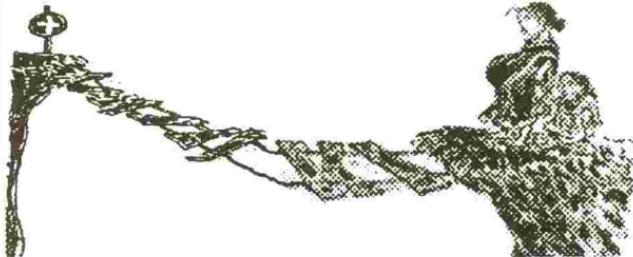
The Personnel: Ensure minimum staff in every PHC and sub-center. If you can't find the staff, allow the local body to fill the vacancy at its initiative. The government pays for the locally appointed person, till the contract period is over.

- ☛ Two medical officers per PHC must be the mandatory minimum. Many states have still got a one medical officer norm.
- ☛ Ensure the norm of 2 MPWs for every sub-center. Check absenteeism of the male MPW by closely monitoring his work. If community is organized, articulate, and actively facilitating their work, the problem of MPW functioning can be resolved. Appointing 2 women workers can be a way out. Or arranging for both to be paid out of state-funds.

- ☛ Ensure minimum service conditions for adequate functioning of cadres. A special rural allowance for doctors to offset loss of city allowances is desirable.

The drugs: Ensure that every PHC has a minimum supply of 60 essential drugs and the sub-center 25. Final choice of the 25 or 60 drugs is made from a state essential drug list based on the area health plan.

The question of Access:
Access to Primary health centers is another major issue. Concerns include:



- ☛ Good all weather road leading to the PHC and out of all habitations to the main road.
- ☛ Proper location or relocation of PHCs so that they are situated at a place where conveyance is easily available. The condition that the village should offer free land for a government to set up a PHC has usually meant a village bigwig donating low priority land, like land next to the cremation grounds, or land that is far from the main road and market. The land for PHC should be chosen at the local weekly or daily market village so that bus services are readily available.
- ☛ Mechanical distribution of villages to PHCs has led to sacrifice of geographical proximity and transport facility considerations.
- ☛ Provision of two wheelers for MPWs to access their field area.

Stronger Referral System: Link every PHC to a fully functional CHC by both ambulance and telecommunications so that expert advice and specialist care is brought much nearer the patient. The two-way referral linkages between PHC and CHC require that the CHC and all the 3 or 4 PHCs and the 18 to 24 sub-centers under it function as a single team. (Usually this means one team per block).

Broad-base secondary health care: A fully functional CHC implies the capacity to intervene in a high-risk childbirth, which includes the capability to carry out a Caesarean and manage a premature new born. Building such infrastructure takes care of all elements of secondary healthcare including the ability to carry out a wide number of investigations and surgeries. The provision of such a center for one lakh population is imperative.

Decentralized Health Planning



From top-down to bottom-up in planning



Ensure community, panchayats and local health officers are equipped and encouraged to plan for health needs in that area.

Community Health volunteers and grassroots health personnel generate data which forms the basis of health status report.



Village Panchayats and municipalities draw up comprehensive inter-sectoral health plans and are assisted in implementing them by the block unit.

The entire block unit participates in drawing up health status report and identifies health priorities.

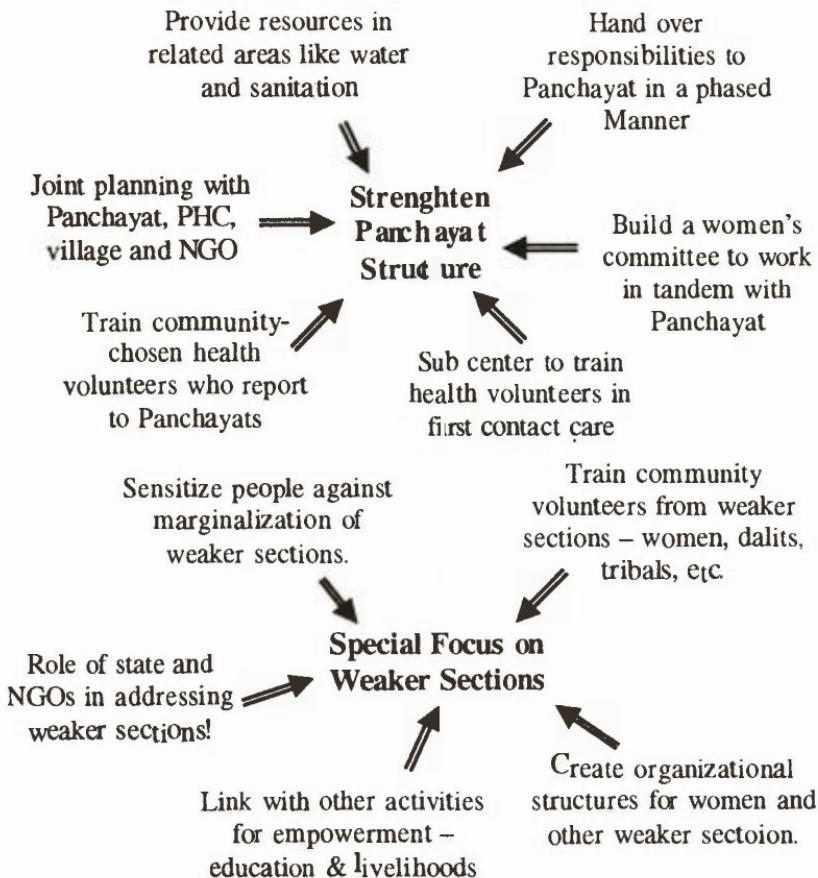


Provide **technical support** for the community planning efforts by linking each CHC to an epidemiologist (posted or available on consultancy from a medical college or from a qualified NGO).

For **resource support**, funds from all central and state schemes, especially the vertical disease control programmes, can be allocated to the block on different heads according to locally assessed priorities.

Monitoring programme effectiveness should be based on indices that are more reflective of the processes of health care rather than fragmented interventions. For example malnutrition in children, birth weight of babies, TB cases suspected on clinical grounds can be some indices. It should be based on health status assessment and involve private sector as well as community volunteers.

Building Panchayat Capabilities and Facilitating Community Participation



Other fronts in which we need policy changes!

1. Making Radical changes in medical education.
2. Ensuring Provision of Basic Needs to all.
3. Regulating the private sector and stopping its encroachment into public health. Ensuring no private practice for government doctors.
4. Strengthening ability of modern medicine to provide holistic care, resisting the trend to medicalize and mystify health and disease. Also resisting obscurantism and irrational understandings of medicine.
5. Systematic and urgent research on traditional health systems and efforts to integrate them into a holistic health care perspective. Efforts to document and preserve the knowledge base as well as conserve the natural biodiversity on which these systems are based.
6. Implementing a policy on pharmaceuticals that ensures adequate and self-reliant production of essential drugs at affordable prices and the banning of all inessential and hazardous drugs.

Local Health Traditions and Primary Health Care

India has a rich tradition in folk medicine as well as in organized non-allopathic systems of medicine like Ayurveda, Siddha and Unani. There is urgent need for systematic research & community-based evaluation of these traditions. Developing these systems, complementary to modern medicine and as part of a holistic healing perspective is possible and desirable. Immediately there is need to integrate some elements of local health traditions in primary health care. Local health traditions can be used to provide care for a large variety of simple ailments. They can also be used to provide relief in a number of chronic ailments, where allopathic care also only offers such relief but at much higher costs. Practitioners of these health traditions can also be involved in the prevention of disease and the promotion of health.

People's Initiatives

In vast areas of the country, the existing PHC network is dysfunctional. We also saw how in all areas there is a gap between the existing PHC network and the concept of Primary Health Care. The question is what we, as part of civil society, can do about it? What can People's Movements do and what can local communities do?

Below are some things that are possible:

1. Create awareness about health and prevention of disease.
2. Act as pressure groups to ensure that health priorities are attended to by the public health system and to ensure that the public health system functions optimally and the private sector functions ethically.
3. Ensure effective utilization of existing government schemes related to health, both by creating awareness and facilitating the functioning of these programmes.
4. Build capacities of panchayats to assess the health situation, to monitor and to facilitate the public health system and organize self-help measures by which considerable health gains can be achieved.
5. Organize massive training programmes and transfer of skills to representatives of the community. Such a transfer of skill will ensure that knowledge for most preventive, promotive and even curative care is available locally.
6. Build organizations of women and weaker sections to use health action as an entry point to contest their marginalized status.



Chapter V

Two Worlds, One Planet!

Let's look at the basic understanding of the **Health for All** slogan...

Health for All

Disparities in health status are unacceptable – whatever the reason!
Reducing the gaps our major goal!

Hey! But
the gaps still
exist!



There is large gap between the rich nations of the west and the health of all other nations! The top 25 countries are all European or North American (western) except for Japan.

	Top 25 countries	Developing countries	Last 43 countries
Life expectancy	76	62.2	51.2
Literacy rate	98.6%	70.4%	49.2%
Maternal Mortality (per lakh births)	30	488	1100
Under Five Mortality (per 1000)	16	65	171

Source: Human Development Report 1998, a UNDP document



And there is also a large gap within the rich nations - between the health of the rich and the health of the last one third.

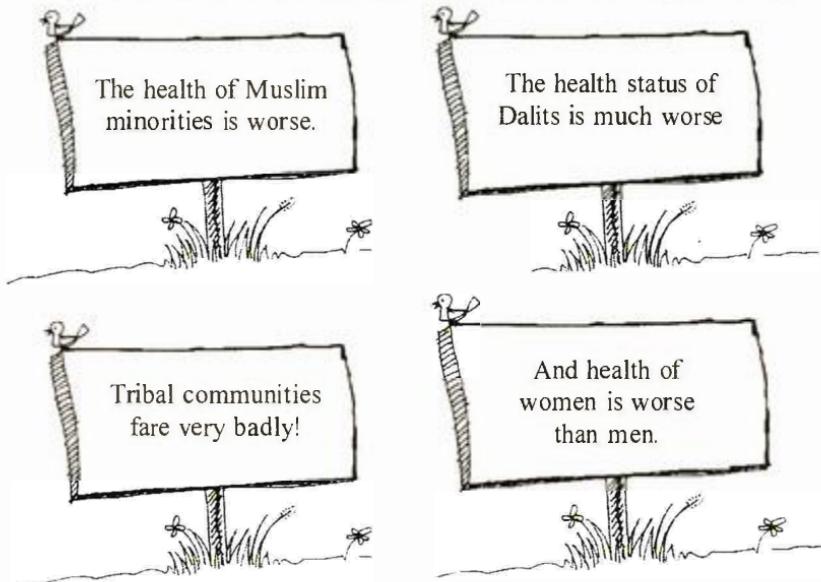
In a developing country like India there is a wide disparity in the health situation between states.

State	Under -5 mortality (NFHS)	Maternal mortality	Literacy rate	Access to safe water	Access to sanitation	TB Per lakh	Per capita income
Kerala	32	<200	89.6	79.2	63.1	504	5778
MP	130	>1500	43.9	65.9	11.0	686	4166
Bihar	127	>1500	43.8	68.8	7.3	496	3691
TN	87	400	64.1	71.6	11.1	583	5122
Punjab	68	500	60.2	96.1	19.8	230	6380
India	109	500	53.5	72.0	15.3	423	4485

Source: India, Human Development Report, Abusaleh Sharif, NCAER, OUP

The state with the best index is Kerala. It's under-five and maternal mortality rate are comparable to the industrial nations. In contrast, states like Bihar or Madhya Pradesh have very poor figures. Even states like Punjab or Maharashtra, which have a relatively high per capita income, have a relatively poor health status.

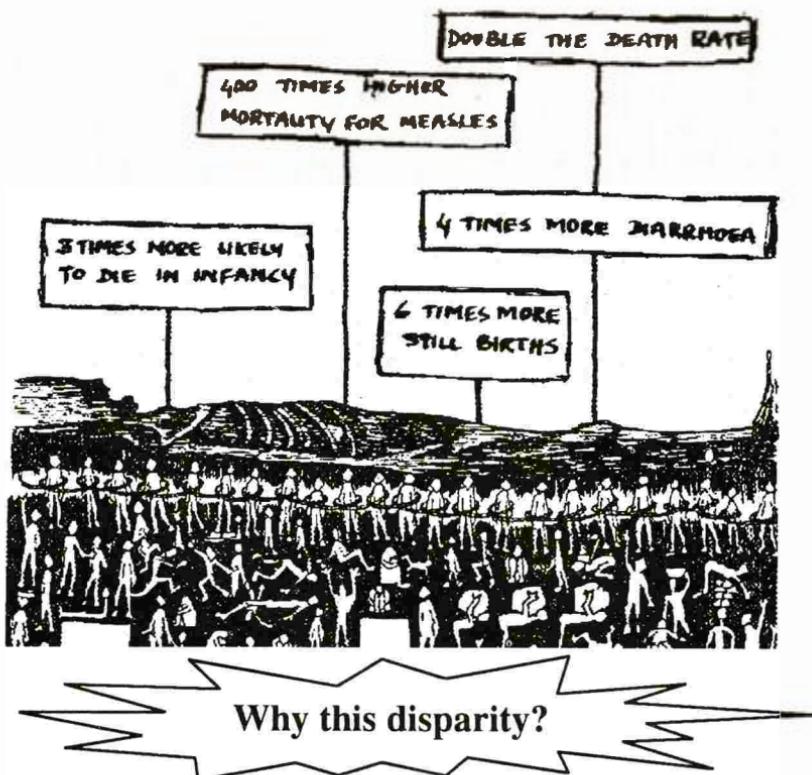
Within any state in the country there is a large disparity between many communities. What can that possibly mean?



**The poorer the family
the higher the chance of ill -health and sickness!**

Social group	Crude Death rate	Under 5 mortality
Tribals	9	129
Dalits	13	140
Landless wage earner	14	135
Above 86,000 per year	7	71
Upper Income Group		
All India Average	11	117

Source: India, Human Development Report, Abusaleh Sharif, NCAER, OUP



Because there is an unequal distribution of power and assets in society

A small privileged section has most of it. The deprived section has less income - therefore less food & basic amenities and lives & works in bad conditions. The poorest live in sub-human conditions, often worse than beasts. The rich on the other hand consume luxuriously and wastefully.

How much inequality are we talking about?

The money spent on perfumes in Europe and the US is enough (\$ 12 billion) to provide reproductive healthcare to women all over the world!

The money spent on cosmetics in just one country – USA, can provide basic education for all or can meet almost all the water and sanitation provision needed for all peoples of the world.

The cost of alcoholic drinks bought in Europe alone is \$ 105 billion. This is two and half times the cost of providing basic social services (basic health, including reproductive health, nutrition, education, water and sanitation) for the entire world. (This will cost about \$ 40 billion).

World's military spending at \$ 780 billion is 20 times the money needed for providing health, nutrition, education, water and sanitation to all.

The 3 richest people have more assets than the GDP of the poorest 48 countries and the richest 32 persons more than the GDP of all Asia.

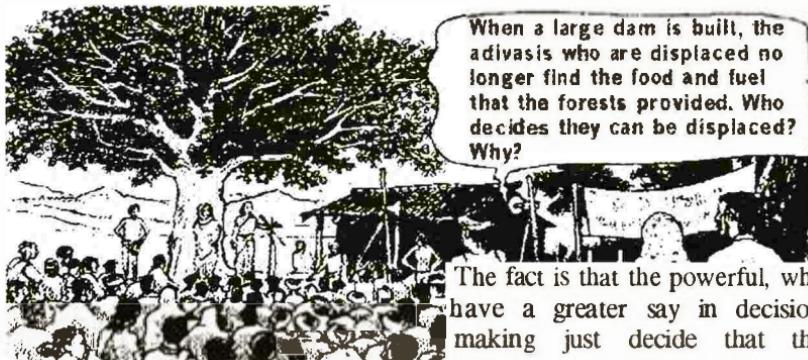
If the richest 225 people donate 4% of their wealth, the money to provide basic social services across the globe will be available.

Source: *Human Development Report 1998 - A UNDP document.*



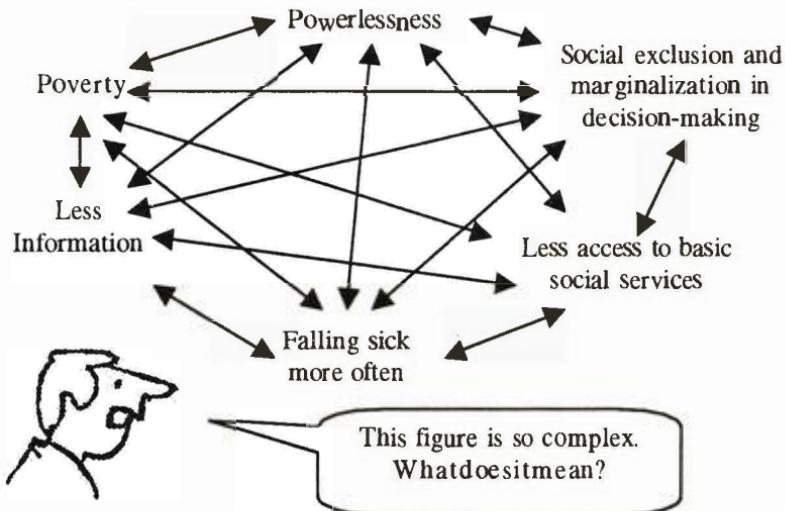
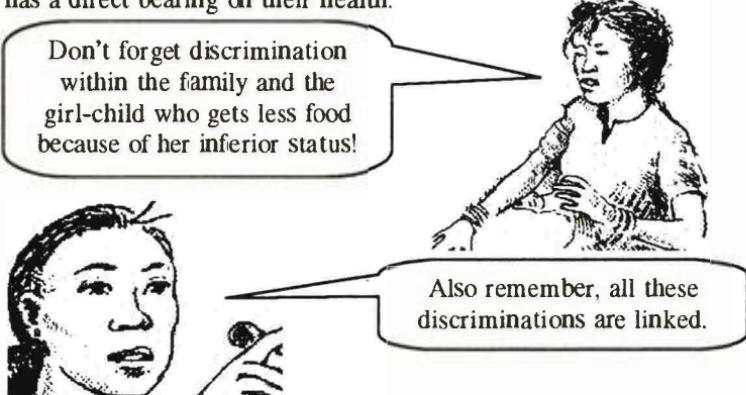
Hey! Don't start thinking that poverty and wasteful consumption are the only reasons for these disparities. Marginalization and social exclusion work in many ways....

The less powerful are actively discriminated against & marginalized from the economy & society. This reduces their access to basic necessities of life.



The fact is that the powerful, who have a greater say in decision making just decide that the priorities of the rich farmers and the cities who look to water from the dam is important, whereas the right of adivasis to their livelihood is not important. The adivasis are just not asked what they think about it!

Dalits in many villages are not allowed to access a clean water source within the village and have to either walk long distances or make do with unsafe water. This is form of discrimination – social exclusion – has a direct bearing on their health.



It is complex because discrimination is complex. Let's understand this...

The poor are powerless and the powerless are poor. Because they are powerless, tribals, dalits and women are excluded from decision-making. Because they are so excluded they have less power and therefore are poorer. Also because they are excluded, they have less access to basic social services. Because they have less access to social services they are sick more often and have even less income. Because they have less information, they are even more powerless.

Precisely because they are disadvantaged, the state should provide more services to these sections. It is the duty of govt. to address these inequities in health so that everyone is guaranteed a basic minimum health. What else is a government for?



Making the same investment and providing them the same access as those who have better social status and wealth is unfair. **Treating unequals equally is wrong.** Unequals must be treated unequally. The reality however is that, these sections that are not able to access even the existing state provided services.

Social Group	Literacy	% Immunised DPT 3 doses	% births unattended	% access to PDS	Per capita income
Landless labourer	36.6	58.4%	54.7	44.3	2308
Tribal	38.7	46.6%	68.1	37.5	3504
SC	41.1	53. 6%	62.4	32.1	3237
High income	74.3	77.1	43.4	28.0	17865
India		57.5	60.0	33.2	4485

Source: India, Human Development Report, Abusaleh Sharif, NCAER, OUP

Don't just give me figures!
Tell me what it means?



Deprived sections need 100% coverage by the state more urgently than the rest. At a per capita income above 17600 per year, a public distribution system is useful and 28% of these families have access to this. But at a per-capita annual income of Rs 2308, access to PDS is a must for survival and a full 56% of this section do not have access to it!

OK. So, have we looked at all the kinds of disparities possible in a country with a skewed development like ours?





Hey! How about the disparities between India and Bharat?

And between the urban rich & urban poor too.

Also, don't forget that disparities between social groups is more in the large Hindi speaking Northern states!

Are such disparities acceptable?

Certainly Not!

தனி ஒருவனுக்கு உணவில்லை எனில் ஜகத் தினை அழித்துவோம் !



If a single individual does not have food to eat, we will destroy the world!

- Poet Subramania Bharati

We have a duty!

Every single individual should have the minimum material necessities for a human existence.

Neither governments nor communities can ever be excused any failure to ensure this!

Do you know why the rich countries are rich and why the poor countries are poor?

Because they work hard and are more enterprising?



How quickly we forget! And it is only 50 years since we became a republic – after such a glorious freedom struggle!

All western nations were colonizers and the entire poor underdeveloped world was colonized and looted by the colonizers.

Man's struggle against oppression is a struggle between memory and forgetfulness!



MILAN KUNDERA

Some western countries like Switzerland or Sweden never actually held colonies but were part of the same economy, acting as its bankers & traders!

Japan is an Asian country but it is part of the industrial world. That's because it was the only Asian country that was never colonized and was the only Asian country that actively colonized other countries.

The rich are rich because they looted the poor!

Talking of disparities... Are they not inevitable ?

Can all five fingers be the same ?

Are not these differences natural ?

Certainly Not! I think you need some history lessons...

But, I don't like history!

And that's why you believe in nonsense like 'disparities are natural'!

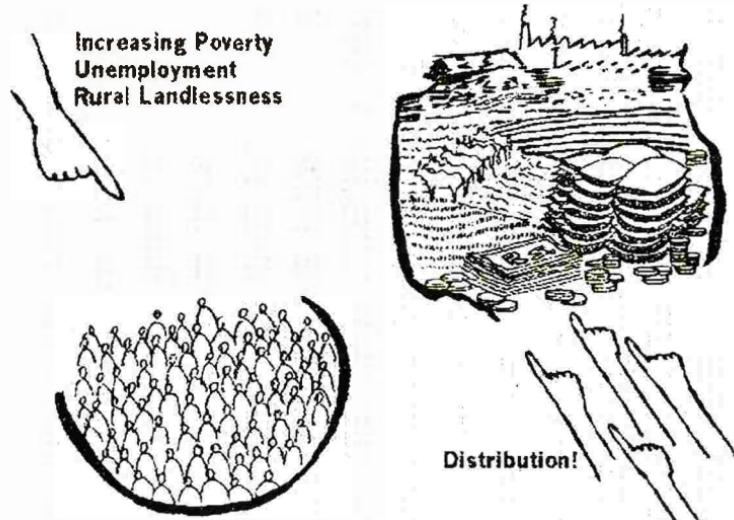


During a certain period in history natural resources held in common were wrested and made the private property of a few. Similarly, assets created by the labour of all came to be owned by some. Often this was achieved by brute force. By declaring that some people were not humans and therefore had no rights. This way the Native Americans were wiped out by white settlers of the Americas, and the invading settler-farmers in India conquered the tribes. This is also the way common village land became the zamindar's property with the permanent settlement act! And the way irrigation water became private property with the energized tube well. Since the few who now held property and power could also have a major role in shaping culture and beliefs, even the memory of the loss became blunted over time. But it never quite disappeared...

The urge to freedom, to basic human rights cannot be obliterated! It is an essential value of all societies.

The fight for adequate access to social services is the fight against discrimination and inequity. Better health and education empowers these sections to challenge discrimination in all aspects of life.

All right-thinking men and women - and not just the marginalized- should join this struggle !

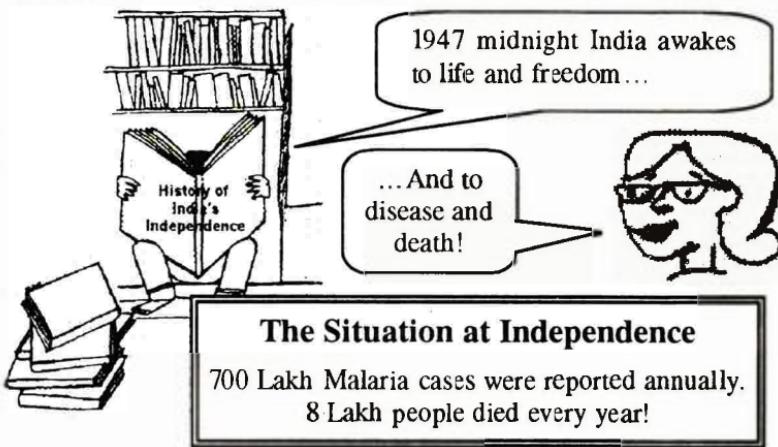


Winning the war: Malaria Recedes...

Chapter VI

Case Study: The War Against Malaria!

Lessons from a war that was won and then lost!



What a shame for a democratic state! We must act at once.



The Solution Proposed...

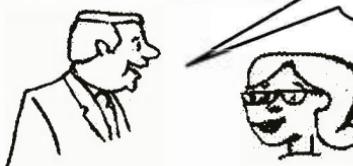
Spray DDT and eliminate all the Anopheles mosquitoes!



Even though other options were considered, DDT spraying along with giving chloroquine for those affected with malarial fever was the mass-scale solution. In every block, malaria workers were appointed for both spraying DDT and for taking regular blood smears to detect outbreaks early. Supervising them were a hierarchy of officials leading all the way to the National Malaria control office at Delhi.

The result was that Malaria fell rapidly. By early 60s there were only a few lakh cases annually.

1965 – our best record! Only 60,000 cases and no deaths. We have won the war !



It didn't! Malaria started to rise again. By 1972, the cases had gone up to over 70 lakh a year. Plans were revised and once more the war started. But this time after lowering the incidence to 20 lakh cases annually and about 30000 deaths by 1985, no further decrease was possible. The incidence actually started to rise again. Painstaking estimates by independent academicians puts the incidence now at about 200 to 300 lakh per year. And is 10 times the government's figure.



Whereas, government estimates are based on positive blood smears reported to them, the independent estimates are based on anti malarial sales and estimates drawn from surveys where prolonged fever is reported. There is every reason to believe that the government figures would increase and show the real figure if cases seen in the private sector (where over 70% of fever cases report) are included and if government does more blood smears.

Worse – more & more malaria cases are now due to a parasite called plasmodium falciparum. This causes more sickness & more deaths & is often resistant to drugs.



Result: The real estimate of deaths is likely to be in the range of 75,000 in 1987. The government only reported 188 deaths.

→ Malaria is also now occurring in many urban areas and newer areas where it has never existed before.

We have to accept that the Malaria programme failed!



Why? Why did it fail? We tried so hard this time...

Many answers have been offered.

The Causes of the Failure !

The insect vector developed resistance to DDT.

Doctor

Carelessness and apathy in vigorously maintaining spraying once the incidence came down. Sustained attack on vector absent.

Administrator

Economist

Not enough money for drugs. And not even for research.

Health Administrator

No! Integrating anti-malaria work into the PHC was the main mistake. We should have retained the cadre of uni-purpose malaria sprayers!



Full points, gentlemen. You are all right. But incomplete and therefore wrong!

The spread of malaria depends on a specific relationship of the parasite, the mosquito and the human, a relationship that depends on the environment – both natural and social environment. Because of this, the exact causes and mechanisms of spread vary widely between one place and another.

Look at the five situations below...

Rajasthan

Major outbreak of Malaria along the Indira Gandhi canal system. Migrant labour from endemic Bihar introduced the infection in this area. The vector bred in waterlogged areas adjacent to the canal especially in areas where seepage was high. Estimated deaths - over 4000. Fortunately there were few resistant strains. However the number of cases who died as compared to those who had fever was high.

Urban South Madras

It has about half the cases of malaria that occurs in Tamilnadu. The vector breeds exclusively in fresh water wells and overhead tanks, collections of rain water in tins or tyres lying around. Most of the parasites are plasmodium vivax sensitive to chloroquine but occasionally also the odd case of resistant vivax or falciparum. This is largely an affluent part of the city except for a few slums where the fever cases are more.

Northern Maharashtra

Here Malaria is low in incidence though showing a mild tendency to increase. The dangerous situation here is that the vector is resistant to all three - DDT, BHC and Malathion. There are however no Falciparum cases.

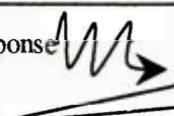
Assam

Every year after the rains there is an outbreak of malaria. The usual insecticide spraying does not seem to help. Each year the number of cases is on the increase and more resistant strains of the germ is being seen.

Tribal District in Orissa

Major malaria prevalence. More than 30% of the children have enlarged spleens. Malnutrition is predisposing people to infection and more deaths. Most parasites are of Falciparum variety and Chloroquine resistant. The mosquitoes breed in forest streams, collections of rainwater in the trees and in small depressions on the forest floor.

The 60s response

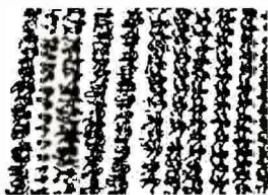


Intensively spray chemical pesticide again and again in all the five places.



Also, those who get fever should take a course of 4 to 6 chloroquine tablets.

In the 1960s all the above five reports would have met with the same technical response. Needless to say in most of the above places it would not have worked. In some places where the mosquito is sensitive to insecticide it would have worked for some years and then the mosquito would have developed resistance.



Friends! Countrytoes!
Join us in the resistance
against the DDT
invaders.

The 90s response 

Still the same! Except for more regular taking of blood smears for surveillance and more powerful insecticides and drugs against the vector and the parasite.

This is a technology centered, fragmented, administratively driven vertical intervention. Such interventions may or may not be successful in the short run, but invariably in the long run they always fail.

Technology centered 

Sees the disease as being caused by a parasite and a vector and fails to see the social and ecological setting of the disease. Thus response is based on a technology attack against the parasite or vector.

Fragmented 

Only one or two of all the factors that go into the disease setting (and that too in isolation) are sought to be addressed.

Administratively driven and vertical 

The entire planning and packaging done in Delhi (or New York). Only local thing about it is the application (under a chain of command). No role for community participation. No local planning. Of course, no question of technology choice.

The Result 

An inappropriate package for local needs. Local people are indifferent - sometimes even resist. Finally, even the administration cannot in perpetuity keep its attention on this programme alone.



What other disease control programmes in India have been like this - technology centered, fragmented, administratively driven and vertical?

The List of Culprit Programmes

The Malaria Control Programme, The Filaria and Kala Azar Control Programme, The Leprosy Control Programme, The Family Planning Programme, The Vitamin A Administration Programme, The Diarrhoeal Diseases Control Programme, The AIDS Control Programme...

My God! You mean all of them?

Yes! The vertical approach worked for Small Pox eradication. But for most other diseases, it did not work. Its biggest failure was MALARIA.

Then, how do we make these programmes work?

- ☛ Plan locally and holistically emphasizing socio-economic, cultural and environmental factors.
- ☛ Involve the community in planning and implementation. Make institutional arrangements to facilitate community participation.
- ☛ Make arrangements for adequate surveillance with inputs from the community, the private sector and the state health sector.
- ☛ Make the minimum resources needed for this approach (and this is usually cheaper than vertical approaches) available through the state health sector.

I almost forgot! What is the right thing to do in those five places?



There are a host of choices and we can choose the most appropriate for our place and situation. Let's look at the technical options available...

Personal Prophylaxis

- ☞ Impregnated nets or Ordinary mosquito nets.
- ☞ Commercially available insect repellants.
- ☞ Local herbal fumigants and herbal repellants.
- ☞ Chemo-prophylaxis – taking a dose of anti malarial drug daily.

Environmental Management

- ☞ Filling up ditches & pouring kerosene on small water-collections that can't be filled up. Regularly (especially after rains) checking for collections of water in upturned trash tins, hollows in the tree bark, rubber tyres and other such spaces and emptying the water out. If done once a week - if we ensure that stagnant water does not stay for more than a week – this is adequate to prevent malaria breeding.
- ☞ Ensuring water tanks have covers that prevent mosquito access.
- ☞ Clearing ponds of excessive vegetation and introducing larvical fish in ponds and irrigation tanks.
- ☞ Changes in irrigation practices like draining of standing water in rice fields at least once in 5-7 days to combat mosquitoes breeding.
- ☞ Planning all development & construction projects (roads, canals, buildings) so that there is adequate drainage & stagnant water collection is prevented.

Spraying Pesticide

- ☞ In house walls after identifying which are the most likely places for mosquitoes to rest. Some species rest on the high walls, and some prefer the bottom. Some do not rest on walls at all.
- ☞ As fog to knock down flying mosquitoes – generally useless though it is very impressive. Sometimes this may be needed in places where a huge crowd is likely to assemble or at travel points like airports & stations.

Drug Treatment

- ☞ Identifying fever cases early and prompt and full treatment.
- ☞ Giving a round of anti-malarial to the entire population!

To ponder over...

Which of the above measures the health department staff can just not implement? Which need the active cooperation of individuals? Which measures need collective action by local communities - they can neither be achieved by individuals, nor by the department? Which of the above needs departmental intervention?

Coming to what can be done in some of those five places...

In Bastar – The Elected Panchayats and specially created Women's Health Committees were motivated to take up this task. To cut transmission of malaria – which was due to high prevalence of disease and high mosquito population in their area – they used impregnated nets and administered chloroquine to all suspect fever cases. Some indoor spraying was done but was given up when the entomologist opined that this sub species of mosquito does not rest on walls.

In South Madras – Indoor spraying does not help. What is needed is a massive mobilization, so that all the potential breeding sites are identified & managed by volunteer brigades. A good way to manage breeding sites in open wells & in seawater along the coast, isn't clear.

In Rajasthan – Better drainage along the canal is the key issue. Improved surveillance, timely treatment, providing health care for migrant labour and the active involvement of a number of local voluntary organizations (Lok Jumbish was one such organisation) were able to control the epidemic. Vigorous spraying operations could help in the short run as insecticide resistance is low, but if drainage does not improve then such resistance is likely to develop soon.

Moral: Beware of vertical programmes. The emphasis should be on local planning, adequate surveillance and on community participation.

Policy Recommendations For Malaria Control

Estimating disease load and surveillance

Make reporting all malaria cases compulsory and operationalise a district level system where regular reporting from multiple sources is collated and a feedback provided. Ensure lab-technicians at the PHC level are present and functional, conducting minimum number of smears needed for effective surveillance.

Decentralize the Planning

Each district should draw up its plan according to local-specific conditions. These plans must be holistic drawn up after studying:

- ☞ The resting, feeding and breeding behaviour of the local vector.
- ☞ Reasons for increased availability of breeding sites.
- ☞ The exact parasite type and whether it is resistant.
- ☞ The mosquito's insecticide resistance, as well as social and cultural determinants of the disease in the area.
- ☞ Other vector borne diseases in the same area.

Community Participation

Both planning and implementation needs the active participation of the community. This means:

- ☞ Creating an institutional mechanism by which the community including the local elected body can participate.
- ☞ Initiating a process for capability building and empowerment of the community. Most important in this is public education.

Resources

The minimum resources and infrastructure should be made available through the local health department. This includes:

- ☞ Adequate anti-malarial drugs and anti-mosquito insecticide.
- ☞ Two multipurpose workers per sub-center with adequate mobility.
- ☞ Adequate equipment for both the laboratory and for spraying.
- ☞ The ability to procure other inputs like fish seedlings or fair priced impregnated nets etc.
- ☞ Resources needed for the provision of basic drainage and other public works to build a healthy environment should be available.

In principle, the government does not refuse the role of either local planning or organizing the community. These measures are accepted on paper. However in practice the government takes no initiatives for this.

People's Initiatives For Malaria Control

We can petition, lobby or pressure the government to take the policy changes suggested above. We can even organize agitations for this. In which case a few token gestures may result. Often the response is something dramatic and visible and rather ineffective. Like the fogging of pesticides or killing of pigs every time there is an outbreak of encephalitis. Instead, we can organize people and with the help of suitable resource persons, begin local planning and community initiatives. Note that much of the technical options outlined in the earlier page can and must be done by the community. While we take such initiatives we can bring pressure for appropriate supportive measures by the government health department and other concerned departments. Done in this manner the voluntary work becomes an instrument of advocacy for policy change; it acquires a political character – like a Satyagraha. And yes, the means would be meaningful in itself! At least some awareness and some amelioration of the problem may result as an immediate outcome!

Case Study: Strategies for Tuberculosis Control

Tuberculosis
Public Enemy Number 1!



Tuberculosis is a sensitive index of a nation's poverty. There is a direct relationship in almost every society between poverty and the prevalence of tuberculosis. Tuberculosis is also a sensitive index for the state of public health services of a nation.

 This is why even governments, which don't care much for equity, have addressed TB as a minimum social service provision.

Of course apart from legitimacy, there is also considerable concern at the infection spreading to other more affluent sections!



And for a good reason! TB is chronic, slowly debilitating and leading ultimately to considerable suffering and death. Not without reason was *consumption* - as it was called earlier - the most dreaded of diseases.

1947
Population: 300 Million
Suspected TB-Infected: 200 Million!!

 But most people who have TB germ do not develop the disease...

1947
TB disease: 2 Million
Death by TB: 5 Lakh Annually

 ...only those whose body resistance is lowered develop the disease.

That's why
TB is an index
of poverty

 Therefore the poor
are most affected!

 Resistance is lowered because
of malnutrition, other diseases,
overwork or poor working and
living conditions...

What is the situation today?

The same of course! Why else would we need this chapter!



The lower death rate is due perhaps to the much better drugs available now.

This makes us the Nation with the Maximum Number of Tuberculosis affected people in the world!

Now - 50 years later...

Active disease: 13 Million
(6 times the earlier prevalence!)

Infectious Stage: 2.5 Million

TB Deaths: 5 Lakh Annually

Now, let's see what measures were taken to control it and how it failed.

The District Tuberculosis Programme - DTP

After independence the govt. started making plans to address the TB problem. Based on carefully done studies led by the National Tuberculosis Inst., a better understanding of the disease and the way people respond to it was gathered. The highlights of this understanding:

- ☞ 3 to 5 per thousand have active tuberculosis.
- ☞ The disease has a rather uniform spread across the country.
- ☞ < 10% of the cases have access to treatment or even diagnosis.
- ☞ At least 50% of people with symptoms had sought medical help but in over 90% of cases they had been sent back with a cough mixture. Even the rest were conscious of their symptoms & desired medical help.
- ☞ Diagnosis can be inexpensively and reliably made based on symptoms alone with confirmation by sputum examination
- ☞ Domiciliary treatment is adequate and seldom do patients need to be hospitalized

Therefore, the DTP sought to evolve a strategy based on the fact that cure for tuberculosis was a felt need and the primary task was providing access to services of adequate quality.





Idea! Let's integrate the DTP with the PHC!

And so they did! It was expected that persons with symptoms coming for help to this system would be examined for the bacilli in their sputum and would be followed up. The PHC would have a lab technician and the sub centers would have a multipurpose worker who would attend to case diagnosis and follow up. The presence of a PHC with a lab technician and health workers would make it possible to improve other general health services with the same investment. If one worked the rest also would succeed!

Sounds like a great idea to me



It was a great idea. There was just one flaw – the DTP was slated to sink or sail with the PHC and the PHC sank!

The DTCP Shall Swim or Sink with the PHC



Sinking with the PHC...

In over 50% of villages and in urban areas effective primary health coverage was not reached till the eighties. Even now, in terms of lab technicians and male multipurpose workers who are assigned TB control duties, the vacancy situation is alarming.

The central reason for the failure however, was the take over of the primary health center by a few vertical programmes.

The Grand PHC Highjack !

50s-60s: FP and to a lesser extent malaria.

70s and later: FP and Immunisation and to a lesser extent Ante-natal care.

Wow! And I thought only planes are highjacked! How did this PHC highjack happen?



Well, each of these programmes, like FP or immunization, was designed for implementation in a top-down fashion and was rigorously monitored, pushing all other activities out. TB was one such activity that got marginalized. Also, at no time was the community involved.

And now we enter the late 80s...

This TB thing is just not working out!
What do we do?



In the eighties, short course chemotherapy with Rifampicin was introduced into the DTP and it did not make much difference. Of course no one was surprised! If anything, because of frequent shortages and supply constraints of this costly drug, case-holding (follow up) became even more difficult to achieve.

Oh, No!
Please No More
Dataaaaaaa.....



1994

- ☞ 391 DTPs operating out of a total of 496 districts.
- ☞ 17381 Public Health Institutions (PHIs) in these 391 districts – average of 44 PHIs per district.
- ☞ Of these 391 districts, 252 have ongoing SCC programmes.
- ☞ Each district has a District TB Center (DTC) that supervises, provides referral back up and training to the workers in the PHIs.

With this infrastructure, in 1994, on an average...

6465 new X-ray examinations and
11094 new sputum examinations are done per DTP.



Of these, 3788 were diagnosed as TB though
only 770 (20.3%) were sputum positive.



X-ray diagnosis was 73.9%
which means a lot of false positive cases were on treatment.



Part of this is due to poor
performance of the sputum
test that misses about half
the positive cases.



Assuming all the cases diagnosed were put on treatment,
only 35% completed treatment!!



Completion rates were
worse for the biweekly
intermittent regime.

Private sector is playing a major role
in TB control, as most people with
symptoms prefer to go there.
However studies show very poor
quality of treatment there. Relapse
rates and drop out rates are known.



It is estimated that only 30% of potential open
or sputum positive cases are being diagnosed
as of now. That would mean that the cycle of
transmission continues undiminished.



Eureka! I have found a new disease!



The Rediscovery of Tuberculosis

In the late nineties tuberculosis became
a central issue again. One reason was a
number of articles that started
appearing abroad on the theme of
tuberculosis - the global epidemic or as

the forgotten epidemic etc. The AIDS related TB increase was also a threat. In 1991, it regained priority within WHO as well. In 1997 the World Bank offered to give a loan of 440 million dollars.



Here's the deal buddy. Sign on the DOTS and we will give you a \$440 million loan.

The WB was very insistent that they would fund only if the DOTS approach was followed. DOTS stands for - Directly Observed Treatment – Short course. It is also called the Revised National Tuberculosis Control Programme (RTCP). In contrast to the earlier programme there was little study or consultation before the new plan was drawn up. No studies were done on the effectiveness of these approaches. The major changes were:

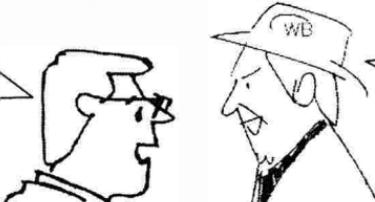
- The programme was limited to 105 districts - 41 in the first phase, 40 in the second phase, 24 in the third phase.
- In these districts the treatment profile was standardized & there was a shift to a regime with higher dose, intermittent, with higher costs.
- The heart of the strategy is to watch the patient consume the tablets. Apparently the presumption is that an Indian patient cannot be relied upon to take the drugs to save himself and only the DOTS approach can ensure this.

The implications of DOTS

There are a number of objections to the DOTS approach.

☞ The programme is limited to only a third of the districts. A high coverage in such a selective manner is not likely to slow down spread in other areas, and after this intensive phase is completed it will not prevent spread in this area either. Moreover, the rationale of choice of districts is the highest likelihood of showing a reduction. Therefore of the 105, 14 are from Kerala as compared to 16 from the 4 states of Rajasthan, UP, Bihar and MP put together! From Rajasthan there are only 3 districts and from Madhya Pradesh only 4 districts.

But Kerala has no need for directly observing patients swallowing tablets!



Never mind!

☞ The insistence of direct observation is leading to a number of cases – about 40% to 70 % - being thrown out of treatment. If the health staff find a patient unlikely to come regularly thrice a week they just do not start treatment for him/her. Rather they prescribe drugs from the market. The poorest and sickest are the least able to come and so don't get treatment.



This programme has an apt name: DOTS - Denial Of Treatment to the Sickdest!

☞ The intermittent regime being followed for DOTS may be associated with a higher relapse. The evidence is not clear. What is clear however is that the chances of transmission are not less under this approach. Even if case detection and treatment is over 80% - and it is not – the spread would be the same as in the earlier approach.

Also remember: The DOTS drug course is a lot costlier!



Despite such reasons many people think it wrong to oppose the DOTS approach!



Why?

They argue that the DTP has failed and there are no funds. If the WB is giving funds for drugs, this will lessen some suffering, even if only for a limited number of districts. So why not?

But isn't the WB money a loan to be repaid? Why take a loan to do something so useless?

Exactly! Especially when there were alternative approaches possible! Approaches that can get more out of the basic DTP strategy if tried in a complementary manner.

Also, these alternative programmes are based on Indian experiences and Indian expertise – and so the results are likely to be much better. These approaches were open to discussion . They did not have to be pushed through a small section of the bureaucracy as DOTS has been done.

As if I like to die! If drugs are regularly available why won't I take it? How could someone have come up with such an obviously stupid idea?



Much of the "good" results due to DOTS is due to the good drug supply (and the careful selection of cases). Direct observation seldom happens in practice. Health workers learn to make adjustments with the local community and leave a week or months' drug supply with them. Junior officials flex the rules at field level while maintaining the correct stance with officers. But policy makers attribute the success to their policy whereas in reality, the limited achievements are due to how people cope with policy! Had policy makers read the correct lesson the alternative approaches would have been obvious.

Alternative Approaches In Tuberculosis Control

Many NGOs have shown that it is possible to involve the community in case detection and case holding. Most of these approaches involve a public education programme, and the formation of organizational structures at the village to help in case detection and case retention. A referral linkage to a hospital equipped with a simple laboratory for sputum examination and where drugs are available free has been an essential component of most of these programmes.

Recently in Tamilnadu, in about 40 villages the TNSF tried an approach that was community centered and community led.

We are helping panchayats in our block to hold TB case detection camps. Would you like to hold a camp in your village?

OK. But what should I do?

First let's call the PHC doctor and nurses and fix a date. We should also make arrangements for a public meeting where the doctor can speak. We should also arrange for their lunch.



You should select a group of volunteers for the camp – we will train them for half a day. Then they should go to each house and enquire whether anyone has the cardinal symptoms of tuberculosis. If they have, then according to the symptoms these volunteers should categorize into one of four grades. 'Almost certain TB' cases should be given a grade of A or B, '50% chance of TB' cases should be graded as C and 'very unlikely but still needs to be confirmed' cases should be given a D grade.



On the camp day, they should ensure that all four groups come and test their sputum.

After the camp, the volunteers should ensure that the suspect cases receive further diagnostic follow up and that those diagnosed are initiated on treatment.

The Actual Experiences

- ☞ Follow up was a problem as some doctors were reluctant to diagnose cases in the public sector. They wanted patients attend their evening clinic. Some doctors were more conscientious. Some doctors refused to come to the camp and the suspect cases had to be taken to the PHC.
- ☞ The quality of sputum testing was poor. The District Tuberculosis Center only took a limited number of X-rays every day. A number of sick people died on follow up while the system still refused to reach a diagnosis or even had excluded the diagnosis.
- ☞ Many patients with blood in sputum were turned back as "Sputum Negative, Not TB", without concern for the alternative diagnosis.
- ☞ The system also tended to exclude the very old even though they were frankly tuberculous and sputum positive. It was only by showing affected children in all these houses that the programme could prevail on the health system to initiate treatment.
- ☞ Case holding was assured by talking to the family and to concerned neighbours. In places, the programme persuaded the nurse to give the monthly medicines through the village volunteer or even use her services as a depot. This saved the patient the task of going to the PHC and ensured better monitoring locally.

The Main Lessons Learnt...

1. Almost always the community, and quite often the elected panchayat are willing and active partners in controlling TB in their area.
2. The system built to tackle this disease, on the other hand, needs a lot of persistence before it responds. Left to itself it cannot deliver.
3. With persistent pressure from the people however, in most cases, the government system does respond.
4. Since there is no absolute lack of drugs or staff (in the TN situation) considerable changes can be made with such pressure alone!

Area Covered Under The DOTS Programme

State	Districts in year I	Districts in year II	Districts in year III	Population Covered (in Lakh)
AP	1	-	-	35.5
Assam	1	-	-	11.6
Bihar	2	5	-	211.6
Delhi	1	-	-	100.0
Gujarat	5	8	6	451.4
HP	3	3	6	68.5
Karnataka	2	4	1	198.2
Kerala	7	5	2	311.7
MP	1	1	2	26.0
Maharashtra	3	-	-	176.4
Manipur	1	-	-	10.0
Rajasthan	1	-	1	67.1
Tamilnadu	2	3	1	168.6
UP	2	2	-	96.4
West Bengal	6	7	5	642.0
Total	38	38	24	2710

Policy Recommendations and People's Initiatives For Tuberculosis Control

Blind adherence to foreign prescriptions, especially those that come with a loan attached are to be guarded against. Such programmes are donor driven. We have to create a situation where the government's health programme is people driven. The best way to do this is to mobilize people against tuberculosis. Detect thousands of symptomatic cases, and demand that the public health institutions treat them. Refuse to be thrown out by DOTS or similar strategies. Make our own collective arrangements to treat them if they don't. As a form of Satyagraha, one could do the camp inside the PHC premises!

Remember: The mobilization against tuberculosis has the potential to transform into a mobilization against the conditions that make tuberculosis so prevalent.

In the immediate efforts to relieve the suffering of tuberculosis there are only two mantras:

- ☛ Minimum resources - infrastructure, human-power and drugs - in the public sector with adequate access to these facilities.
- ☛ Community leadership at all levels of the programme. A people driven programme, where the public sector is kept under constant pressure to respond at utilize its resources optimally.

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