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World Bank and India's Health Sector

-T.K. Sundari Ravindran[1]

1. Background

The World Bank's involvement with India's health sector dates back to 1972 with the funding of the First India Population Project (IPP). Between 1972 and 1988, the World Bank (WB) funded five India Population Projects. During this period, the Bank's role was limited to helping the government of India implement its Family Welfare Programme. According to a review of Bank's activities carried out in 2002, the Bank did not have much influence on the direction of these programmes (1).

After 1987, following a reorganisation in the Bank, sectoral work began to gain more prominence. A number of studies were carried out on India's health sector and in 1992, the Bank funded the first free-standing health project. Currently (2007), there are five specific disease-control projects (Cataract blindness, leprosy, TB, malaria and HIV/AIDS) and nine health system development projects being supported by the World Bank.

The nine health system development projects are being implemented at the state level, and aim to reform the health sector in fundamental ways. This paper focuses on the health system development projects and the changes that they have attempted to bring about, and the outcome of these projects where these have been completed and end-of project evaluation documents are available. The information presented draws mainly on World Bank Project Appraisal and Evaluation documents.

State Health System Development Projects provided the Bank "with an opportunity to influence more fundamental determinants of how public health system works, to do at the level of the states, which are responsible for health care, and where the Bank can have more leverage than is possible at the national level" (1, p.73).

A 1997 document of the World Bank makes recommendations for policy directions to be adopted by State Health Systems Development Projects (HSDPs), and an examination of the project components of HSDPs show that most of these were taken on board.

Some important recommendations were that State governments should:

- Develop Essential packages of services to be publicly funded. These should be based , among other factors, on considerations of cost-effectiveness of and large positive externalities of interventions
- Create an enabling environment for greater private sector participation in health, through for example
  - fostering public-private partnerships
  - promoting the expansion of the private sector especially where they have comparative advantage, such as super-specialty and support services
  - providing incentives and developing schemes to finance, train and integrate private providers in case-finding, diagnostics and treatment for priority health problems
- Increase opportunities for contracting out of non-clinical and clinical services, because contracting was "more efficient and effective than directly hired labour" (2)

2. Components of State Health Systems Development Projects

The first state level project was the Andhra Pradesh

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First Health Referral System Project, implemented during 1995 -2002. The objectives of this project were to:

- "Improve efficiency in allocation and use of health resources through policy and institutional development
- Improve systems performance of health care through improvements in the quality, effectiveness and coverage of health services at the secondary level to better serve the neediest sections of society" (3, p.15).

A series of policy reforms were spelt out in a Health Sector Development Policy Statement of the government of Andhra Pradesh (AP), towards achieving the first objective. Investments were to be made in improving physical infrastructure and clinical quality and effectiveness in the 21 district hospitals and 49 Area hospitals and 80 Community hospitals. Assessment of the first objective was to be based on timely implementation of the policy reforms. The second objective was to be assessed through a set of indicators of hospital activity, efficiency, quality and access indicators (3).

As part of policy reforms, user fees levied were to be increased at all levels of hospitals for outpatient services. While there is mention that the introduction of user fees was to be done "while protecting the poorest section of society", criteria for exemption of the poor were not clearly spelt out. Another source of revenue generation was to be through setting up special outpatient clinics and diagnostic services for the private sector.

The proportion of pay-ward beds was to be increased to at least 20% in all district and Area hospitals. The project was to add incremental beds to district and Area hospitals, and 65% of these were to be allocated as paying beds. Paying beds were to be of three categories: A, B and C, and the bed charges were to be Rs 50, Rs 30 and Rs 5 respectively. However, only 20% of the paying beds were to be Category C, thus reducing the proportion of beds available for low-income groups that are not below the poverty line. Those in Category A and B beds were also to pay for major and minor surgeries. Drugs, disposables, X-Rays and ultrasonography were to be charged separately (3, Annex 4).

Contracting-out of services to the private sector was to be actively pursued. In terms of involvement of the private sector in health, the document talks mainly about monitoring the quality of services and improving referrals between the private and public sectors.

Another reform measure was to maintain the share of allocation to health in the government budget "at least at current (1994) levels", and increasing the allocation for primary and secondary care as compared to tertiary care (3).

The Andhra Pradesh Project was followed by the Second State Systems Project covering West Bengal, Karnataka and Punjab, implemented starting 1996. The main objectives of this project were very similar to those proposed in the Andhra Pradesh project, and included maintaining the share of allocation to health in the state budget and increasing the proportion allocated to primary and secondary care levels; expanding access to health care for the neediest sections of society; increasing user charges for outpatient and in patient care and increasing the proportion of paying beds; encouraging contracting out especially of "support services", and reviewing the role of the private sector (4).

However, there were some important differences in the Second State Systems project as compared to the AP project especially where the role of the private sector was concerned. In Karnataka, the proposal was to develop a legislation to regulate all medical institutions, public as well as private. In Punjab, regulations were to be implemented to improve service quality, and the Nursing Home Registration Act was to be implemented. Further, the private sector was to be "encouraged to invest in health". In West Bengal, the Clinical Establishment Act of 1950 and Rules of 1951 were to be reviewed and amended as necessary and the private and NGO sectors were to be monitored for quality of care (4).

Health Systems Development Projects were implemented in Maharashtra and in Orissa starting 1998, with the same objectives as the Second State Systems Project. The project appraisal documents for both these projects also contain detailed discussions on raising revenue through user charges "while protecting the poor", and also mention monitoring and regulating the private sector (5,6).

Uttar Pradesh was the next state to implement a HSDP, starting 2000. The project appraisal document mentions the setting up of a public-private forum on health care,

"to develop an agenda for common action". Further, private sector partnership was to be encouraged in training and manpower deployment (7).

The language of the Rajasthan and Tamil Nadu HSD Projects (2004) changes substantially from those of the earlier projects, with "access to the poor" being mentioned as an important project component, rather than resource allocation, efficiency or effectiveness (8,9). In Rajasthan, community-based health insurance schemes were to be piloted. Public-private partnerships were to be developed and implemented, not only with the NGO sector but also with the private for-profit sector for non-clinical services, diagnostic and pharmacy services (8).

The components of Tamil Nadu's HSDP were very different from those of the previous State Systems Projects. Its four major components were:

- Increasing access to and utilisation of services by the poor: Reducing maternal and neonatal mortality, improving tribal health and facilitating use of hospitals by the poor and the disadvantaged
- Developing effective models to combat non-communicable diseases and accidents: Supporting health promotion; Pilot-testing clinic-based NCD control; Traffic injury prevention and treatment
- Building capacity for oversight and management of the health system: Improving monitoring and evaluation, quality of care; Strengthening health care waste management; building capacity for strategy development and implementation
- Improving the effectiveness and efficiency of the public sector in delivering essential services: Rationalisation of secondary care hospitals and of equipment; Human resource planning and development; Enhancing management of public facilities (9)

As part of the last component, several packages of public-private partnerships with the NGO and private for-profit sectors were proposed by the project, and included contracting out not only support services but also some clinical services, health insurance projects and counselling services (9).

Overall, HSDPs in all nine states have some common features, such as introduction and increase in user fees in public hospitals, encouraging private sector participation in health through a series of policy actions, increasing quality, efficiency and effectiveness of services and expanding access to care for the poor, SC/ST population and women. All HSDPs also mention the commitment to at least maintain at current levels the proportional allocation to health in the state budget and the allocation to primary and secondary levels within the health budget.

3. Assessment of Outcomes of HSDPs

Six of the nine HSDPs have been completed: Andhra Pradesh, West Bengal, Karnataka, Punjab, Orissa and Maharashtra. There exist "Implementation completion and results" reports, summarising the achievements of these six projects (10-13). In addition, a recently completed World Bank discussion paper provides information on equity effects of quality improvements in the Uttar Pradesh HSDP (14). The description in the following paragraphs on outcomes of the State HSDPs, are based on these reports.

It is important to mention here that the project completion reports do not contain information on many of the indicators set out in the project appraisal documents at the beginning of implementation. For example, some states do not have a break-down of service utilisation statistics by SC/ST, women or population below poverty line, although this is one of the major objectives of the project. Where data are presented, it is not always clear how these were collected and the period and sample that they pertain to. There are some indicators that are not well defined. For example, "Increase in the number of admission to institutions under the project due to pregnancy-related complications to increase by 5 percentage points by midterm review and 15 percentage points by end of project" – it is not clear whether the denominator is all inpatient admissions to project institutions, or all pregnancy-related admissions to project institutions. As a consequence, it is not easy to compare data for such indicators provided in the Project Completion reports with other sources of information, or even to compare data across various HSDP projects.

a) Allocation to Health in State Budgets

One of the objectives of HSDPs was to maintain the proportional allocation to health in state budgets. As Table 1 shows, this objective has not been achieved in three states, and just achieved in three others. Overall, the share of health in the state budget remains below 5% in all the states.

Table 1: Changes in Budgetary Allocation for Health

State	*Base Line (% of State Budget)*	*End of Project (% of State Budget)*	*Source*
Andhra Pradesh	4.3 (1997)	4.5 (2001)	(10)
Karnataka	6.0 (1996)	4.3 (2003)	(11)
West Bengal	3.5 (1996)	3.8 (2003)	(11)
Punjab	6.0 (1996)	4.0 (2003)	(11)
Orissa	2.7 (1998)	2.8 (2006)	(12)
Maharashtra	3.2 (1999)	3.38 (2005-06)	(13)

b) Increase in Share of Resources Allocated to Primary and Secondary Health Care

A second important objective of HSDPs was to increase the share of health resources allocated to primary and secondary care. This was in order to improve health system efficiency, on the grounds that treating a patient at a lower level facility (when appropriate) is more cost-effective. Barring West Bengal, the share of allocation to primary and secondary care has increased in the remaining five states. It is not clear, however, whether the 'total health budget' includes also the HSDP project fund, most of which was for infrastructural investments.

Table 2: Changes in Allocation of Health Resources to Primary and Secondary Care

State (% of Health Budget	*Base line (% of Health Budget Allocated to Primary and Secondary Care)*	*End of Project (Allocated to Primary and Secondary Care)*	*Source*
Andhra Pradesh	68.0 (1994)	71.0 (2001)	(10)
Karnataka	57.5 (1996)	90.1 (2003)	(11)
West Bengal	84.3 (1996)	80.8 (2003)	(11)
Punjab	55.0 (1996)	64.3 (2003)	(11)
Orissa	83.0 (1998-99)	85.0 (2002-03)	(12)
Maharashtra	79.8 (1999)	80.0 (2005-06)	(13)

c) Expanding Access to Health Care, Especially for the Poor and SC/ST Populations and to Women

All HSDP project completion reports indicate a substantial rise in the total annual number of inpatients and outpatients in public hospitals (10-13). For example, in the 160 secondary hospitals covered by HSDP in Andhra Pradesh, the number of inpatients increased from 0.6 million in 1995 to 1.2 million in 2001, and annual number of outpatients increased from 9 million to 18.2 million during the same period (10). In West Bengal, Punjab and Karnataka, the percentage increase in number of inpatients in project hospitals were 30%, 65% and 84% respectively, and the corresponding figures for increase in outpatients were 45%, 112% and 72% respectively (11). In Orissa the increase in outpatient attendance was 72.5% but no specific information on increase in inpatient admissions is given (12), while for Maharashtra, the increase in outpatient attendance is said to be "substantial" (no figures are given), and no information is available on overall inpatient admissions, but the number of surgeries are reported to have increased continuously (13).

Information on utilisation by the population below poverty line, SC/ST population and women is limited. For Andhra Pradesh, there is a mention that 75% of the "beneficiaries" were below poverty line, 18% of inpatients were SC/ST (10). For Orissa, there is no breakdown of users by sex, caste or poverty level (12). In Maharashtra, the proportion of women among outpatients increased from around 30% at baseline to 50% at end of project, but the targeted increase from 10% to 15% for ST population was not achieved. The report fails to mention the actual percentage change (13). West Bengal, Punjab and Karnataka do not report

on proportion of Below Poverty Line (BPL) population or SC/ST population among inpatients or outpatients.

Information on change in the proportion of institutional deliveries is fraught with ambiguities. Institutional deliveries "increased by 36%" between 1996 and 2001 – it is not clear whether the increase is as a proportion of all deliveries in the state, or as a proportion of all admissions to the hospitals covered by the project (10). The Orissa report states that there was an 81% increase over the baseline in the number of deliveries taking place in project institutions (12). Deliveries as a proportion of inpatient admissions was 12% in project hospitals in Maharashtra at baseline, and did not increase beyond 14% at the end of the project (13).

Data are available for four of six states on the share of institutional deliveries in total deliveries, and share of institutional deliveries by public and private sector in 1999 and 2003, a period covered by HSDP projects: West Bengal, Punjab, Karnataka, Andhra Pradesh (Table 3). Similar information is also available on institutional deliveries among the poorest group are also available for these same states (Table 4).

Table 3. Institutional Deliveries in Selected States, 1999-2003

State	*Share of IDs in Total Deliveries*		*Share of IDs by Public Sector*		*Share of IDs in Private Sector*	
	1999	*2003*	*1999*	*2003*	*1999*	*2003*
Karnataka	49	53	55	33	45	67
West Bengal	37	49	77	74	23	26
Punjab	42	46	97	26	3	74
Andhra Pradesh `	46	59	35	33	65	67

Source: (11)

Table 4: Institutional Deliveries by the Poorest Groups in Selected States, 1999-2003

State	*Share of IDs in Total Deliveries*		*Share of IDs by Public sector*		*Share of IDs in Private Sector*	
	1999	*2003*	*1999*	*2003*	*1999*	*2003*
Karnataka	30	30	77	75	23	25
West Bengal	16	27	92	93	8	7
Punjab	20	24	91	21	9	79
A. P.	29	33	48	47	52	53

Source: (11)

It can be seen that the proportion of institutional deliveries among all deliveries has increased overall, and also among the poorest group except in Karnataka. In every state, the share of institutional deliveries in the public sector has declined during the project period and that of the private sector has increased, the increase being particularly dramatic in Punjab. Further probing is needed on what lies behind this change within a period of four years.

For poor women, the public sector still remains the main delivery service provider only in two states: Karnataka and West Bengal, while a little more than half in Andhra Pradesh and the vast majority in Punjab who have institutional deliveries seek care from a private facility. Factors underlying the lower use of public facilities in these two states even by the poorest group need to be investigated.

d. Improvement in Quality of Care

In all six states, considerable investment has gone into developing infrastructural facilities –better buildings, more beds, more equipment and drugs and more facilities with vacancies for health providers' positions filled (10-13).

Information of improvement in actual quality of care:

waiting time, privacy, adequate time spent with provider, drug availability and availability of diagnostic services when needed; quality of patient-provider interaction – are nowhere to be found.

A feeble mention of some "client satisfaction surveys" is made in all reports. These "suggest increase in satisfaction" with a few features such as cleanliness or drug availability. No mention of proportion of clients expressing satisfaction, profile of those satisfied versus those not satisfied and the specific aspects of care which patients found to be better after the project was implemented (10-13).

A study of the Uttar Pradesh HSDP (before end of project) shows differences in the proportion of satisfied clients by income level, and to a smaller extent, by caste status. Between 1999 and 2003, mean patient satisfaction scores declined for all sections of patients, with the decline being steepest among the lowest 40 percent of the population (14).

e) Collection of User Fees

This is reported to be very successful in all states, with collections from user fees increasing many-fold even in real terms. All states exempted those below poverty line from user fees. The increase in user fees collected at 149 secondary hospitals in AP increased from Rs 0.1 million in 1995 to Rs 18 million during April-December 2001 (10). In Punjab, the increase was from Rs 4 million to Rs 120 million in 2003 and in Karnataka, from Rs 3 million in 1997 to Rs 145 million in 2002 (11). In Orissa, the increase was from 3.8 million rupees in 1998-99 to 26.3 million rupees in 2005-06, in real terms (12). West Bengal and Maharashtra only mention increases but no figures are given.

f) Involvement of the Private Sector

None of the project completion reports give any details of the work with the private for-profit or not-for-profit sector.

In Andhra Pradesh, all 160 upgraded secondary hospitals contracted out at least some non-clinical services such as cleaning and facility maintenance (100% of facilities), laundry and security 980%) and ambulance services (63%). These are said to have "reduced costs and increased efficiency markedly", but no supporting evidence is provided for reaching this conclusion (10). Regulation of the private sector, review of existing legislations and implementing new ones, monitoring quality of care in private sector facilities were among objectives mentioned in the Appraisal documents for the other five states (West Bengal, Karnataka, Punjab, Orissa and Maharashtra), but the project completion reports are silent on these aspects. It is also not clear whether or not steps were taken to encourage/promote the private sector's participation through new partnerships and so on.

3. Discussion

From its own project completion reports, it may be seen that the World Bank funded State HSDPs have had limited success. One of the issue of concern is the low proportion of allocation to health in state budgets, and actual decreases in some states in this proportion. Once funding from the project comes to an end, there is likely to be a major financial crisis in the health sector of these states.

Another issue of considerable concern is that after substantial investment in infrastructural improvements, and while figures show increase in numbers of users of public facilities, the proportion seeking delivery care in public facilities has fallen in all HSDP states. At the same time, a large proportion of poorer women seeking institutional delivery are dependent mainly on public sector facilities. Does this mean that HSDPs have resulted in better targeting of delivery services to benefit the poor? What proportion of poor women are unable to use even the public sector facilities because of costs involved? We need studies to examine these aspects.

The equity implications of HSDPs are not at all clear, because so little data has been collected on this aspect. Likewise, information on changes in quality of care is also scanty. Not much is known about the functioning of contracting services and of any steps taken to regulate the private sector. Failure by the project to track information on salient indicators relevant to assess project outcomes is surprising and not acceptable for projects of such scale.

Overall, after completion of the project, state HSDPs appear to have contributed most to the increase in infrastructural facilities and increase in collection of revenue through user fees. The issue of user fees needs to be considered at some length.

Econometric studies based on household survey data have found that vulnerable groups without access to financial resources –e.g. adolescents, elderly, and women not engaged in the formal economy have greater price elasticity for health care services as compared to the rich (15). This means that when fees are introduced or increased, these groups of people will be discouraged from using health services- both preventive and curative. This in turn has both equity and efficiency implications. The poorer and vulnerable groups experience an increase in adverse health outcomes, seeking care in more advanced stages of illness and becoming more impoverished. In addition, because of the seriousness of the problem when people finally present to the health services, the cost to the health system and to the households will be greater.

Widening inequalities following the introduction of user fees is well documented in China. According to the 1993 National Health Services Survey, 60% of rural patients who had not complied with physicians' advice of hospitalisation reported inability to afford the costs as the main reason. It is estimated also that 30-50% of rural households living below the poverty line became impoverished because of illness (16).

According to WHO if equity is the objective, user fees 'should not be chosen as source of financing except for low-cost relatively predictable needs…and should not be used unless no other alternative is available' (17, p.99).

Even the World Bank, the main proponent of user fees now recognises that fees can have adverse consequences for the health of the poor. The chapter on Health, Nutrition and Population in the Bank's Poverty Reduction Strategy Paper (PRSP) Source Book clearly states that alternative mechanisms to user fees should be actively sought, and where user fees become necessary because of budget constraints, 'fees can be designed such that they do not create barriers at the point of use for the poor, through the use of waivers, prepayment, credit or other options (18, p. 222).

The extent to which the poor and vulnerable groups have been protected through exemptions from user fees needs to be studied, since studies from several countries indicate that the poorest often do not have the resources to establish their poverty.

In the light of the above evidence, it is important to study the consequences of increases in user fees for hospital services for access to care by vulnerable groups, especially in states where user fee revenue is reported to have increased several fold: e.g. Punjab and Karnataka.

In conclusion, state HSDPs funded by the World Bank do not seem to have contributed significantly to increasing allocation to health, improving quality of care or expanding access to vulnerable groups, and may have several negative consequences. There is an urgent need to document people's experiences with the health care system and to draw attention to the adverse implications of HSDPs for people's right to health care.

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The Independent People's Tribunal on the World Bank Group in India

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Over the past few years, several groups have systematically come together to closely monitor the World Bank's functioning in India, especially with regard to its Country Assistance Strategy; its review of its social and environmental standards; its proposal of using Country Systems in lowering regulatory standards, etc. As part of this process, it has been considered important to undertake a broad-spectrum enquiry into the World Bank and the functioning of its allies and to review their impacts nationally. This is the origin of the Independent People's Tribunal on the World Bank Group in India.

The purpose behind the Tribunal is to provide a just and unbiased forum for people who have faced the impact of projects and policies funded or promoted by the World Bank Group. The Tribunal is an opportunity to express their grievances and propose alternatives. Given what seems to be the record of the projects funded and promoted by the World Bank in terms of human rights violations and environmental degradation; the feeble response of these agencies and the Indian government to proposals and appeals by the people of India to reconsider its projects and approaches, it is time to examine and judge their claims to serving the wider public interest. The chief focus of this exercise will be to study the impact of the World Bank's policies and projects as it is increasing its influence in all directions encompassing the country's economy as well as its educational, social and cultural fabric.

In order to formalize the process, several consultations have been done with groups, individuals and organizations in various parts of the country. At the National Consultation on Housing and the Urban Poor held in Mumbai in October 2005, where over two hundred groups participated, a call was issued to take forward this process.

Terms of Reference

The People's Tribunal will look in to the national impact of the World Bank and its allies on:

1) Vulnerable communities, including women, children, dalits, minorities, adivasis, workers, fisher folk, and farmers;
2) The environment and human rights;
3) The World Bank's agenda and whether it is largely influenced by transnational corporate interests;
4) Financial indebtedness and loan conditionalities' effects on social sectors (food, health and education), particularly in terms of poverty alleviation and reduction of inequality;
5) Transparency, corruption and accountability within the government, the private sector and NGOs;
6) Governance (role of bureaucrats, consultants and technocrats), sovereignty and democracy;
7) Conflicts, including militarisation. Some of the key questions that the Tribunal hopes to address are:

• How do the WBG and other IFIs influence or determine government policies, particularly those affecting the poor? What domestic policies have they changed to the detriment of those living in poverty? Has the policy reform process been democratic? Are IFIs part of a 'behind-the-scenes parallel government'?

• Are the World Bank and other IFIs serving the welfare of the Indian people, especially the poor and vulnerable sectors on whose behalf they claim to act? Or, are they acting to safeguard the interests of other actors, such as transnational corporations, the U.S. government, bureaucrats, the governing elite, and/or their own financial health?

• After operating in India for so many years, why do the WBG and IFIs continue to provoke criticism from grassroots organizations and NGOs that claim they contribute to environmental degradation, displacement and human rights violations?

• Why are ministers and bureaucrats in central and state governments so anxious to enter into contracts with the WB and why do they sanction sovereign guarantees? Is there an element of corruption and kickbacks involved in the granting and accepting of WB loans? Whether the key officials and decision makers of the country have been compromised and placed in a conflict of interest situation by the World Bank and its affiliated agencies offering them jobs, consultancies, contracts, travel grants, etc?

• How have WB contracts contributed to the indebtedness or bankruptcy of the central government and various state governments?

• How has the WB's role as a "knowledge provider" impacted both the process and the results of policy-making in the country?

More details are at <http://worldbanktribunal.org/>
For those wanting to depose related to the health sector, please contact :
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This is Not a Story about Binayak Sen

-Subhash Gatade[1]

This is not a story of the fifty plus Children's doctor Binayak Sen from Raipur, Chattisgarh who is at present languishing in jail under draconian provisions of a law which has declared him a 'terrorist' because he had the courage to speak truth to power.

This is not meant to be a story of two young daughters of this man who are eagerly waiting for their father who is one of their closest friends and with whom they have shared all secrets of the world.

This is not a story of Illina, whose companionship with Binayak exceeds more than three decades, and who recently penned down her experiences at the jail gate, where ordinary people - who want to have a glimpse of their near and dear ones lodged in the jail - are even robbed of their last Penny by the custodians of law and order.

This is also not a story of those kids from nearby villages who joined a protest demonstration held in Raipur to express their bewilderment over the arrest of their doctoruncle who use to tell them interesting stories when he could find some free time at the community clinics.

This is also not meant to tell you my first meeting with this gem of a man way back in 1981 in Dalli Rajhara, District Durg where the legendary Shankar Guha Niyogi had charted a new path in worker's struggle and where the idea to start a Shahid Hospital - a hospital started by workers of the mines for the other toiling masses of the area - was germinating then.

This is also not a story of the institution called Christian Medical College at Vellore which felt honoured to have produced a student of such calibre and felicitated him for his conscious decision to work for the poor and downtrodden.

This is also not a story of the manner in which ex-students of this college who are spread in different parts of the world have taken the initiative to mobilise the medical community of the world to tell the powers that be that the proper place for a children's doctor should be among childern and their parents and not the confines of a jail.

This is also not a story of the work Dr Sen did as an adviser to the community health scheme of the state called 'Mitanin' nor a description of the program wherein he was awarded the prestigious Paul Harrison award for his commendable work in community health.

This is also not a story of the appeal sent by world renowned individuals/activists like Noam Chomsky, Romila Thapar, Irfan Habib etc. who felt 'dismayed' at the 'continued detention of Sen' and who have demanded that all charges against Dr Sen be dropped immediately and he be released forthwith.

Of course nor it is a report of the widening ambit of state harassment which today includes Illina Sen, Gautam Bandopadhyaya and Rashmi Dwivedi, Rajendra Sail - members of People's Union For Civil Liberties and other organisations who have refused to bow before the machinations of the state machinery. It is the same state machinery which has acquired the dracula like qualities of bumping off innocents and which did not have any qualms going to the ridiculous extent of arresting Dr Sen as an 'emissary of a naxalite' when the said meetings were held in the presence of police themselves.

This is not a critique of the manner in which a broad section of the media preferred to toe the government line and putting all journalistic ethical norms to the winds presented sensational, juicy stories to demonise this ex-adviser to the state government on its community health schemes.

This is also not a story of the frightening message on wireless sent by a Superintendent of Police stationed in one of those 'troubled districts' in Chattisgarh itself which clearly instructed the armed police to target journalists, individuals who seem to be overzealous about the question of human rights.

This also does not deal with the so called Peace Campaign called *Salwa Judum* - where a section of the tribals have been armed at the behest of the government-who have become a law unto themselves, where they have been found to be burning villages and abusing their women. It also does not deal with the manner in which this 'Peace Campaign' has uprooted more than 40,000 villagers and placed them in camps along the road, reminding people of the failed "strategic hamlets" used by the US military in South Vietnam more than forty years ago.

The following writeup does not intend to once again bring to the fore the grief of a mother called Madiyam

[1]Reproduced from <http://www.kafila.org/2007/07/05/this-is-not-a-story-about-binayak-sen/>. Published by Subhash Gatade at July 5, 2007 in *Genders. Tags: No Tags.*

Soni (there are thousands of such women) from a non-descript village Ponjer whose son's life was snuffed out by the security forces and whose body was found with similar eleven bodies at a place called Santoshpur much farther from her village.

To be very frank all such insignificant sounding details about ordinary people's ordinary lives, their travails and tribulations, and the response of the powers that be towards their attempts to aspire for a normal life with dignity is not the crux of this writeup. One very well knows that neither do they carry any import for the custodians of this country nor the articulate sections of our society. Perhaps all such details from the hinterland of India are meaningless for the young generation also which is busy networking with friends from the other part of the globe .

This is in fact a story of all those people who have rather stopped thinking about all these relevant things. This is in fact a story of the continuous bombardment of messages through various channels which has rather desensitised a greater lot among us towards the mundane looking sufferings of the people.

This is in fact a story of the criminal silence which all such stories, reports normally encounter - may it be the declaration of a children's doctor as 'Public Enemy No. 1' or for that matter fake encounter killings in some hinterland of India .

This is in fact a story of reassessing whose lives we should value and prioritize.

This is in fact a story of getting ready to ask some discomforting questions about the system in which we live.

Perhaps the need of the hour seems to be starting with a simple query : When would the two daughters meet their father ?

Free Dr. Binayak Sen, Immediately!

-Analytical Monthly Review

[*Analytical Monthly Review*, published in Kharagpur, West Bengal, India, is a sister edition of *Monthly Review*. Its June 2007 issue features the following editorial. — Ed.]

Some of the respected friends of *Analytical Monthly Review* have recently argued to us on the basis of various election results that the threat of Hindutva fascism has abated, if not disappeared. We are not persuaded. Rather, it seems to us on the basis of events in Chhattisgarh that a more dangerous and virulent form of fascism, marked by an alliance of the Hindutva fascists with domestic and international capital, union-level Congress officials, security commanders, and the judiciary, is emerging right in the heartland of India.

The renowned public-spirited paediatrician Dr. Binayak Sen is General Secretary, People's Union for Civil Liberties ("PUCL"), Chhattisgarh and the Vice-President, National PUCL. He was arrested May 14th, 2007, under the provisions of the Black Laws (The Chhattisgarh Special Public Security Act [CSPSA], 2005, and the Unlawful Activities [Prevention] Act, 1967 as amended in 2004). The CSPSA, a creation of the Manmohan Singh regime, provides for arbitrary detention backed by an "ouster of jurisdiction" clause providing that action under the "Act by any officer authorized by the government for this purpose or by the District Magistrate shall not be questioned before any court." The charges are farcical: meetings with Narayan Sanyal, an imprisoned leader of the Communist Party of India (Maoist) that took place in jail and in the presence of a jailer. For those who argue that preservation of the safeguards of civil liberties justify the alliance of secular forces represented by the "common minimum programme," the arrest should be a crucial test. The issue raised cannot be more serious: is the defense of civil liberties itself now to be made criminal? This outrage is no aberration that, if ignored, shall resolve itself. The Chhattisgarh context is a microcosm of today's India.

Tribal lands are the most sought after resources now. They are forested, rich with mineral resources (80 per cent of India's minerals and 70 per cent of forests are within tribal areas) and also the site of significant plans for industrial growth. The tribal districts of Chhattisgarh, Orissa, Jharkhand, Karnataka, and Maharashtra are the destination of us $85 billion of promised investments, mostly in steel and iron plants, and mining projects. This investment will require huge amount of lands, crucial for the survival of tribal people. All these states have movements demanding the rights of tribal peoples to forest produce and against land acquisition. The state governments say these protests are Naxal-inspired. Local people say, however, that they are trying to protect their land, forests, and livelihood. Indeed there is a strong Naxal presence in these states and in Chhattisgarh; its strength today is the *result* of the adivasi struggle to protect their rights, not its cause.

Within a few years of its inception in the year 2000, the state of Chhattisgarh entered into 53 memoranda of understanding with international and Indian companies. According to official report, 9,620 hectares (23,774 acres) of land is already under the process of acquisition. There is demand for more and more land and forest areas.

All the large cement producers have a significant presence in the state, including AV Birla Group (Grasim Industries,

Ultratech Cemco), Gujarat Ambuja Cement, ACC and Lafarge. Metals and mining operations in the state include Essar Steel, Jindal Steel and Power Ltd, South Eastern Coalfields Ltd, and others. Plans for new or expanded steel and aluminium plants in Chhattisgarh that would require land acquisition have been announced by SAIL, Jindal Steel, Monnet Ispat Ltd, Visa Industries Ltd, Bhushan Ltd, Sanvijay Rolling & Engineering Ltd, BALCO, a part of the Vedanta Resources Group, Bajrang Power and Steel Industries Limited, SKS Steel Limited, Raipur Alloys & Steel Limited, and Ind Synergy Limited.

Subsidiaries of the giant global U.S. AES Corporation are setting up a coal-based power plant in Chhattisgarh and will undertake coal mining for captive consumption. AES has been condemned for environmentally abusive projects from Uganda (the planned destruction of the Bujagali Falls) to Panama (rainforest destruction). In Argentina, AES claims that under international law a "sweetheart" deal it had with a prior (and now universally acknowledged to be corrupt) government cancels the nation's laws.

It has been reported that six companies seek the state's diamond resources, led by the international giants De Beers and Rio Tinto. Many of these plans would require strip mining.

Real estate speculators are of course at the heart of this opportunity for plunder. PACL India, a company developing and building townships and housing units, has planned to purchase up to 5,000 acres in various districts of Chhattisgarh during the current financial year for different projects. A proposed new capital city would see in its initial phase of construction an IT Park, a golf course, and a five-star hotel. IL&FS Infrastructure Development Corporation is partner and advisor for the project.

The entire process is the very opposite of planned rational industrialisation: it is a mad rush to seize what can be seized. And all these "plans for development" are to be implemented in a state where 32% of the state's population is tribal, classified as indigenous people. Dantewada has the highest concentration of ST in Chhattisgarh with ST accounting for 79% of the district population, followed by districts of Bastar (67%), Jashpur (65%), Surguja (57%), Kanker (56%), and Mahasamund (28%). The proportion of families below the poverty line in Dantewada is 79%, matching the percentage of tribal families.

But there has been vigorous resistance to the theft of land for strip mines, five star hotels, and golf courses, in short to the "India Shining" world of the top ten percent spitting on the misery of the majority. The response of the state and of the union government to this resistance has been brutality of obscene proportions. The centerpiece of the governmental response has been the creation of a U.S.-model "counter-insurgency" vigilante group with adivasi participation, known as Salwa Judum. Created in June 2005 in the impoverished Dantewada District by the security services with the participation of both Congress and BJP politicians, it was presented to a non-critical media as a spontaneous reaction to supposed Maoist oppression. But quickly reports began to seep out of the forcible emptying out of villages, and of atrocities committed by members of the Salwa Judum and security forces.

A fourteen-member team from five organizations conducted an investigation between 28 November and 1 December 2005 in Bijapur and Bhairamgarh blocks of Dantewada district, focusing specifically on the violation of human rights and the impact on people's everyday lives. The organisations were: People's Union for Civil Liberties (PUCL) Chhattisgarh, People's Union For Civil Liberties (PUCL) Jharkhand, People's Union for Democratic Rights (PUDR) Delhi, Association for the Protection of Democratic Rights (APDR) West Bengal, and Indian Association of People's Lawyers (IAPL). On the basis of the fact-finding, three facts stood out strongly: First, it is clear that the Salwa Judum is not a spontaneous people's movement, but a state-organized anti-insurgency campaign. Second, it is misleading to describe the situation as simply one where ordinary villagers are caught between the Maoists and the military. The Maoists have widespread support, and as long as people continued to live in the villages, it was difficult for the government to isolate the Maoists, and the government has resorted to clearing villages on a large scale. Tens of thousands of people are now refugees in temporary roadside camps. Third, the entire operation, instead of being a "peace mission" as the name "Salwa Judum" claims, has escalated violence on all sides. But only violence attributed to Maoists is publicised, and the Salwa Judum and paramilitary operate with complete impunity.

The People's Union for Civil Liberties - Chhattisgarh has demanded enquiry by the Central Bureau of Investigation (CBI) in all extra-judicial killings in Chhattisgarh since 2005. Fake encounters in the past two years have claimed the lives of at a minimum 155 people. In a single fake encounter case at Santoshpur in Bijapur on 31st March, 2007, the State Police killed not less than 12 innocent citizens.

The pattern that has developed has many of the indicia of fascism: a state-organised private militia murdering opponents; apparent complicity in a reign of terror by both state and union security forces; what appears to be impunity granted by the judiciary; the active complicity of large capital; and now the brazen arrest of a nationally known and respected advocate of peace and civil liberties who dared to expose and to protest, Dr. Binayak Sen. As civil war engulfs Chhattisgarh, well-intentioned and left-wing elders will urge young militants to give yet another chance to legal and electoral paths. The question such elders will have to answer is "what did you do when Dr. Binayak Sen was arrested?"

Novartis Loses Case but Battle is on[1]

Dear Doctor,

Greetings from Jan Swasthya Abhiyan (JSA)! One of the principal areas of work for the JSA has been the promotion of access to essential medicines.

We are writing to you on a matter that can deeply affect access to medicines for your patients. The issues we highlight in this appeal are two-fold – one pertaining *specifically to access to treatment for thousands of patients suffering from the lethal Chronic Myeloid Leukaemia (CML), and the other to a broader issue of the cost of new medicines that may be provided Patent protection*. We would urge you to read this appeal carefully and consider taking the measures suggested in it.

As you might be aware, Novartis, a Swiss Multinational pharmaceutical company operating in India, through it's subsidiary, has been involved in challenging the India authorities through two petitions. In the first petition now referred to the Intellectual Property Appelate Board, Novartis has challenged the decision of the *Indian Patent office in Chennai, rejecting its application for a patent on imatinib mesylate, which Novartis markets in India under the trade name: Gleevec.* In the second application filed in the Chennai High Court, Novartis had *challenged the constitutional validity of Section 3(d) of the Indian Patents Act by claiming that this section does not comply with the TRIPs agreement.* The facts of the two cases that Novartis has filed against the Indian authorities are explained below.

Novartis Challenges the Indian Patent office's Decision about Gleevec

In the first case, Novartis has challenged the order of the Indian Patent office in Chennai, rejecting its application for a patent on imatinib mesylate, which Novartis markets in India under the trade name: Gleevec. As you would know, *Imatinib mesylate* is extremely useful in the treatment of *chronic myeloid leukemia (CML)*. In addition to Novartis, several Indian companies – viz. NATCO, Cipla, Ranbaxy and Hetero — also produce and market the drug. *Treatment with Gleevec (manufactured and marketed by Novartis) costs rupees 1,20,000 per month, whereas Indian companies market the same drug at a price of about Rs. 8,000 per month.* If a patent were to be granted to Novartis for imatinib mesylate, Indian companies would be forced to stop production of the drug. At a treatment cost of Rs.1,20000 per month, this would mean that over 99% of patients requiring the drug would be denied access to it. The huge difference in the price of the same drug is an illustration of how a patent monopoly can be used by drug companies to generate super-profits while endangering the lives of thousands, or even millions.

The Indian Patent office had *rejected the application for a patent on sound principles*, entirely consistent with the country's laws and the agreement on Trade Related Intellectual Property Rights (TRIPS), to which India is a signatory. Novartis had obtained a patent for the same drug in 1993, i.e. two years before the TRIPS agreement was signed. At that time the Indian law did not recognise patents on pharmaceutical products. As per the TRIPS agreement, if a drug has been patented before 1995, countries like India, which did not recognise patents on medicines before the signing of the TRIPS agreement, do not have to recognise such patents. Novartis tried to circumvent this by filing a fresh patent application in India for the beta crystalline form of the same drug. Novartis claimed that this form of the drug was an advance on its earlier patent on the "amorphous" form, because it is less hygroscopic and hence more stable. The patent office rejected this application because it felt that the *application was not for a "new" molecule* and someone who understands the chemistry of the patented molecule (imatinib mesylate) would realise that the beta crystalline form of the molecule would have these useful properties. Thus it opined that the patent application failed on two counts for the required criteria of patentability – it did not demonstrate an "innovative step" and it was not a "non-obvious" invention. The Patent office further felt that the application by Novartis was not consistent with section 3(d) of the Indian Patent Act, which specifically states that a different structural form of a known substance cannot be patented. Hence in January 2006, the Patent office rejected the Gleevec patent application on the ground that the application claimed 'only a new form of an old drug'.

Novartis claims that those patients, who cannot afford to purchase Gleevec, receive the drug free of charge, through Novartis's Gleevec International Patient Assistance Programme (GIPAP). What it does not say is that this programme is there in India because, before Novartis' patent was rejected and it had an exclusive marketing right on the drug, the Chennai High Court had specifically asked that Novartis provide access to this drug to all those who need it and whose monthly income was less than Rs. 3,50,000. Further, *while Novartis claims that 6,700 patients get free Gleevec, there are an estimated 20,000 new U of chronic myeloid leukemia every year.* Dr. Purvish Parikh, professor and chief of medical oncology, Tata Memorial Hospital, Mumbai, has filed an affidavit based on his experience, debunking Novartis's claim about GIPAP.

[1] *This is a draft circulated by Anant Phadke with inputs from Gopal Dabade & Amit Sengupta.*

Novartis' Challenge to our Country's Law

Novartis had filed a second case – one that *challenged the constitutional validity of Section 3(d) of the Indian Patents Act by claiming that this section does not comply with the TRIPs agreement.* It may be recalled that Section 3(d) was specifically introduced by the Indian parliament as a safeguard against the misuse of product patents on medicines. Novartis has claimed that this section is not in compliance with the TRIPS agreement and is in violation of the Indian constitution. These claims are patently false. Many experts have confirmed that Section 3(d) conforms to the requirements of the TRIPS agreement, as the agreement clearly allows each country to set its criteria of patentability and does not prevent countries from including safeguards against the grant of fresh patents on old drugs. Section 3(d) is also in keeping with the "Doha Declaration on the TRIPS Agreement and Public Health" that was adopted by the Ministerial meeting of the WTO, held in Doha in 2001.

This challenge by Novartis is of particular concern for several reasons. *It is a matter of grave concern that a foreign company chose to challenge the constitutionality of a law that has been passed by the Indian Parliament to safeguard public health. Members of the medical profession need to be particularly concerned about such attempted misuse use of India's legal system.* The company has legally circumvented this issue by filing the case through its Indian subsidiary, but the fact remains that the challenge has been made on the directions of a foreign entity. Further, Indian courts cannot hear the company's contention that Section 3(d) of India's Patent Act violates the TRIPS agreement, as they do not hear appeals regarding conformity of Indian law to international treaties. Such a challenge needs to be made in the WTO's Dispute Settlement Mechanism, and that too can be made only by a member state of the WTO and not by a private corporation. No government has, till date, challenged the Indian law in the WTO. Interestingly, the company's arguments regarding the constitutional validity of the Indian law have been shifting continuously, even while the case was being heard. Initially it had not made out a case on the issue of constitutionality, but later changed its line of attack to argue that the language used in section 3 (d) was vague and not used anywhere in the world and that it did not give enough guidelines to the Patent Controller.

It should be understood that if Section 3(d) of the Indian Patents Act was to be *removed it would open the door for a large number of trivial patents. This Section is the principal safeguard against the misuse of the Patent system by the patenting of known medicines, by making slight modifications in their structure.* Such patents do not contribute to any therapeutic benefits but do increase corporate profits by extending patent monopolies on frivolous grounds. Thus the removal of this important section would mean many new medicines would have to be granted patents on trivial grounds and multinational corporations like Novartis, who hold these patents, would charge exorbitant amounts for these medicines.

Clearly, the challenge by Novartis to the Indian law meant an *attempt to profiteer at the expense of tens of thousands of poor and sick patients.* It is also an attempt to *open the floodgates for other MNCs so that they to can apply for trivial patents.* The consequences will not be limited just to India. Today *India is known globally as the "Pharmacy of the Third World",* because Indian companies export cheaper versions of patented drugs to over 150 countries. For example, over half the medicines currently used for AIDS treatment in developing countries come from India. If Indian companies are to be prevented from making generic versions of patented drugs, *tens of thousands of poor patients in Africa, Asia and Latin America will be denied access to essential medicines.* That is why hundreds of thousands of people all over the world signed an online 'drop the case' letter to Novartis, asking it to withdraw the case it has filed in the Chennai High Court. The *'Drop the Case'* campaign was launched by the organisation 'Doctors Without Borders'.(http://www.doctorswithoutborders.org/) – winner of the Nobel Prize Award for best medical relief during the year 1999. Many reputed personalities publicly appealed to Novartis to withdraw the court case. They include Erik Solheim, Minister of International Development, Norway and Henry Waxman, Chairman, Congress of United States. Separately, the *Indian Health Minister, Dr.Ambumani Ramados also appealed to Novartis to drop the legal challenges.* In spite of such appeals, however, Novartis continued to pursue the court cases vigorously. The Chennai High Court's decision on 6th August 07 to dismiss Novartis's plea has vindicated our stand. The Chennai Court agreed that Indian court does not have the jurisdiction to decide whether the Indian patent law is TRIPS compliant or not; the appropriate forum, being the WTO Disputes Settlement Body. After this judgement, the Swiss govt. clarified that it would not take this issue to this body. Instead of giving up, Novartis has decided to pursue with it's second case to be heard by the Intellectual Property Appelate Board!

Appeal to you as a Medical Professional

It is in this background that, on behalf of Jan Swasthya Abhiyan, we are sending this appeal to you to do the following:

1.Boycott products that are manufactured and marketed by Novartis by refraining from prescribing drugs that are marketed by Novartis. We feel that your action will be a powerful message to the Swiss Company. Medical professionals are an important link between the people and the pharmaceutical industry, as the latter depend on medical professionals for the sale of their

products. The Jan Swasthya Abhiyan sincerely feels that your action can be decisive. *The campaign for boycott is proposed to last till Novartis stops its actions that prevent patients from getting access to essential medicines.* This includes the upcoming appeal to the Intellectual Property Appellate Board. The JSA is compelled to call for this boycott as a last resort, and in this we seek your support because Novartis has failed to respond to all other approaches by leading global organisations and state heads. *As a professional who places the welfare of her or his patients foremost, we believe that you will agree to join this Campaign. This is a campaign that is not just about one valuable medicine, but also about the broader issue of ensuring access to essential medicines and of holding pharmaceutical companies accountable to their societal duties.*

For your ready reference we are providing a list of drugs marketed by the company. *We are sure that you will find therapeutically equivalent or superior substitutes for virtually all these medicines from those marketed by other companies in the country. In case, however, you feel the need to continue prescribing a drug marketed by Novartis because of the absence of a suitable substitute, we would urge you to boycott other Novartis products.*

2. *We also appeal to you to sign the attached letter that urges Novartis to desist from jeopardizing the lives of countless poor and sick people* and send it to the Jan Swasthya Abhiyan at the following address:

Do feel free to edit the suggested contents of the letter to reflect your personal understanding of the issue. It would be useful if the letter were composed on your personal pad. Please do not hesitate to contact us for more details through email or correspondence.

Yours sincerely,

Dr.B.Ekbal
Convenor Jan Swasthya Abhiyan

To

Novartis India Ltd, Sandoz House, 8th floor, Shivsagar Estate, Dr Annie Besant Road, Worli, Mumbai 400 018, India. Fax 022 24950221

Sir,

Over the past year, media and other reports have highlighted Novartis' actions in India and abroad in impeding patients' access to essential medicines. This is because Novarti's in India had filed a case in Chennai High Court, (now referred to the Intellectual Property Appelate Board) against the decision of Chennai patent office to reject its claim for imatinib mesylate and to challenge the legal validity of section 3(d) of the Indian Patents Act . In doing so Novartis had taken the Indian government and cancer patients to court over absolutely essential public health protections in India's patent law. It is unfortunate that Novartis has taken such a decision and it is Novartis' decision not to drop the case in spite of pressure from Indian and global quarters that has sparked my decision of "BOYCOTTING ALL PRODUCTS OF NOVARTIS".

Novartis' claim for patent on the beta crystalline form of imanitib mesylate is not valid under India's patent law. Even after the patent application was rejected, Novartis continues to pursue its attempt to get a monopoly on this drug. In doing so, Novartis has done the unthinkable and challenged the constitutional validity of an important public health safeguard in Indian law, which ensures access to essential medicines. Hundreds and millions of people all over the world depend on drugs produced by Indian generic companies and Novartis' case may have an impact on this.

The cost of one month's therapy with imatinib mesylate sold by Indian generic companies is rupees 8,000 whereas Novartis' version sold under the 'Gleevec' costs rupees 120,000 per month. Such enormous price of Gleevec makes it beyond the reach of most Indians.

Further Novartis' claims that those patients, who cannot afford to purchase its version of imatinib mesylate, receive the drug free of charge, through Novartis' outlet by name 'Gleevec' International Patient Assistance Programme' (GIPAP). But it is well known that only 6,700 patients get the drug from Novartis free, whereas in India 20,000 new cases of chronic myeloid leukemia occur every year. Moreover, it is the right of every patient to get life saving medicines and we strongly object to any system that puts our patients at the mercy of the charity of a company.

Given the realities mentioned above it is strongly urged that Novartis should drop all legal proceedings in India in the imatinib mesylate case including the upcoming appeal to the patent controller's order. I, as a socially conscious doctor, will continue the boycott of all products marketed by Novartis till Novartis stops the legal actions; till Novartis drops the global price for imatinib mesylate; and till Novartis stops trying to influence the Indian Government to introduce laws and policies that hinder access to medicines.

The greatest duty of a medical doctor is to save the lives of people and I, as a socially conscious doctor, am doing it by boycotting Novartis' products as I am left with no other choice because of Novartis' stand.

Yours truly, etc.

cc JSA with your address

Book Review

For More Reliable and Relevant Research on Treatments

-S. Srinivasan

Imogen Evans, Hazel Thornton and Iain Chalmers. *Testing Treatments: Better Research for Better Healthcare.* The British Library, 2006. pp.113.

Even as this writer sat down to write this review, he came across a study published in *PloS Medicine* which concluded[1] that the type of sponsorship available for randomized controlled trials of statins was strongly linked to the results and conclusions of those studies, even when other factors were taken into account. "...There are many possible reasons why this might be. Some people have suggested that drug companies may deliberately choose lower dosages for the comparison drug when they carry out "head-to-head" trials; this tactic is likely to result in the company's product doing better in the trial. Others have suggested that trials which produce unfavorable results are not published, or that unfavorable outcomes are suppressed. Whatever the reasons for these findings, the implications are important, and suggest that the evidence base relating to statins may be substantially biased."[2]

The book under review is further evidence of this kind: it shows the troubling sloppiness in contemporary medical research and treatment. It is therefore a book very useful for our health. While what the book says may not be applicable for the entire universe of clinical trials in modern medicine, even if 10 percent of the trials were unfair and biased, it has frightful consequences for the public at large.

Untested Advice

While the authors' try to keep down the shock factor, what emerges is indeed shocking. The case studies and evidence cited for the practice of this unscientific medicine seems to be across academia, medical profession and the pharma industry. Over-reliance on untested theory from experts coupled with biased studies (called "unfair studies" by the authors) has led to avoidable illness and premature deaths. Patients' feedback on unexpected effects of treatments have been routinely ignored.

Dr Spock in the 1956 edition of his famous book *Baby and Childcare* advised to place infants to sleep on the front - an advice that led to the steep rise of SIDS (Sudden Infant Death Syndrome) during the 1970s and 1980s, although not all deaths could be attributed to his advice. Dr Spock's advice, never rigorously evaluated was the result of untested theory – reversing the advice with "back to sleep" led to a dramatic decline in infant deaths

Sometimes what is logical does not work especially if it is based on untested theory: antiarrhythmics - drugs that suppress abnormal heart beat rhythms – do not appear to reduce the risk of premature death after a heart attack, if one were to extrapolate from the drug's behaviour before the onset of an attack. In fact the opposite seems to be the case: after a heart attack, using antiarrhythmics on patients having abnormal heart rhythms increases the chances of early death. The authors point out that at "the peak of their use in the late 1980s, one estimate is that they caused tens of thousands of premature deaths in the USA alone. They were killing more Americans every year than had been killed in action during the whole of Vietnam War. It emerged that for commercial reasons, the results of some trials suggesting that the drugs were lethal had never been reported."[3]

There are fashionable in vogue treatments like HRT where more and more beneficial effects were/are claimed based on little evidence: HRT was/is apart from being of some use in osteoporosis was/is touted to be useful in prevention of heart attacks and strokes. Current evidence shows that HRT increases the risk of stroke and of developing breast cancer.

More is not Better

More is not better; and looking for disease in apparently healthy people, as is done in mass screening, can do more harm than good, the authors point out. Harmful effects of mass screening have not been sufficiently emphasized especially with its chances of not detecting all or most who have the disease (not sensitive enough), and the risk of attributing the disease to those who do not have it (not specific enough). The latter as much as the former, once identified as having the disease, are sent into a tizzy of treatments, tested and untested. Examples discussed by the authors are: doubtful mass screening for neuroblastoma (a rare malignant tumour affecting especially young children), screening older men for prostate cancer, screening newborn babies for cystic fibrosis, and dental screening leading to removal of impacted wisdom teeth.

For decades, doctors have been uncertain how much of the breast needs to be removed in case of breast cancer: should one go for total/extended radical mastectomy or selective lumpectomy followed by radiation therapy? Which one has the greater risk of early death? Despite studies showing that there is little difference in outcomes, mutilating surgery continues to be preferred by some as contrasted to breast conserving therapy. "Although there has been much research into breast cancer diagnosis and therapy over the years, the wide variations in the interpretation of screening mammograms and in the use of surgery, radiotherapy and chemotherapy indicate that many uncertainties remain. There are numerous unanswered questions about the basic biological features of the disease such as the role of genes, enzymes, or differences in patients' metabolism. The best treatment of very early stage breast cancers and 'pre-breast cancers' is unresolved, as is the ideal number of lymph nodes to remove from the

armpit. Optimum organisation of screening and treatment services remains contentious, and so requires more evidence to inform practice." (p.52)

In cancer especially, there is need for randomized trials comparing less drastic treatment with more drastic treatment.

The point at issue is medicine, if attention is not paid to biases and chance, tends to be even more of an uncertain science. Our knowledge as Popper points out is finite and ignorance infinite. Biased under-reporting seems to occur rather too frequently for user comfort. Dramatic effects of treatments, like penicillin, are rare even as they are easily recognizable. Moderate treatment effects are usual and not so obvious

Practitioners are seldom clear on treatment and interpretations. Years ago tonsillectomy was all too frequently done on children irrespective of whether a surgery was really indicated. In the US, tonsillectomy rates and hysterectomy rates as well as percentage of men who had undergone prostate surgery varied drastically from community to community within a State – 15 to 60 percent for prostate surgery and 20 to 70 percent in case of hysterectomy.[4]

The authors also are critical of medical ethicists and ethics research committees not doing their job properly. "Strange as it may seem," aver the authors, "medical ethicists and research ethics committees have helped to sustain the double standard on consent when there is uncertainty about the effects of treatments. Ethicists often seem more concerned with protecting 'the vulnerable' than with encouraging the proper contribution of patients through equal partnerships."

In fact patient involvement in research is a recurring theme throughout this book. The authors continuously point out how research that does not consult patients at the design stage can often be poor research. That research needs to be relevant is indeed a given. But even relevant research can be done poorly by ignoring patient needs. Activists and patients of breast cancer and AIDS have over the years succeeded in influencing the course of research by demanding that attention be paid to patients' preferred outcomes.

The book ends with a "blueprint for a revolution" calling for transparency on the part of researchers and practitioners when there are uncertainties about effects of treatments. The same amount of stringency should apply to research on comparing treatments as contrasted to clinical trials of new drugs. Industry should be required to provide better, more complete, and more relevant evidence about the effects of treatment.

In all this is a very useful book for clinicians as well as laypersons on the pitfalls in research on drugs and new treatments; the importance of fair research and how easily lack of vigilance can let unfair, biased and sloppy research and policy making become the norm.

Within India, the importance of such attention to treatment and clinical research and health policy making cannot be overstressed. The kind of subterfuge in polio vaccination that has gone in India - underplaying or suppressing inconvenient data like vaccine-associated paralytic poliomyelitis (VAPP), jumping to unwarranted conclusions, repeatedly changing the definition of what is a polio case – is bad and dishonest science apart from willfully ignoring hard evidence.

Another instance is that of nimesulide: it does not get banned despite all studies abroad indicating life-threatening adverse events with the use of nimesulide such as hepatotoxicity, renal toxicity, severe skin reactions including fixed eruptions, gastrointestinal toxicity, potentiation of seizures, potentiation of colitis in passive cigarette smoking. In a court case on the issue, the Drug Controller General of India (DCGI) even quoted in defence a "study" done by the Delhi branch of the Indian Medical Association. The "study" in question was a peculiarly Indian twist to evidence-based medicine: an "opinion poll'' among just 50 doctors of the over 400,000 doctors in India. The Indian Medical Association (IMA), Delhi branch, came to the conclusion that nimesulide was "safe and effective for all age groups starting with day one to over 60 years'' for a variety of conditions, including fever. Later after several twists and turns, round May 2003, the Drugs Controller General of India (DCGI) directed nimesulide manufacturers to withdraw the paediatric "drops" formulation from the market not before IAP (the Indian Academy of Paediatrics) vouchsafed to its "safety".

On the other hand, the DCGI during 2004-05 promptly banned the Cox-2 inhibitors, Rofecoxib and Valdecoxib, on the basis of its withdrawal by Merck - which raises the question as to what is the modus vivendi of banning/retaining a drug: its international practice or local adverse effects? If it is the former, nimesulide has not been licensed for public use in its originator countries. But it continues to be used in India, thanks to dubious opinion polls and a reluctant regulatory authority. Whereas Coxibs were banned with little or no push from anybody in India using their withdrawal in USA as a precedence. And then several other harmful drugs like analgin continue to exist even though they have been withdrawn from the first world countries.

Reporting bias and underplaying of risk – things that this book warns of – at its worst display.

Endnotes

[1]Bero L, Oostvogel F, Bacchetti P, Lee K (2007) Factors Associated with Findings of Published Trials of Drug–Drug Comparisons: Why Some Statins Appear More Efficacious than Others. *PLoS Med* 4(6): e184 doi:10.1371/journal.pmed.0040184

[2] Quoted from the Editors' Summary, op.cit.

[3] Authors quoting references on p.8 of the book.

[4] Gigerenzer G. *Reckoning with risk: learning to live with uncertainty.* London: Penguin Books, 2002, p.101. Quoted by the authors.

Annual Meet 2006 Paper

The Indian Experience of PSM Departments and the Teaching of Public Health

-Dr. N.S. Deodhar, Pune

Prologue

Traditionally, the subjects of physiology and hygiene, and hygiene and public health were taught in secondary schools and medical colleges, respectively, in Indian educational system. What was the rationale in discontinuing this practice? In the late 1940s in the Western world, there was a paradoxical situation of the decline in the status and fall of the discipline of public health as a result of the successful control of communicable diseases, improvement in environmental health, etc. Insights and contributions of Professor Edward McGravran of University of North Carolina, and Prof. Huge Leavell of Harvard School of Public Health, USA, in regaining the lost ground resulted in broadening the pure curative function of family physicians and consultants to include the disease preventive and health promotion aspects; this was the origin of community health.[1]

With this backdrop, the first International Conference on Medical Education was held in London, UK, in 1954. One of the recommendations was to discontinue teaching of the subject of public health and hygiene in the medical colleges because it was considered as outdated. It was proposed to create a Department of Preventive and Social Medicine (PSM), British equivalent of community medicine, in every medical college. The objective was to strengthen the prevalent curative clinical medicine by supplementing it with the preventive and social components. The idea was to make the practice of medicine, especially of the general practitioners and/or of family physicians more health-oriented and community-focused. As it has often happened in many efforts in reorientation of medical education (on foreign 'expert advice'), the good intentions and objectives are lost during the process of 'advancement'. There are many reasons for this, especially of lack of clarity and insight on the implications such as provision of appropriate and adequate inputs which are required to effectively implement recommended measures or reforms, apathy and tendency of the faculty members and management to maintain status quo, and the failure of the authorities to provide necessary inputs adequately and in time. The aim of this paper is to stimulate introspection on the part of the authorities like Governments and Medical Council of India, Faculty Members of the PSM Departments and Indian Association of PSM for an in-depth evaluation of the current status of teaching of the subject at the undergraduate and postgraduate levels vis-à-vis the objectives with which these special departments were established. Hopefully, this will result in discovering their present role in strengthening the moribund public health services and system in India, and developing a flexible plan of action for restructuring, designing and empowering the departments to play the new envisaged role effectively and efficiently.

Take Off

Our Governments and authorities are quick in accepting recommendations originating from international sources, but characteristically implement them half-heartedly and ineffectively. Firstly, two departments of Preventive and Social Medicine in India were established in 1953 at B.J. Medical College, Pune, and S.S.G. the Government for this highly demanding task was a professor, junior lecturer and a clerk put in a single room. Dr. J.K. Adranvala at Pune and Dr. A.K. Niyogi at Vadodara, who initiated the discipline of PSM were highly successful public health experts and managers with insight for amalgamation of the old subject of public health and hygiene (discarding the non-essentials for a general practitioner) into the teaching of new discipline of PSM and making it meaningful to the students by its practice in the community and hospital situation. I happened to be the first junior lecturer at BJMC, Pune. I was surprised at my selection by Prof. J.K. Adranvala because in the interview I had explicitly declared that my primary interest was in surgery and getting M.S. degree. I also vouched that my interest in surgery will not come in the way of my discharging my duties fully and efficiently. These two departments developed and evolved different patterns for teaching PSM, but both laid emphasis on epidemiology. Teaching of biostatistics,[2] epidemiology and comprehensive bed-side clinical sessions at the Infectious Diseases Hospital, were initiated at Pune, while CPGP (Curative Preventive General Practice) Units at Vadodara, were some of the items of variation.

In 1955, the Government of India decided to create a department of preventive and social medicine in each

medical college.[3] In due course, more departments of PSM were established. Persons, who were in charge teaching of preventive and social medicine, had different backgrounds, capabilities and vision. The concept of preventive and social medicine was rather nebulous. The scope and potential for development of PSM was so wide that various ideas – some of them vague – were tried out and teaching of this subject at different colleges in India disclosed amazing variety of content and method. This teaching was not a smooth task. There was no recognition of the new discipline by many clinicians. Early phase up to 1970 constituted a transition period when there was philosophical talk on positive health when illness was rampant. Transformation of 'public health' to 'preventive medicine' was hampered by a shortage of qualified and suitable teachers, and teaching was also affected by the fact that students were admitted in progressively increasing numbers. Administratively, there was more of hindrance than support, more ridicule than help, and much unrewarding paper work. While these conditions still prevail to a varying extent at some places, there is a general improvement. The new discipline is, however, still far from mature. There were unwarranted moves for empty educational reforms such as for change of the name from Preventive and Social Medicine to Community Medicine.[4]

Emergence of the new Departments of PSM in many divergent ways was, in fact, a healthy trait. Like Pune and Vadodara, PSM Departments at Banaras, Nagpur, Mumbai, Delhi, Lucknow, Hyderabad Indoor, Vellore, etc., have their own distinctiveness. These various PSM departments developed their own ways and specific activities. Their performance has been neither reviewed nor elaborated. For want of information, and need for objectivity, stories of these departments cannot be included in this paper. The success story at B.J. Medical College, Pune, is given in details so that some lessons can be drawn.

B.J. Medical College, Pune

The Department of Preventive and Social Medicine at B.J. Medical College, Pune, was established in 1953. Dr. J.K. Adranvala, M.R.C.P., D.T.M. and H., D.P.H., an eminent public health scientist and an efficient administrator, was the first full-time professor who directed the department up to 1960. At that time, the department was located in one big room, and only one Jr. Lecturer, Dr. N.S. Deodhar, and a clerk were on the staff to assist the professor. The teaching was limited to two academic terms for the undergraduate students only. There were hardly any field programmes, and the separate examination in the subject of preventive and social medicine at the University of Pune, was just abolished. From June 1961 to March 1974 I was in charge of the department. The staff, various aspects and final stages of development are indicated below.[5]

Staff

(a) *Full-time Staff at the College (H.Q.)*

1.	Professors	2
2.	Readers in PSM	3
3.	Reader in Social Paediatrics	1
4.	Reader in Social Obstetrics	1
5.	Reader in Demography	1
6.	Reader in Social Sciences	1
7.	Epidemiologist	1
8.	Statisticians	2
9.	Lecturers	7
10.	Medical Social Workers	2
11.	Research Assistant (non-medical)	1
12.	Public Health Nurse	1
13.	Health Educator	1
14.	Curator of Museum, Health Educator	1
15.	Artist and Photographer	1
16.	Projectionist	1
17.	Stenographer	1
18.	Nurse Midwives	3
19.	Auxiliary Nurse Midwife	1
20.	Basic Health Worker	1
21.	Laboratory Technician	1
22.	Laboratory Assistant	1
23.	Clerk-cum-storekeeper	1
24.	Laboratory Attendants and Peon	4

(b) *Honorary staff at the college*

25.	Hon. Lecturer in Infectious Diseases	1
26.	Hon. Consultant in Occupa. Health	1
27.	Hon. Consultant in Social Sciences	1

(c) *Staff at the Urban Health Centre, Poona*

1.	Reader in PSM I/C (from H.Q. staff)	1
2.	Lecturer	1
3.	Medical Officer, Dispensary	1*
4.	Hon. Dental Surgeons	2*
5.	Lecturer in Paediatrics	1
6.	Tutor in Midwifery	1
7.	Medical Social Worker (From H.Q.)	1
8.	Public Health Nurse, Sister Tutor	1
9.	Sanitary Inspector	1*
10.	Laboratory Technician	1
11.	Health Visitors	2*
12.	Vaccinator	1*
13.	Malaria Worker	1*
14.	Compounder	1*
15.	Statistical Assistant	1
14.	Clerk	1*
15.	Dresser	1*
16.	Class IV staff	2*
17.	Driver (from H.Q. staff)	1

(d) *Staff at the Rural Training Centre, Sirur*

1.	Reader in PSM I/C	1
2.	Lady Medical Officer	1
3.	Medical Officer, I/C PHC	1#
4.	Medical Officer, I/C Dispensary	1#
5.	Medical Officer, I/C Dispensary	1#

6.	Dental Surgeon	1
7.	Public Health Nurses	2
8.	Health Educator	1
9.	Health Inspector (Sanitary Inspector)	3+1**
10.	Lab. Technician	1
11.	Nurse Midwives	4+8#
12.	Auxiliary Nurse Midwives	8+1◆
13.	Basic Health	3** +2#+1◆
14.	Clerical staff	4
15.	Drivers	4
16.	Class IV staff	9+8#+1◆

(e) ***Visiting Specialists from Sassoon General Hospitals, Poona***

1. Professor of PSM, once a week.
2. Asso. Prof. of Medicine, twice a month.
3. Asso. Prof. of Mid. and Gynaec, twice a month.
4. Director of Paediatrics and 3 Hon. Prof. ? once a week by rotation
5. Asso. Prof. of Surgery, Once a month.
6. Hon. Dermatologist, Once a month.
7. Hon. Chest Specialist, Once a month.
8. Hon. General Practitioners from Poona, Four, once a week by rotation.

Note: Post borne on:

** - Poona Municipal Corporation,*
*** - Director of Health Services,*
 # - Zilla Parishad Poona,
◆ - Zilla Parishad Ahmednagar.

Space and Locations

The main department was located on the ground floor and the basement of the college building and occupies over about 775 sq. metres. Additional space in the basement of the adjoining block of the hospital building with an area of about 350 sq. metres was to be acquired. Immunization Clinic, Family Planning and Welfare Clinic, Antenatal Clinic, Postnatal Clinic, Well Baby Clinic, Cancer Detection Centre, Medical Social Service Department, Diabetes Clinic, Genetic Clinic, etc., were located in the Sassoon General Hospitals, Pune. Once established and stabilized, the services were directly run by the respective departments in the college and hospital, not necessarily by the PSM Department.

Field Practice Areas

The Urban Health Centre was located within a 5-minute walk from the college. A two-storied building with a paved open space, garden and playing facilities for children, was provided by the Poona Municipal Corporation.

The Rural Training Center was located at Sirur, about 69 km from Pune, serving a population of 48,000 spread over an area of 663 sq. km. Ample space was provided at the H.Q. with Clinic Buildings, Administrative Block, Teaching Block, Hostels for medical and other trainees, etc. At all sector villages, Health Clinics were provided.

Undergraduate Training

The teaching of preventive and social medicine passed through many phases of development and the following is the account of the final stage of evolution. The training extended throughout the M.B.B.S. course. Besides, integrated clinics were conducted at a near-by rural health unit, a subcentre, or a P.H.C., jointly in collaboration with Director of Paediatrics and his staff, during the senior paediatric clinical clerkship for one month.

Broad headings of the syllabus and the distribution are given in Table 1. A course of lectures during pre-clinical period was designed to point out the differences between the hospital and general practice of medicine. The method used was informal 'interactive talks' and discussion with smaller batches of students. Students' health service was specially developed as a practical demonstration in PSM, i.e., health care by doing it. This was a unique exercise of experience of learning through participation.

Bed-side clinics on infectious diseases at IDH were integrated with teaching of epidemiology of communicable diseases. These two hour sessions were conducted exclusively by the PSM department. Special feature was epidemiological exercises and application in clinical practice.

Our basic objective was to train a clinician for comprehensive medical care of the community, with a strong bias in preventive and social aspects so that he identifies and practises its principles at every opportunity as a family physician. We did not deliver a diluted 'Public Health' course.

Hours of Teaching

Excluding the internship, over 380 hours were devoted to teaching of preventive and social medicine. Out of these hours, 130 were for the theory classes and 250 for practical work. The whole period of 26 weeks during internship was used for practical experience and students were required to stay at Rural Training Centre, Sirur, for 2 weeks for orientation and at an upgraded Primary Health Centre for 24 weeks for comprehensive experience.

Table 1: Syllabus and Distribution of Topics

Period	*Topic*	*Time*
I M.B.B.S. – 1st term*	Students Health Service and Health Check-up	2 hr/wk
I M.B.B.S. – 2nd term	Introduction to Practice of Medicine .	1 hr/wk
	– Psychology	1 hr/wk
II M.B.B.S.– 1st term	Principles of Environmental Sanitation	4 hr/wk
II M.B.B.S.– 2nd term	Biostatistics in Medicine	4 hr/wk
II M.B.B.S – 3rd term	General Epidemiology	2 hr/wk
III M.B.B.S.– 1st term	Communicable Diseases, Epidemiology and Clinical	5 hr/wk
III M.B.B.S. – 2nd term	Community Health Practice	5 hr/wk
III M.B.B.S. –3rd term	Tutorials and Group discussions	2 to 3 hr/wk
Internship	– Comprehensive Medical Care, Family Study, Rural Medicine	26 wk

Evaluation and Assessment

Evaluation and assessment of the students were regularly done at the end of each academic term, and in some instances at the mid-term. Students maintained complete record of the practical work in the 'prescribed journals' which were certified at the end of the course. Both the content and methods of training various topics were critically reviewed and evaluated, and courses modified, if necessary.

At the III M.B.B.S. (final) examination of the University of Pune, there was a separate paper in PSM carrying 100 marks, viva voce, and clinical examination at Infectious Diseases Hospital. Question papers and examinations were designed so as to stimulate thinking and application of PSM knowledge and technology.

Postgraduate Teaching

The Department was recognized by MCI for conducting courses leading to D.P.H., D.I.H. and M.D. (PSM) of the Pune University. The Department was also recognized by the College of Physicians and Surgeons, Mumbai. Postgraduate students in other subjects also used facilities of the PSM set-up.

Most of the teaching was through participation and involvement, guidance, attachments and clerkships, visits, seminars and dissertation, guest lectures, journal club, field work and discussions. Action learning was important.[6] In addition to the central college library and other medical libraries in Pune, the department had an abstracts library, some periodicals and reports, and over 1,000 books and other publications, complete with subject index. It was rich in teaching aids and material. Eight good vehicles and a mobile laboratory van were available.

The postgraduate students participated in training of the undergraduates. They had to select and study a problem in detail and write a dissertation. The students were involved or even held responsible for managing Rural Training Centre at Sirur, investigating disease outbreaks, reported epidemics, or other health problems as and when occurred. Several other institutions and authorities such as Armed Forces Medical College, the Directorate of Public Health, Regional Family Planning Centre, Statistical Bureau, Central Public Health Laboratory, Pune Municipal Corporation, Infectious Diseases Hospital, University of Pune, etc., provided their full co-operation in the training programme.

Rural Health Centre, Sirur

This was established in 1939 by the Government of Bombay with the aid of Rockefeller Foundation. Up to 1956, the centre and 8 sub-centres were serving a population of 48,000 spread over an area of 663 sq. km. From January, 1968, Health Unit, Sirur, came under the control of the Dean, B.J. Medical College, Pune, and functioned as a part of PSM department. Apart from the medical students, the Unit trained postgraduate students for M.D. (PSM) and D.P.H. from, both B.J. Medical and Armed Forces Medical Colleges, the students for B.Sc. (Nursing), and the nurses and midwives, etc., for varied duration. Medical interns were trained throughout the year and good residential facilities are provided for this purpose.

The Centre was upgraded to train 40 interns at a time and to fulfill the requirements of the Pune University. Establishment of a second Health Centre at Khed (Manchar) to take up the additional load of 35 interns was considered, but the proposal was dropped in light of the scheme of revised internship programme. From 1st April, 1968, a new syllabus came into force for the rural internship. Interns maintained a Journal and recorded the work done, a requirement for the completion certificate.

Several authorities were working in the field practice area of Rural Health Centre, Sirur. Administrative agreement were reached and from 1st July 1970 all the health and medical staff from various agencies be put under the control of the Reader I/C of the rural Training

Centre for day to day work, supervision, etc.

One of the major defects in teaching of Preventive and Social Medicine was the lack of practice and demonstration of whatever is taught at the theoretical classes. It is a well-known fact that the students learn and know what they do themselves, they understand, try to retain what they see and read, and tend to forget what they only hear. Therefore, the solution to the effective education in PSM obviously was to design and develop the rural (Sirur) and urban field practice areas so as to provide an effective instrument of teaching and demonstrating practice of PSM and comprehensive medicine. A lot was also done even in the Sassoon hospitals. However, a teaching hospital, the well established traditional institution of medical education, provides only a limited opportunity for the practice of PSM, especially community-oriented and at a level of general practitioner.

Health Clinics (comprehensive dispensaries) at sector villages were developed so as to demonstrate a desirable set-up of general practice which ensures a high standard of rational and scientific medical practice, and brings about a positive relationship and partnership with the local health services for mutual benefit and welfare of the people. Not only all the basic health needs were satisfied, but also specialist and some diagnostic services were provided. We successfully secured support of the Sassoon General Hospitals, and Senior General Practitioners from Pune. Facilities such as clinical laboratory, 50 MA X-ray machine, etc., were provided to help the consultants who attended primarily to guide and provide consultation to the interns. General practitioners and paediatricians visited the sector villages and conducted "community-side" clinics. These speciality clinics were organized on all Thursdays.

1st Thursday: 1. Prof. of PSM. 2. Asst. Prof. Mid. and Gynaec. 3. Hon. Prof. Tuberculosis. 4. Hon. Asst. Prof. Paediatrics. 5. General practitioner.
2nd Thursday: 1. Prof. of PSM. 2. Asst. Prof. Medicine. 3. Lecturer in Paediatrics. 4. General practitioner.
3rd Thursday: 1. Prof. of PSM. 2. Asst. Prof. Mid. and Gynaec. 3. Hon. Asst. Prof. Dermatology. 4. Hon. Prof. Paediatrics. 5. General practitioner.
4th Thursday: 1. Prof. of PSM. 2. Director of Paediatrics. 3. Asst. Prof. Medicine. 4. Asst. Prof. Surgery. 5. General practitioner.
5th Thursday: Prof. of PSM. or Pharmacology or Ophthalmology, etc., visited as required.

Rural Training Centre was considered as an integral, part of Sassoon General Hospitals. Patients could be admitted directly from the Centre to the hospital, if necessary. Ambulance service was also available. This rapidly developing wing of the Department, recorded its full activities in its annual reports. Details are elaborated elsewhere.[7]

Basic Health Services

Rapid expansion of the medical and health services on *ad hoc* basis, etc., made the administration of health services a complex problem. Thus, it was decided to plan an alternative and establish Basic Health Service (BHS) as an experiment at Sirur. For the first time in Maharashtra, a nucleus was created to implement B.H.S. in replacement of the classical vertical pattern of the delivery of health care. Pooling the staff of various agencies and unifying the authority on purely voluntary basis on persuasion, it was been possible to put the dream into action. One basic health worker and one ANM were provided for a population of 4,000 to 5,000, with adequate supervisory staff. These services were used for demonstration and to train paramedical trainees.[8]

Revised Internship Programme

One of the important problems we faced was 200 admissions annually resulting in a large number of interns to be posted in each term. While we organized undergraduate training at college by sub-dividing the big batches and at the same time maintaining efficiency, this was not possible during internship. In order to make the internship programme meaningful, an attractive and more effective, revised plan was introduced. Initially, the intake was limited to 20 seats, but it was expanded every year to accommodate all the interns eventually. The main features were: (a) Experience in one of the district hospitals for six months instead of at a teaching hospital. We realized that one of the difficulties in teaching of comprehensive medical care was what was seen, practised, and continuously experienced by the students for three years in a teaching hospital, as was ours – an example of overstrained hospital practice of medicine with its high specialization and sophisticated grandiose. An easy and practical way out was to discontinue their posting at Sassoon General Hospitals, Pune. (b) More closely guided and supervised rural medical experience at selected P.H.C. for six months.

Initially, seven Primary Health Centres in Pune District were upgraded. Later the number was raised to 21 covering three districts. Items for upgradation included provision of good residential accommodation to two or four interns at one PHC, satisfactory boarding

facilities, suitably equipped clinical laboratory, transport, experienced and interested Medical Officer, PHC fully staffed with an addition of a post of laboratory technician and additional annual recurrent grant for extra medicines, laboratory supplies, specialist visits, etc.

For a selected population the interns were to provide comprehensive medical care with 'total coverage'. This was in addition to participation in the normal functioning of the Centre. The experiment was successful with encouraging response of the students and staff. Specialists regularly visited the PHCs. Separate vehicles and allowances were provided for specialist visits to selected PHCs. Outline of a minimum programme for training of Medical Interns during six months of rural posting is reported elsewhere.[9] The programme was evaluated and in general, the work done by each intern was found more than the required minimum. The interns were enthusiastic, showed considerable interest and maintained fairly good records.[10] The unique success of this six-month rural internship resulted in its recognition by MCI as an alternative and the Government of Maharashtra extending this programme to all Medical Colleges in the State.

Urban Health Centre

The Urban Health Centre was established for demonstration of community health services, relevance and impact of social and economic factors on health and disease, comprehensive and integrated medical care, continued care, etc., and covered population of about 25,000 consisting of all the socio-economic groups. The area included small industries and the Gadital slum was nearby. The area was about 518 hectares (two sq. miles). U.H.C. was developed as a field practice area for undergraduates and postgraduates from B.J. Medical College and Karve School of Social Work. Interns and Pubic Health Nurses were also attached to the Centre for training purposes. In addition to training and research, the U.H.C. provided the following services to the people through its various clinics: (a) Medical care (b) Antenatal care (c) Family planning (d) Well baby clinic, including milk and diet supplement (e) Crèche (f) Immunization[11] (g) School health service including mid-day meals (h) Dental care (i) Follow-up and extension services and (j) Health education. Senior students are posted at the centre for case-studies and presentations, participation in the health services such as school health check-ups, counselling and referral services, immunization, health education, morbidity surveys, nutritional projects and research, MCH, etc.

Other Activities

The PSM Department of BJMC initiated many other fields of activities, e.g.:

***1. Family Planning Centre*:** This was attached to the hospital. This centre and field unit of the regional family planning training centre was used for training of medical students.

***2. Immunization Clinic*:** This clinic for comprehensive immunization was established with the help of the Immunization Committee of Pune. This Centre promoted triple immunization and polio protection in Pune. Both the public and the doctors were active resulting in couple of lakh of children fully being immunized within a few years.

***3. Cancer Detection Centre*:** This was established with the help of the Pune Branch of the Indian Cancer Society. This weekly activity was one of the few such centres in India then.

***4. University Students Health Service*:** This was established in 1962 as an activity of the University Board of Students Welfare and run by the Medical Advisory Committee on both of which PSM professor was a member.

***5. Health Education*:** This was a permanent and specialized activity at the OPD of the hospital. Many instructive charts and posters were specially prepared and permanently displayed in the hospital at suitable places. Once or twice a year, health exhibitions were arranged on a large scale for the public in and outside the hospital. Special days and occasions such as World Health Day; anti-fly week; smallpox, leprosy, tuberculosis and other control programmes; voluntary blood donation drives; etc., were scrupulously used for educating the public. Health talks were given by the Curator of the Museum to the in-patients at Sassoon as a part of a project 'Health Education in Hospital.'

***6. Museum*:** A permanent health museum was provided for the undergraduate medical students and nurses for study. The department had its own library, charts, posters, films, slides and other audio-visual aids, material, in good quantity and standard.

7. Health Exhibitions became a characteristic and well recognized expertise of the department which acquired proficiency in this field by practice. Several exhibitions, general medical, health or in special topics such as cancer, food adulteration, leprosy, family planning, smallpox, diabetes, etc., were very popular in Pune. The exhibits were mostly prepared by the artist section, and real specimens from anatomy and pathology museums and energetic explanations by the students made them live.

8. Medical Social Service Department of the Sassoon General Hospitals was reorganized and guided by PSM

Department from 1961. It became one of the well-developed activity of the departments and looked especially after many social and non-medical aspects of patient care, rehabilitation[12] and welfare. It was staffed by two experienced and efficient medical social workers, a craft teacher, clerks and other personnel. A band of voluntary social workers from Pune assisted them. In due course, it was given the status of a separate department dealing with several hundred of cases every month. The staff participated in teaching. Of special significance was establishment of an association of helping citizens of Pune, "Society of Friends of Sassoon Hospitals". Its primary concern was the welfare of Sassoon patients. It raised funds and worked closely with administration.

Consultations

The PSM Department provided consultation services not only to the practising doctors in the city and others on technical matters, but assisted clinical and other departments in the diagnosis and management of communicable diseases, immunization, statistical advice and help, and several other problem solving. It also assisted the Health Department of the Pune Municipal Corporation, and Directorate of Health Services, Maharashtra, Pune, in epidemic investigation and dealing with other health problems.

Assistance was rendered to the Outpatient Department to improve the services, and for training medical students and interns in general medical practice. Through planning, modification and decentralization into multiple GP Clinics remarkable results were achieved. General waiting period in OPD was reduced from couple of hours to just half an hour.

Research

Many studies were carried out by the department. Several papers and three books were published. Some of the important works included, (1) Early diagnosis of smallpox by skin-smear and other tests. (2) Socio-economic study of medical students. (3) Study of susceptibility to infection and herd immunity against diphtheria. (4) Epidemiology of "Poona Disease" ? a new discovery, a polyuria and polydipsia syndrome, which was earlier wrongly called epidemic diabetes incipidus. On investigation, epidemiology was defined, etiological factor was discovered and the disease was reproduced in animals. (5) Intradermal immunization against Typhoid. (6) Investigations on outbreaks of smallpox, epidemic dropsy, typhoid fever, infectious hepatitis, etc. (7) Rural pre-school children, studies on growth and nutrition. (8) Long acting penicillin in prophylaxis of post-traumatic tetanus. (9) Study of General Practitioners in Pune. (10) Study of Calcium and Vit. D on growth of pre-school children. (11) Students' Health Service. (12) Polio project and Enterovirus study at Sirur Unit were some of the biggest. They were jointly taken with the Haffkine Institute, Mumbai. Serological surveys and virus isolations from stools were reported to the polio study group of ICMR. Over 4,000 paired-sera were collected from immunized and unimmunized children between 1 to 10 years in Pune, and serologically tested as a follow-up study of efficacy of regular polio programme. Prints are available on a CD.

Publications

Medical education was one of the major interests, and some of the publications related to training of medical students. The financial difficulties were solved mostly through improvisation and economy. Use has been made of the regular resources available at the college and other institutions in Pune. From time to time research grants were also procured from sources such as ICMR., University of Pune, pharmaceutical industries, etc.

UNICEF Support

The department was recognized by UNICEF and was strengthened by supply of books, many vehicles, special laboratory equipment such as spectrophotometer, etc.

Upgradation of the Department

With these contributions and development, the Department of Preventive and Social Medicine at B.J. Medical College, Pune, was the first to be upgraded for post-graduate training by the Government of India during the IV Five-Year-Plan from March 1970. Additional staff and special equipment were sanctioned. A lot of equipment including 80 column data-processing equipment of I.C.L. was installed. Bio-statistics, occupational health and nutrition laboratories were in established. The project was completed in four years.

Eye on Future

For us what remains to be done was always important. A dynamic approach was necessary in developing the discipline of preventive and social medicine or community medicine. Newer perspectives in medical education were needed and newly acquired knowledge and techniques of communication, environmental and social sciences were to be passed on and made meaningful to future medical practitioners. The people were to be informed and organized in constantly changing and divergent community settings, environment, etc. Motivation remained an important

determinant for action - individual and social. An average general practitioner may not be able to employ the latest advances in diagnosis and therapeutics owing to lack of resources, but his/her failure to avail him/herself of the opportunities for preventive actions, has been often because he/she never thinks of it. How to make them think of and realize these opportunities? The 'bed-side' model of teaching and learning has been singularly effective in clinical medicine and surgery. For training of tomorrow's basic doctor "community" has to be the "ward" for future students.[5] A new 'community-side' model for educating medical students was to be perfected. Serious efforts are necessary for institutionalizing the approach.

Vision[13]

Major considerations were as below:

1. Much that was being taught in the traditional 'Hygiene and Public Health' to medical students was outdated and not relevant for medical practice.
2. Specialization and overprofessionalization of medicine weakened doctor-patient relationship and human values were neglected.
3. Significance of social factors in the causation, impact and management of ill-health, prevention of disease and promotion of health in medicine was recognized. Ryle introduced the term 'Social Medicine' to describe a new discipline.
4. Preventive and Social Medicine is purely a clinical subject with emphasis on comprehensive community practice and epidemiology.
5. Aim of teaching PSM is development of concepts and acquisition of skill and knowledge for practice, not in isolation, but integrated with the practice of general medicine or its specialties.
6. Students should be trained not only in class-room (this was inevitable), but also by making them learn through demonstration and participation. making them learn through demonstration and participation.
7. Development of 'teaching communities' where PSM is practised regularly should be an essential activity as a tool for training purpose. Objective is to remove the notion from the mind of students that this subject is to be studied only for passing examinations; and that the principles of PSM are good, but have no place in practice.
8. Aim of teaching undergraduate students is not to supply public health specialists, but to turn out good practitioners of medicine, who are aware and capable of providing comprehensive and integrated medical care, duties towards the community, and responsibilities in the national health programmes.
9. Preventive medicine is not the only important subject; it has no existence without curative medicine. Prevention is a part of medical care.
10. Students have a mental barrier in appreciating the needs of rural population, role of environmental sanitation, traditional customs and beliefs, and inadequacy of medical and health facilities, etc. Thus, special attention has to be given to make PSM teaching meaningful and interesting.
11. Last but not the least, in teaching PSM, one has to work closely with all other departments, viz. paediatrics, medicine, midwifery, surgery, and others, e.g. tuberculosis, dermatology, venereology, dentistry, ophthalmology, etc. Good cooperation, collaboration and informal relationship with the Directorate of the Health Services and the local health authorities – both municipal and rural – are vitally important. Constant and effective contact with the community is necessary; and this can be ensured only through high quality and uninterrupted services. Teaching of medicine in a community can never be effective without winning the confidence of the people and their active support and participation.

This provided guidelines in designing the curriculum, method and manner of its delivery. With a continuous evaluation for over 15 years, programme of teaching PSM was evolved at the B.J. Medical College, Pune. Details are available elsewhere[14]. On all courses, care was taken to provide illustrative examples which had direct bearing on real-life situations as related to medical practice, people, socio-economic development, sanitation, etc. For example, in the practical work in statistics, data on physiological variations collected from the students' themselves is made use of. Extramural teaching was done as much as possible through field visits and demonstrations, etc. For example, most of the teaching in environmental sanitation was through the visits and demonstrations. In most of the courses the proportion of class-room lectures to practical and field work was 1 is to 2 or 1 is to 3.

Highlights

The success of our endeavour did not lie in recognition and upgradation by the Government of India. It was not so much on acclamation received nationally and internationally, as on the exploratory and study visits by the national and international experts, officials of the international agencies and governments, students, etc. Real contribution was expert manpower development and practitioners. There are score of students who are practicing community health in a variety of fields such as comprehensive general

practice; environmental health; health education; clinical specialties like paediatrics, orthopedics, obstetrics and gynaecology, ear-nose-throat; epidemiology, health administration and applied research. A second line of command was in place.

Decline of PSM

The PSM Departments were neither reviewed nor their functioning evaluated. Barring a few exceptions, PSM Departments failed in the development of expertise and proficiency in one or more of the sub-topics and sub-disciplines, e.g., epidemiology, biostatistics, communicable and non-communicable diseases, environmental health, nutrition, lifestyle and behaviour, health systems research, health education and so on. This is reflected in paucity of publications. Examinee Appendix Table A. Of the several reasons, major ones were mediocrity, lack of insight and research, lack of practice and proficiency, etc. Statements by two of the highly reputed personalities in India are revealing.

The late Dr. R.V. Sathe said, "Despite these multiple developments, the impact of this discipline of preventive and social medicine on the medical college on the whole including their various departments, is not as distinctive and enduring as one would have hoped."[15] The late Col. Amir Chand observed, "Has such teaching of PSM which has been expected to have been going on for several years, made any real impact on the teaching and practice of 'Medicine or Community Medicine', if you like to call it? No it has not." [16]

Prof. D. Anand has deliberated on this topic in an editorial, the title of which is self-explanatory, "Community Medicine - The Never Born - A Story of Two Decades."[17] Some of his statements are note worthy, viz., "(1) … attempting to entrust so much to so few with so little. (2) … the faculty members in this department continue to be second-class citizens. (3) Today teachers lack enough field experience. (4) Faculty not responding o the need for establishing out-of-the wall field training sites. (5)…medical students got impression that community medicine is the name of a mental concept that is to be talked and discussed, but it is not seen in day-to-day practice."[17] Bhatia provided a very long list of reasons for failure of PSM Departments in India and classified them in seven broad categories.[18] Bir Singh supplemented.[19]

As I feel, the initiation of post-graduate course of six month's duration leading to M.D. (PSM) was a disaster and the beginning of decline in quality, etc. It was too premature, having been initiated when the newly introduced discipline was far from mature development. The duration was soon changed to two years, but the quality left much to be desired. For want of quality, adequacy and high standard, barring few exceptions, qualification MD(PSM) is not synonymous with expertise, proficiency and capability. I preferred to give up examinership because of the disgraceful low standards I experienced.

Further, there is always a gap between the syllabus, curricula and the actual teaching of the subject. In order to rectify this inevitable limitation and to ensure to satisfy the educational aims and objectives of the training courses, text-books were developed as an instrument to facilitate self-learning by the students. In this respect, the most popular current text-book was a disaster. Basic Preventive and Social Medicine edited by me and the late Prof. J.K. Adranvala was designed to promote practice of PSM by general practitioners and NOT to serve as a guide to pass examination. It failed to survive for second edition. Some more text-books have come up, but the popular book predominates and forms basis even for the postgraduate studies. Naturally, the standard has reached the very bottom. Efforts to persuade the office bearers of the Indian Association of Preventive and Social Medicine for taking up the task of producing a text-book separately for the under- and post-graduates have fallen on deaf ears.

One can get insight into any discipline only after its application and practice which promotes thinking and leads to proficiency. Unfortunately, this has not happened. We can imagine the path of a department of surgery, were it without operation theatre and otherwise no surgery undertaken. Precisely, this is what has happened to most of these departments in India. My personal observation infers that the performance of health care services was poorer, if any, at the nearby primary health centre. There may be couple of exceptions that prove the rule.

Unfortunately, with lack of leadership and direction, mediocrity, lack of interest and support from the college and State authorities, PSM Department, B.J. Medical College, Pune, also has fully abandoned its special and unique characteristic and activities. The degree of deterioration is unbelievable and all-round. The field practice areas are defunct. Faculty totally lack clinical background, interest and experience, and special posts have been converted into 9 posts of Associate Professors and 6 posts of Lecturers in Preventive and Social Medicine. All of them are confined within the four-walls of the much withered department and have nothing to do even with the Sassoon General Hospital,

Internship, Public Health, etc. It has fallen in line with the majority of PSM Departments in India.

The Future: Since the First International Conference on Medical Education held in London in 1954, much has been said and repeated in many conferences and seminars on reorientation of medical education in this country. But in reality, medical education continues, more or less, in the same fashion as it did in the beginning of the 20 Century. Necessary reforms in our teaching hospitals are considered elsewhere.[20] How to go about PSM? It is best that some of the active and progressive young faculty members deliberate this endeavour and chart a flexible plan of action on experimental basis. Some of my thoughts are briefly given here. The case of B.J. Medical College, Pune, is provided earlier. Although it has been totally ruined, field practice areas are defunct and the only activities are confined to class-room, it is possible to draw some lessons.

Even if the defunct internship is revived, this programme for one year will certainly not provide a remedy. It is our experience that this period cannot be used for bridging the defects in the training imparted at a medical college. One year is too short a period to undo wrong impressions, habits and attitudes acquired in a teaching hospital and then to train the interns in comprehensive medial care. The experiments at Colorado and Tennessee schools of medicine in the USA have shown that the set-up of a medical college hospital can be changed by removing the restrictions and making room in a big way for general practice units. In Poona a beginning was made, but discontinued. However, it is felt that this modification is neither difficult, nor is it expensive.[20] Nevertheless, very few, if any, of our medical colleges will be willing to do this, and let us not depend on this reform. The proposed adoption of three primary health centres by each of the medical colleges by the Medical Council of India, has not found any takers.[21] In fact, PSM Departments have failed even to manage one subcentre of PHC efficiently. Some of the possible methods that will help to improve the pathetic situation are discussed elsewhere and need to be considered seriously.[22,23]

The five levels of prevention, based on the natural history of disease, form the pillars on which the teaching of PSM/community health should be based. This is what the curriculum revised by MCI requires. Rest of the structure can be provided by epidemiology and social medicine. The students should be able to witness and experience some of the social factors that may initiate or influence the disease process, and may determine the patient's reaction to the disease. It is also essential to expose them to the social consequences of the disease and to demonstrate what the best compromise between the theoretically ideal treatment is and what is possible in the patient's social circumstance. The above will be served only if there is a strong field programme before internship. The field programmes in comprehensive medical care are, therefore, most important in training of the future doctors whose dual function is curative and preventive medicine. Unless such an integrated practice becomes the rule, there will be no worthwhile progress in the promotion of health and long-lasting relief of suffering. It is unfortunate that this most important facet of teaching is the most neglected, mostly because of the indifference and apathy in providing the necessary staff, equipment, transport and other facilities to the departments of preventive and social medicine.

In light of the new redesigned PSM curriculum by the MCI, it is essential to restructure and reorganize PSM Departments. Qualification and experience required for the faculty should be revised. In every major clinical speciality department, there should be an associate professor of PSM who has postgraduate degree in that discipline and training in PSM. PSM Department should be a part of Health Services Department Professor of PSM should have post-graduate degree in public health and five years experience in field of public health at a level that of a deputy director of health services. He/She should be responsible for the delivery of health services in the relevant district. The staff of PSM Department should be exchangeable with that in the Health Services, e.g. those of the clinical specialists who have worked for two years at Community Health Centre should be considered basis of their performance for the post of Associate Professor (PSM) in appropriate clinical department of a medical college.

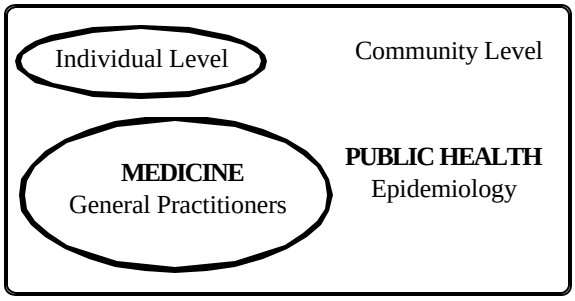
The indispensable requirement, however, is to improve expertise and capability. It is obligatory to demonstrate successfully advancement and/or development in any of the wide field of PSM or public health. This should be self-revealing and need not be told or advertised. The late Prof. D.N. Pai of G.S. Medical College, Mumbai did precisely this in the field of family planning and brought not only prestige and recognition to the discipline, but also was awarded Padmashri by Government of India.

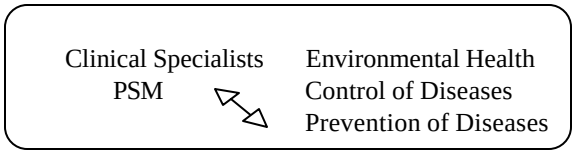
"Public Health"

Background

There is big confusion in the use of common terms such as public health, Community Medicine, PSM, Health Care, Health Services, etc. Often some of these terms are taken as synonymous, e.g., PSM and Public Health, Health Care and Medical Care, etc., although it is not at all true. It is desirable that at least in the academic and management circles, these scientific terms are correctly used. Explicit definitions are available.[25] It is vital to understand that PSM is only a part of medicine and both are part of public health. See diagram 1.

Diagram 1: ***Relationship: Health and Medicine***





Promotion of Health and Quality of Life

PSM is a mechanism or instrument for adjusting medical practice to subserve some of the objectives of public health. PSM should serve as a functional link between clinical and public health practices. It is in this regard, the PSM specialist should be primarily an expert in public health and related sciences such as epidemiology. Unfortunately, the story of postgraduate education in public health in India, is as pathetic, if not worse, than that in the case of PSM.

History of Education in Public Health in India

High standards of environmental sanitation which were manifested during the Indus Valley period in Mohenjo Daro must have had a tremendous back-up of education and training. The essentials for health care were neatly woven into the daily activities of life or "dina charya". In fact, the modern concept of primary health care for all has been aptly and beautifully expressed in an ancient Sanskrit verse: "Sarve santu niramayaha, sarve sukhinaha santu". Surgical procedures such as reconstruction of the nose would never have been successful long before days of Lister Pasteur without sterilization (Pavitra) and unquestionably high standard of aseptic techniques.[25]

With adoption of the Western model of 'health development', the lopsided development of the medical component of the health services has significantly slowed the pace of providing essential health care to the rural population and urban poor.

Nevertheless, the School of Tropical Medicine was established in Calcutta in 1922 and All India Institute of Hygiene and Public Health was established also in Calcutta in 1932. The purpose was to investigate methods of applying knowledge for benefit of the community and to train the health officers in local settings rather than train them in England. The Bhore Committee furnished a blueprint for the health services in India and recommended education and training of public health specialists, including strengthening of teaching of preventive medicine and public health at the medical colleges. It stated that the teachers of hygiene (now PSM) should be members of the Public Health Department who are actively engaged in public health work or who were till recently so engaged. Very ambitiously, it envisaged that the future basic medical practitioner's training in public health would be on par with that of the then current curriculum for the Diploma in Public Health at Calcutta.

Failed PSM

PSM departments were expected to do quite a lot, but, in practice very little happened except for some notable exceptions. The inputs were too meagre, while the expectations were too high. Hardly any talented person joined the discipline of PSM as first choice. With the formation of a separate teaching cadre, PSM staff stood fully insulated from the practice of public health, and even that of preventive medicine. The Departments have built cocoons around them. Under these circumstances, it is not surprising that PSM and public health training at undergraduate level remained substandard and far from satisfactory. Integrated medical care is not easy in practice.

Notwithstanding the sad state of academic accomplishment, developmental contributions and proven tract of record quality training, etc., about 60 of the PSM Departments have been recognized by the Medical Council of India for conducting a post-graduate course leading to MD (PSM), and about 20 of them for awarding a Diploma in Public Health. It is

obvious that MCI has neither basic expertise nor insight in post-graduate education in health and related sciences. In this connection, it will be worthwhile to examine as to how many of these departments satisfy the recommendations (for undergraduate course) of the Bhore Committee mentioned under Appendix 29, Volume III of its report. Instead of improving it, MCI has helped to lower the standards of training in 'public health'.

Further, medical and public health services were integrated. This resulted in a gradual, but substantial erosion of the discipline of public health. Public health, at one time, was not even recognized by the Ministry of Health and Family Welfare, Government of India as a discipline. Now it has been equated with the narrower subjects of PSM, community medicine, etc. Over a period of time, the medical officers who were posted as the health services administrators or managers at different levels have had neither formal training in public health nor familiarity with the developments in modern management techniques, and more so in planning and provision of health care to the poor.

In effect, the current health services are in name only. In reality, they provide medical services. Preventive and promotive health services have received a much lower priority in development in comparison with that for the curative services. While resources were mobilized to open over 200 medical colleges in India during the last 50 years, the only school of public health – the All India Institute of Hygiene and Public Health – at Calcutta suffered from almost total neglect. There were no takers when the VII Plan provided funds for opening schools of public health or equivalent.

The only ray of hope was establishment of the National Institute of Health Administration and Education (NIHAE) in New Delhi, in 1964. Its Staff College course in Health Management of three months' duration was unique and innovative. I was fortunate to have undergone and experienced the quality and high standard of this excellent course. In fact, this institution would have tremendously contributed in promoting meaningful practice of public health in India. However, this was not to be. The National Institute of Health and Family Welfare (NIHFW) was started by amalgamating NIHAE and National Institute of Family Welfare. Salt was added spoiling the milk. In the process, NIHFW and the courses run by it got aborted.

All India Institute of Hygiene and Public Health: This was established in Calcutta in 1832 with an objective of training public health officers locally in India in preference to training them in the UK It was in a key position and provided the country most of its public health specialists including the public health engineers. Its multi-disciplinary departments included Public Health Administration, Epidemiology, Biostatistics, Microbiology including Parasitology and Entomology, Biochemistry and Nutrition, Occupational Health including Physiological Hygiene, Environmental Sanitation and Sanitary Engineering, Maternal and Child Welfare, Health Education, Preventive and Social Medicine, Veterinary Public Health, Anthropology, and the urban and rural field practice areas at Chetla and Singur, respectively. It conducts several post-graduate degree and diploma courses. The total annual admissions are about 250. It has contributed significantly in health services research and many of the recommendations of the Bhore Committee were based on the work done at this Institute. The major course leads to DPH. Yet, it has remained static and has become out-dated for the current and future needs for health managers. With general lack of interest, available seats are not fully utilized by State and Central Governments.

Few more institutions can be legitimately deemed as centres for training in public health:

1. *National Institute of Health and Family Welfare, New Delhi*: This Institute plays a complementary role to AIIHand PH, Calcutta. It has almost all the components of a school of public health except departments such as Environmental Sanitation, Health Education, Occupational Health, Parasitology and microbiology. Apart from several orientation training programmes, it conducts post-graduate courses leading to M.D. in Community Health and Hospital Administration. It also conducts health systems research.
2. *National Institute of Communicable Diseases: Located in Delhi*: It was established by expanding the scope of the famous Malaria Institute of India which was universally known for its research and contribution to epidemiology of malaria. Now the NICD is engaged in research and training in the control of communicable diseases.
3. *School of Tropical Medicine*: This was established in Calcutta in 1922. It has contributed significantly in the clinical and epidemiological aspects of tropical diseases. It offers post-graduate diploma in Tropical Medicine and Hygiene.
4. There are several other Institutions and Centres in India which are devoted to one or the other aspect of research or training in public health components. These are listed elsewhere.[25]

Prescription

If the training of public health manpower is to be ensured, the following are the minimum requirements: (1) In the first place, public health shall have to be accorded the priority it deserves. In order to attract talented persons and those with a proven tract of success and leadership qualities, it is essential to ensure professional career development. Most feasible and best available alternative in the current situation is to create a new cadre of National Health Service (NHS) which is on par with that of IAS and IPS.

(2) The very challenging task today is to strengthen the key leadership positions within the health services and within the various institutions for education, training and research. This is a fundamental prerequisite for providing Health for All through primary health care approach. The leadership will have several critical roles to play. These include: (a) Organizational, in harmonizing all activities at community level in all its components, by decentralization and adequate empowerment of the Panchayati Raj Institutions. (b) Epidemiological and health systems research for community diagnosis, decentralized planning and implementation of the programmes, monitoring and evaluation. (c) Managerial, to administer the huge and complex health organization, including meaningful and effective coordination with all developmental sectors. (d) Technological, in developing appropriate, relevant and cost-effective interventions to solve the varied national, regional and local problems. (e) Social, in ensuring community involvement and participation, and promoting self-reliance and initiative on the part of the people.

(3) Establishing new schools of Public Health with whatever titles one desires to give them, and to maintain high standards and excellence in education and research will be a right step. High standard of public health in USA is due to establishment of about 25 schools of public health during the last forty years. Many are of high repute in terms of the competence and proficiency of their alumni. The success of NIHAE was because its second director Dr. T.R. Tiwari could gather and nurture a world class faculty for it. This is the secret formula for institutional building. The Study Group of ICSSR/ICMR in its report, "Health For All – An Alternative Strategy (1981) recommends establishment of a chain of schools of public health in India. Report of the Working Group of the Planning Commission for the 7th Plan on Medical Education, Training and Manpower Planning (1984) provides the estimates for the number of public health administrators / managers from 9,600 to 10,750 by 2000 A.D. It recommends establishment of new Institutions for training and assessment of training needs, and the qualitative requirements.

(4) As regards other types of health manpower, issue was deliberated by Banerji.[1] Potential schemes such as MPWs and CHWs (HGs) have failed. It is felt that if the first three suggestions given above are taken care of, the questions such as comprehensive health manpower development, etc., will resolve automatically.

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Appendix

Table A: Papers published in Journal of PSM/Community Medicine by Broad Classification

Topic	'75-80	'81-85	'86-90	'91-95	'96-97	2000-02	Total
1 Health determinants,environmental sanitation, nutrition, health education	7	10	7	10	3	15	52
2. Epidemiology, research, Health informa	7	12	1	4	3	5	32
3. PSM Teaching	3	1	1	2	1	4	12
4. General practice	5	1	0	0	2	0	8
5. Primary health care, social sciences, MPW, CHW schemes, smoking, drugs, alcohol, health economics	13	32	6	9	3	10	73
6. Urban and occupational heatlth	1	6	2	5	1	4	19
7. Family welfare	5	6	5	4	1	5	26
8. MCH and immunization	24	26	13	17	8	30	118
9. Communicable diseases*	24	17	6	13	5	20	85
10. Non-communicable diseases	9	8	4	11	6	8	46
Total	98	119	45	75	33	101	471

Note: This is a qualitative analysis, but without consideration scientific qualities. Since there are missing numbers and years, quantification may not be valid.

(*) Priorities distribution was Intestinal worms-15, HIV/AIDS-13, Diarrhoea and Malaria-5 each, Tuberculosis and Leprosy-4 each, Poliomyelitis-3, Cholera-2, and Hepatitis and Rabies- 1 each.

Considering the number of medical colleges and faculty size, the number of publications appears rather on low side for 25 years duration. There also appear to be distortion and fashion in the topics selected. Readers may interpret and draw their conclusions as to what this data suggest.

A Letter from Dr. N. H. Antia

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19th December, 2006.

Dear Dr. Ritu Priya,

Thank you for inviting me to the XXXII Annual General Body Meeting as well as the XXXIII MFC Annual Meet of Medico Friend Circle to be held in Bangalore at the end of this month.

I would have very much liked to attend this meeting because of my interest in Public Health Education. Unfortunately, it will not be possible to do so, since all my children from abroad will be with us at that time. Nevertheless I would like to get the proceedings of this meeting when available.

Here are a few of my comments on this subject:

Education in Public Health has always had the lowest priority in medical education though it is probably the most important. The present interest in converting medicine into a marketable commodity does not help in this field.

Despite producing 15,00,000 doctors except for a motivated few, it is uncommon for any doctor to willingly serve at the PHC and even at the CHC, lave aside at the village except under conditions of extreme duress. No amount of pressure from Dr. Ramadoss can solve this problem. This was attempted as a six month internship several years ago and was easily circumvented by the doctors for both monetary, cultural and social reasons.

It is important to first define which Public we are aiming to serve and differentiate Health from curative medicine which is the stock in trade. The attempt to circumvent this by establishing five Public Health Institutions based on the AIIMS and Johns Hopkins model can hardly be expected to serve the needs of our people who live in rural India and urban slums. The majority of them will emigrate to serve the needs for Public Health in the US and other western countries.

The problem is not of education but of the values that go with it. Even a state like Kerala has difficulty in this field.

The answer lies in defining both the Public as well as the problems of the health; a futile wild goose chase. It is hence necessary to devise alternative means to serve this laudable purpose, like the bare-foot doctor of China or the feldsher of the USSR, both of which are on the decline. The solution to the problem hence lies more in the field of politics than mere education.

Fortunately for us there are several experiences in our own country by motivated NGOs like the Aroles and FRCH demonstrate that the involvement of local female health functionaries with modest but highly practical training can undertake almost 80% not only of the problems of health but also of curative medicine of our people.

The recent resurgence of Panchayati Raj and the Right to Information can help them, but also to ensure that the government and even the private sector can be forced by them to serve the remaining needs that require greater knowledge, skills and facilities. The present induction of ASHAs in the National Rural Health Mission is an attempt in this direction, but cannot be restricted only to health and medical care but must be part of overall rural development for which adequate funds are available to the people of which they are not aware.

Ms Aruna Sharma an economist who has served as a senior IAS Officer in Madhya Pradesh for 10 years now provides us this much needed information which must be communicated to the people at large; not merely the Panchayats who are presently only extensions of a corrupt and inefficient political as well as bureaucratic system.

With regards,

Yours sincerely,
Dr. N.H. Antia

Annual Meet 2006 Paper

Overcoming the HealthCare Crisis: Bold Reforms in Medical Education and Health Service Systems

A Note Prepared for the XI[th] Five Year Plan Task Force on 'Planning for Human Resources in the Health Sector', 2006

-Ritu Priya[1]

Strengthening public health as a discipline through expansion of public health education is a widely recognized need, as is the constituting of an Indian Public Health Cadre (Kolkata Declaration, SEARO-WHO; D.Banerji; N.S.Deodhar). The MFC Anthology 'Medical Education Re-Examined' (1991) presents the earlier discussion in MFC on factors shaping the products of medical education. It draws links between the students' social background and thereby admission policies; the curriculum, teaching and evaluation methods they are subjected to; and the service system they finally go to work in.

This note, written for discussion in the 'Task Force on Planning for Human Resources in the Health Sector' for the XI Five Year Plan, places Public Health Education (PHE) within the context of the overall health service system on one hand and medical education on the other. It presents an outline for structural changes, not as a final blueprint for action but to generate discussion in the concrete for the present and future development of the health service system and its humanpower. It proposes one possible perspective for expanding public health education in India, and is therefore being circulated as background material for discussion at the MFC Annual Meet–RP

The Crisis and the Challenge

A crisis in our country's health services system is growing increasingly evident. The middle class and poor experience it as absence of affordable, effective and trustworthy services with stark shortcomings in the functioning of health care institutions and professionals. Doctors experience it as professional insecurity, since specialization has come to be perceived as necessary while opportunities are inadequate. Sub-standard work conditions in both public and private sector further frustrate them. This is not an exclusively Indian crisis. It is being experienced world-wide, albeit with variation across regions and countries. In India a body of official committee reports and health systems research repeatedly points to factors responsible for the crisis, among which is the urban and elite bias of medical education. Over the years proposed solutions to rectify this have been half-heartedly implemented. In this note we argue for a strong commitment by the senior political and administrative leadership to deal with the crisis. We are proposing comprehensive reforms aiming for appropriate human resource development and enhanced performance in the health services field. This calls for planning with bold and long-term vision. Hereby we mean to enhance the discussions on urgently needed reforms in the health care sector and the corresponding human resource requirements. After briefly identifying the major problem areas as we see them, we outline a broad framework and focus on some concrete measures towards long-term restructuring that can be initiated under the Eleventh Five Year Plan.

Perspective of the Proposed Reforms – the Problem Areas

Major shortcomings identified in health personnel over the years are:

i) social alienation from people to whom they are providing services, and

ii) lack of a sense of responsibility towards patients and communities.

Systemic factors that require rectification include:

1. Inadequate Professional Education: it neither orients nor motivates doctors to face the vulnerable sections' needs; it reflects in elite social behaviour, career choices, and technical approaches to health problems.
2. Overcrowded & Ill-Maintained Work conditions in Public Institutions: they do not favour establishment of norms for good medical practice.
3. Over-emphasis on Specialization: practice for high-profit is justified by high investments of time/money on education and specialized infrastructure; malpractices (over-prescription of tests, unnecessary surgeries, and so on) become the norm.
4. Absence of Monitoring and Public Accountability: there is no monitoring of professional performance in either public or private health services sector.

Clearly, a multi-pronged and comprehensive approach is necessary to deal with this all-round crisis. It needs to simultaneously address equity and quality issues relating to both service delivery and human resource development which are inter-twined. If implementation

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of the NRHM is to succeed in the Eleventh FYP, all health personnel will need to undergo a shift in orientation and attitude both through training and through re-oriented administration of the services. To foster re-orientation in medical education, the work-culture in training hospitals (where under-graduates and post-graduates learn) will need to encourage norms of good practice. Contradictions will have to be faced. For instance, doctors working in the private sector may imbibe patient-friendly behaviour, but they may also learn to protect profits at patients' expense. On the other hand, public sector work-norms are less commercial and more cooperative, but they are also more bureaucratic. Developing mechanisms to combine the best of both is the challenge.

Systemic restructuring is therefore necessary. Administration and management structures and measures that promote appropriate and locally responsive work-culture should supplement all efforts at human resources development. For the Health personnel to perform well according to their education and training, the professionals must be allowed decision-making powers at various levels for local resource allocation, personnel deployment and priority-setting. At the same time, recognition for good performance in providing routine and responsible services has to be built into administrative structures and processes. Criteria for assessing quality of performance and mechanisms for appropriate deployment need to be evolved and implemented. For all levels of personnel, mechanisms for incrementally upgrading skills are required. We must insure accountability to communities and society and produce health personnel and norms of medical practice that fit our context.

For facilitating such system-wide changes, we are proposing the creation of an Indian Public Health Service on par with the Indian Administrative Service (IAS). To guide and monitor the transformation process, we propose that a 'Steering Body for Health Systems and Human Resource Development' be set up within the Directorate General of Health Services. .

Feasibility and Benefits of Proposed Restructuring

In India at present there are 229 MCI-recognized medical colleges. Of them 125 are government institutions, which generally have a greater number of students. Thus, if the Government at the Centre and the State Governments gather the political will to improve medical education as called for, much can be done. By international performance standards, India is doing fairly well as doctors and nurses produced in our country are in demand and perform well in other countries. However efforts at adapting medical education to rural Indian settings have not taken off, starting from the Sokhey Committee and Bhore Committee recommendations in the 1940s to the ROME Programme in the early 1980s. Why will another such proposal succeed now? is a good question.

At this point in time there appear to be greater possibilities of change for several reasons. One is a shift in conditions and context. Earlier proposals came when the number of doctors and secondary hospital care facilities in the country were inadequate, when modern medicine was unquestioned as the ultimate science for health care, and when western state-of-the-art medical care was taken as 'quality care'. So medical education and doctors tended to cluster around the tertiary hospitals and specialists in clinical subjects became the leaders of the profession. Today the situation has changed. On the one hand, a massive public and private sector infrastructure has come up in most parts of the country and there is 1 doctor per 2000 persons. People are increasingly resorting to modern medical care. On the other hand, at the global level there is a growing recognition of the limitations and unsustainability of the western industrial model of 'health care'.

Medical professionals are a disgruntled lot, too. Currently, with poor working conditions and unexciting assignments, doctors are not attracted to the public sector. Yet the drawbacks in the private sector (competition and commercial considerations often winning over professional ones) restrict job satisfaction there as well. Increasing numbers of doctors joining the IAS or going into non-medical business is evidence of professional dissatisfaction. Therefore, significant support for the bold initiative that this proposal entails may come from enthused doctors.

Thirdly, in this time of drastic economic reforms and political reformations, it appears that such measures may make headway, provided active support comes from the highest levels. Demonstrable forms of low-cost effective health care in our country may even provide lessons for international health services and humanpower development. The international set of needs and conditions are changing as well. Saturation of medical and nursing professionals and limitations on immigration in the industrialized west is becoming offset by a growing demand for public health workers in the Middle East, Central Asia and Africa. In order to produce humanpower suitable for 'export' to these

parts, developing skills to suit developing country contexts will be meaningful.

HRD Plan for Indian Health Services: A Framework

A comprehensive framework for restructuring the Health Services and HRD Systems is proposed. Within the essential focus being on meeting Primary Health Care goals, it gives primacy to three outcomes:

i) Building up low-cost rural/urban healthcare settings as the hub of medical education ween primary, secondary and tertiary healthcare levels.

Primary Health Care includes health-sustaining measures at community level, first-level diagnosis and treatment (first contact care) and appropriate referral. Its development is the most critical 'felt need'. At present, in fact, various 'alternative' systems unofficially function to meet the need, from traditional folk healing practices to ayurveda, homeopathy unani, siddha, yoga, to 'allopathy' in the hands of private practitioners, informal and formal, alongside the Government institutional set-up. Lack of access to effective and affordable first level medical care leads to greater resort to the secondary and tertiary levels and creates an unnecessary overload in hospitals. Clearly, there is need for strengthening each link across this continuum of care: from home-care to a team of doctor-supported community-level (PHC) personnel to secondary and then tertiary level hospitals and research institutions. Professionals and para-professionals in the AYUSH streams need to be integrated into this overall schem.

Health services system development must define the rational role of each type and level of health care personnel, and HRD must give due consideration to the appropriate set of knowledge and skills required by each. Inculcation of 'cooperative spirit' must be part and parcel of the pedagogy, so that health care providers grow to act in the best interest of people, facilitating optimal care at all levels and by other providers as well as themselves.

Central to reorientation of the health care system is changing the mindset of doctors trained in 'modern' western medicine, since they are the leaders in the Health arena. But equally important are:

a) Increasing the numbers of nurses and paramedical personnel to meet shortfalls, and
b) Giving them a similar reorientation as the medical professionals,
c) Building up cooperation and responsible team functioning ,
d) Strengthening the part of 'AYUSH' and its practitioners in the health services, and
e) Developing comprehensive health care practices across the health systems.

Categories of Health Services Personnel

We are defining the Indian Health Services Sector to include all public (Government), private and non-governmental / non-commercial institutions concerned with provision of healthcare in India. We have re-considered the conventionally used categories of health personnel in the changed health services context. The categories used here are based on the major tasks required of them in the health sector (see the Box, next page).

Strengthening the Human Resources (Health)

Planning for the optimal development of categories of health personnel requires the Health Ministry to take initiative in medical and para-medical education and training, areas under its purview. In this it also needs to coordinate with Departments in other Ministries, such as Education, Bio-technology and so on, for developing appropriate training, services and research agendas. For the Health ministry itself, some urgent measures to face the present crisis are discussed below:

A. Assessing Need and Defining Quality of Health Care (Personnel & Services)
B. Re-Orienting Medical Education to Meet Low-Cost Health Care Needs
C. Appropriate Development of Health Care within the AYUSH Systems

A. Assessing Need and Defining Quality of Health Care (Personnel & Services)

Measures to quantify the need for all categories of health personnel in public, private and non-governmental non-commercial institutions, for the purpose of creating corresponding teaching and training capacities, are as follows:

- Estimation of the requirement for specialised Health personnel has to be based on the real needs of the whole system. The numbers projected for immigration should be added, since otherwise planning will lead to shortages in the services in India.

Categories of Health Services Personnel
(Re-structured in the Current Context of the Indian Health Services)

1. Basic/Primary Health Care (Preventive & Curative)
   - TBAs (dais), Other Folk Practitioners (bone-setters, herbalists, etc.)
   - Community Health Workers (CHW / ASHA)
   - Paramedics (MPW, ANM, HA, PHN, LHV)
   - Nurses (Staff, PHN)
   - Allopathic Physicians, (MBBS - MO, GP, FP)
   - AYUSH Physicians (BAMS, BHMS etc.)
   - Non-physician AYUSH Practitioners (Yoga, etc.)
   - RMP 'Doctors' (non-MBBS, in communities)
   - Health Team Managers (doctors, non-doctors)
2. Specialised Physicians and Clinical Researchers
   - Clinical Specialists, including Dentists and Super-specialists
   - Para-Clinical Specialists (Pathologists, Microbiologists, Radiologists, etc.)
   - Specialist Nurses (Surgery, Public Health, etc.) … Etc.
   - Specialised AYUSH Physicians and Researchers
3. Medical Care Support Personnel
   - Pharmacists
   - Laboratory Technicians
   - Physiotherapists… Etc.
4. Public Health Specialists and Researchers
   - Public Health Management Specialists (at secondary & tertiary levels)
   - Interdisciplinary Health Systems Researchers (Bio-Medicine – Epidemiology–Social Sciences–Management)
   - Epidemiologists & Social Scientists in Health Area
   - Legal Experts in Regulation of Professional Services and Education (Public Health & Law, Industry & Law, Medical and Health Ethics)
5. Public Health Support Personnel
   - Sanitary Inspectors
   - Entomologists
   - Laboratory Technicians
   - Biostatisticians… Etc.
6. Researc0h &Teaching in Non-Clinical & Bio-Medical Subjects
   - Non-Clinical Subjects linked to Medical Colleges (including AYUSH Systems) (anatomy, physiology, histopathology, pharmacology, immunology, etc.)
   - Non-Clinical Subjects in University Departments and Research Institutes (Biochemistry, Chemical engineering, Genetics, Biotechnology, Bioinformatics, etc.)

• Note: There will be overlap between research and teaching of these subjects in medical colleges, university departments and research institutions.

• This exercise is to be undertaken with the best existing database. Several figures will have to be rough estimates, but even that will be worthwhile.

Quality criteria for each category of personnel need to be laid down based on technical requirements, effectiveness in the social context, and affordability.

For instance:

• For doctors, good medical knowledge, ability to give effective treatment at low cost, empathy, understanding of urban/rural social dynamics, communication skills, team-functioning and ethics, and inter-sectoral coordination should be important criteria.

• For para-medicals, appropriate knowledge/skills, other qualities (as for doctors), team-work skills, ability to debate issues and input in decision-making.

At Primary Health Care Level

At the primary level, the need is for a 'community physician' with the technical expertise of a family doctor, capable of early diagnosis and treatment of the majority of health problems. She or he needs to listen and advise competently, allaying fears and anxieties; to have an understanding of public health issues, and the ability to lead a team of community level health workers if needed. An order of intellectual input and reasonable grasp is required to meet analytical demands, as clinical diagnosis is to be made with basic testing facilities and optimal medical intervention is to be determined. A willingness and ability to co-operate with other systems of healing for reducing ill-health has to be cultivated. Such doctors must themselves demonstrate the best quality, as they create a base for health and health care.

Increasing the number of doctors who will act as generalist family physicians and community health team leaders is the need of the hour. Since such 'generalist' work is as intense and demanding as that required of specialists, equity in status and payment needs to be established. At this primary level, good performance by doctors demands that they interact with people and gain familiarity with their communities on an extended-term basis. Hence, the policies of arbitrary transfers and short-term contractual hiring of doctors will have to be re-examined. For generalist doctors, if their status and performance quality is equated with that of specialists, then the leadership role, work satisfaction and quality of life that they can achieve will become attractions. Their role as teachers of under-graduate medical students (as discussed further on) can give added career satisfaction. Moreover, these doctors would henceforward be involved in health planning and policy-making. Considering their social role, those 'high achievers' among who wish to go for Public Health specialisation might be sponsored. Naturally, these roles would include qualified physicians of the AYUSH systems on par with MBBS qualified physicians.

All in all, creating a cadre of Indian Public Health Service will consolidate the experience of such doctors and use it for health sector planning.

At Secondary and Tertiary Health Care Levels

Secondary level health care at District level again requires a large number of general practitioners. But here they work in consultation or in referral relationships with experts in the basic specialities (surgery, gynaecology & obstetrics, paediatrics, ENT, ophthalmology, psychiatry, dentistry, geriatrics, and so on).

At the tertiary care level, specialists and super-specialists are in charge. These physicians have greater expertise in a focused area of the human body or portion of the disease spectrum. Therefore generalist doctors, whose professional focus is on patients as whole persons in family and social contexts, can call upon them to deal with special medical problems. Their status should arise from demonstrated competence in specific fields, and as clinicians at both secondary and tertiary levels. Additionally, they may be researchers and educators.

B. Re-Orienting Medical Education to Meet Low-Cost Health Care Needs

Given the framework of health humanpower needs of both rural and urban populations, and the poor and middle class in both settings, the priority is to re-orient all medical professionals to provide appropriate quality low-cost health care. Since doctors are leaders in the health sector, re-orientation of other health personnel will follow.

First, let us briefly review some of the measures tried in the past decades to 'reorient' medical education and produce basic doctors in order to pose fresh options:

i) Making service in rural areas mandatory for medical graduation or before applying for postgraduate courses has not worked. Not only have most students resented these postings, but it has also expected fresh graduates to perform competently on their own at the rural level after having been trained in tertiary hospitals.

ii) The category of 'licentiate doctors' trained in a three-year course is proposed to be resurrected. It may have been meaningful when there was a shortage of medical colleges and doctors. Today no such shortages exist, so it would be better to re-orient medical graduates rather than re-create this category. However, a large number of unqualified (non-degree-holder) 'doctors' are providing medical care in poor rural and urban communities. It is a reasonable option to evaluate and upgrade their knowledge and skills. Still, their function in providing basic health care must be viewed as additional and not as a substitute to the public sector. What we are suggesting now is not a piecemeal solution, but rather a whole restructuring of medical education and of the public health cadre simultaneously. We are suggesting a direction for

initiating deliberations in various fora. The main foreseen spheres of action are:

a. Intake for medical education, with heed to the social base of students

b. Appropriate restructuring medical colleges, curricula and teaching methods

c. Improved functioning of teaching hospitals and all levels of health care services

d. Strengthening of regulatory mechanisms for health care providers, and Creation of an Indian Public Health Services cadre.

a. Intake for medical education

Dealing with the social alienation of doctors must relate to their social base becoming representative of the populations that they serve. Measures for ensuring this are to be taken at the time of student intake into medical colleges, and this is possible in the following ways:

1. Reservations for Disadvantaged Student Categories:
   - For SC and ST students, reservations may continue as such.
   - For OBC students, 'backwardness points' on the lines suggested by Deshpande & Yadav[1] can be applied (for admissions to be based on individual merit plus social background), similar to what is already in use at JNU for several years.

2. Abolition of capitation fees in medical colleges:
Colleges should have other ways open to them for raising the funds they need.

3. Professional Up-gradation through Scholarships/ Sponsorships: Committed, competent lower-level health personnel (medical, nursing, etc.) may sponsored for professional enhancement, enriching the academic environment with their presence. Not only will this be an incentive for performance, it will also create a pool of professionals with rich grass-roots experience.

4. Preference to Student Sponsorships from CBOs & Pancyayats:
Such medical and nursing students would be committed to returning to their communities for later work.

b & c. Re-structuring Medical Education for Professional Re-orientation and Strengthening all levels of the Primary Health Care system

That current medical education is biased towards urban culture and high technology is well recognised. Furthermore, teaching is rigidly text-book and lecture based. Clinical skills are taught at bedsides in crowded tertiary hospitals, which fail to provide adequate social and managerial skills or instill patient-friendly attitudes. The knowledge base that is imparted lacks a public health orientation informed by people's perspectives and the social determinants of health.

To rectify these great shortcomings, two broad structural measures are being proposed:

i) Move under-graduate medical teaching away from cities/tertiary hospitals, and

ii) Revamp the medical curriculum and teaching methodology appropriately.moving under-graduate medical teaching away from cities and tertiary hospitals
As oft-stated, clinical exposure needs to be imparted in appropriate settings. Since we envision the majority of under-graduates becoming general practitioners and community health team leaders, their education and training should take place at secondary-hospital level with strong links to the primary level. This would mean re-setting the standards for hospitals attached to medical colleges with regard to number of beds, etc. For public sector teaching institutions, the senior teachers will be doctors at District hospitals; their numbers will have to be increased to deal with the added workload.

Thus, the logical aim is simultaneously towards re-orienting medical education, bringing specialists to District Hospitals and CHCs, and strengthening secondary and primary infrastructure and functioning. The implications are that

- All undergraduate teaching and technical training will take place at secondary and primary level institutions.
- Post-graduate teaching will be at secondary and tertiary hospital levels, with periods of posting in rural and underserved urban areas.
- A Public Health specialist will be placed at District level for consultation with all levels of health personnel in epidemiological analysis and health system planning. This job will include orienting clinicians, including the teachers of clinical subjects, on the current and local public health issues.

While post-graduate and super-specialist teaching will happen at tertiary hospitals, post-graduate students of clinical subjects would serve for periods at the secondary hospitals and visit primary level institutions on a rotational basis. They may bring in fresh ideas and information of scientific advances to be considered

[1] Satish Deshpande & Yogendra Yadav, 'Reservation - An Alternative Proposal', *The Hindu*, 23rd May, 2006.

by the teaching faculty for fitness in local contexts.

Since existing training schools for paramedical personnel are largely placed at District level, the location of medical education there will enhance the opportunity of team training. The PSM course for medical under-graduates may well include bringing the various health personnel categories together for practical experience of team functioning.

Revamping the medical curriculum and teaching methods

Some measures towards making medical education problem-oriented, community-based and informed by the social determinants would be:

• A comprehensive review of existing curriculum, textbooks and teaching methods:

This would be followed by text-book writing geared for Indian contexts by teacher-practitioners with extensive work experience under Indian conditions. For this, good teachers in each subject would be identified and their interaction with the system facilitated to improve the quality of pedagogy. Guidelines for medical teaching would be prepared, with special attention to strengthening of public health teaching.

• Tailoring of social science teaching for doctors to understand their social role: This would be an important component of medical education, so that doctors grasp the social determinants and dynamics of health with regard to what is expected of them.

• Skill-building in critical analysis towards appropriate solutions: This is important so that the doctors are able to work out optimal solutions in diverse contexts and insure that inappropriate universal solutions do not remain in practice.

• Quality regulation and innovation in teaching institutions

Teaching institutions are to be strengthened according to defined criteria for teaching quality and encouraged to innovate appropriately.

The professionals who come out of this kind of educational process will be familiar with and sensitive to the conditions of the majority in this country and are thus likely to develop norms more of practice suited to them, whether they work in the public or the private sector.

Monetary and non-monetary supports will be needed. Revamping could be initiated in the Eleventh Plan.

d. Building Regulatory and Accountability Systems

Progressive principles of personnel management need to be applied to change the work-culture and stimulate professional responsibility. Both administrative controls and encouragement for good performance are essential. There must be transparent rules for transfers, promotions, selection for higher education etc. and limitation of political pressure to flaunt these rules. The word has to come from the PMO and Health Ministry downwards.

Formal incorporation of community monitoring mechanisms into the health services system is called for. Besides the *panchayati raj* institutions (PRI), some other structures for social audit have been suggested by various people. This needs to be decided upon after careful consideration and consultation, and seriousness about it has to emanate from the higher Government levels as well as from civil society.

The Medical Council of India is already under review. Aside from re-structuring, it needs a person of high moral and professional standing to be nominated as its head, perhaps by the President of India. The MCI has to exercise its authority freely and fully for ensuring maintenance of standards and quality. It must encourage innovation in teaching, rather than stifle new initiatives.

Besides the external regulatory measures, professional accountability mechanisms are something that professionals will themselves have to get serious about. Unless they create self-evaluation and self-regulation structures they will be only technicians and commercial entrepreneurs. Professional associations such as the IMA, IAP, FOGSI, etc. would do well to deliberate on such issues within their membership.

e. Creation of an Indian Public Health Service Cadre

From among the generalist medical officers and health team leaders performing at the peripheral level, some should be supported for public health specialization and move up to play data analysis and planning roles. The service would create public health analysts and planners with backgrounds of experience in rural and other low-resource conditions. It will also enable professional mobility from primary to secondary-level service delivery and to analysis, policy formulation and

planning positions, from the Block and District to State and National levels.

C. Development of AYUSH Systems and Human Resources

India has the advantage of having a number of health and healing systems in operation for generations and even millennia. However, they have not developed or kept pace with the modern western or 'allopathic' system which is dominant in both medicine and public health fields. Health care providers of the AYUSH systems currently studying or employed within and outside the public health services should be encouraged to strengthen their respective science and practice.
Some suggestions are:

· Encouragement of practice according to the respective health and healing systems rather than expecting them to mimic 'modern medicine'; that only undermines them further.
· Developing an institutional framework in tune with what has been suggested for medical education, where the colleges of AYUSH systems are also linked with the public sector service delivery institutions at primary, secondary and tertiary levels.
· Training of the same paramedical personnel to be imparted by these professionals as well.
· Stimulation and support for research in both the formal and the folk knowledge systems for development within their own philosophy and principles.
· Creation of a mechanism for interaction across the systems, such as a 'Core Committee for Dialogue Across Healing Systems'.

Beginning the Process of Restructuring

Obviously, such restructuring cannot happen overnight. Sweeping systemic measures are necessary to clear the identified flaws begin to move towards reorientation of the health services and doctors. Some steps can be taken with soon and others need to planned in a staggered yet co-ordinated fashion. Immediate measures could be to ensure that no new colleges are be allowed to come up in the cities and towns above district headquarter level; that the hospitals attached to them should not have more than 100-150 beds; and that post-graduate students specializing in clinical subjects at tertiary hospitals must spend periods of duty at the secondary hospitals and visit primary level institutions.

Demonstration of the will to implement such change will be critical. It calls for a wide consultation between all sections involved in medical education and concerned with professional quality of care to the people. Once the direction is decided with long-term view and a consensus built around it, such changes will be guided to unfold over time. Budgetary allocations will have to increase, but the non-monetary inputs will be equally crucial. All levels of people involved will need to start thinking and come up with better ideas and fresh commitment to move forward.

The Eleventh Plan can facilitate and support:
i) Review of medical education, with special focus on PSM and public health teaching,
ii) Consultations on restructuring medical education especially in government colleges,
iii) Pilot re-structuring at a few sites,
iv) Production of quality text-books by appropriate Indian authors.
v) The building of an Indian Public Health Service cadre
vi) Consultations on restructuring education in the AYUSH system colleges.
vii) Setting up of a Core Committee for Dialogue Across Health and Healing Systems.

Thus, reorientation of the health providers and service systems with an appropriate, futuristic vision is an urgent and crying need for our health and wellbeing. The health care crisis afflicting all sections of the Indian people and the crisis being experienced by the health care providers calls for a major initiative well beyond the significant measures that are already on the anvil– increasing the financial outlays to 2-3% and increasing the infrastructure and number of personnel. How can we all come together to rise up to the challenge?

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[Acknowledgements: This note has drawn on reading of the several committee reports of the past and available writings of public health analysts. It has gained from interactions with colleagues at the Centre of Social Medicine & Community Health, JNU and the Medico Friend Circle. Special inputs by Drs. I. Qadeer, C. Sathyamala and Mira Sadgopal are gratefully acknowledged. This does not imply agreement on all issues in the note. The author alone bears the onus for its shortcomings.]

Critical Public Health: Operationalising a Vision

-K R Nayar and Ritu Priya[1]

Even when public health was experimenting unsuccessfully with various reorientations to produce socially sensitive physicians in the 1970s and 80s (Poulose and Natarajan, 1989; Panackel and Ramalingaswami, 1990), there were instances of alternative experiments in the provision of training, research and practice in public health. It is possible to delineate three distinct processes at work that are inspiring dissatisfied professionals to breakout of the set pattern (Qadeer and Nayar, 2005). The first of these is complete dissociation between the practitioners and the conventional institutions. These professionals set up their own experimental projects of providing alternative models of care, training and education of health workers. A number of examples are there, such as, the Shaheed Hospital run by Chattisgarh Mukti Morcha which is experimenting with a need based hospital for workers of an industrial area. Rupantar, an organization involved in training and monitoring work of community health workers is another example (Sen, 2001). Similar efforts are afoot in Bilaspur and Maharashtra (Ashtekhar, 2001). The Community Health Cell being run in Bangalore is an innovative group of public health workers providing support to different voluntary groups and individuals, both at the level of training as well as research. The other examples are the well-known establishments like Comprehensive Rural Health Project, Jamkhed and Foundation for Research in Community Health, both in Maharashtra. The second trend is to develop interactive and multidisciplinary networks of professionals to share ideas and experiences, generate debates and take up socially relevant research. The Medico Friend Circle (MFC) is such a group set up in the early 70s (Priya, 1986). Through its meetings, activities, research and publications, it has argued for a new vision of public health. Health Watch is yet another network set up in the 1990s, which is focusing on monitoring the implementation of the ICPD agenda of a target free, voluntary and comprehensive family welfare program. The third set is the evolution of teaching institutions that are taking up the challenge of rejuvenating public health. Some medical schools such as CMC, Vellore, AIIMS, New Delhi and the Centre of Social Medicine and Community Health (CSMCH) at the Jawaharlal Nehru University (JNU) have been experimenting with alternative programs of teaching and research. The University of Health Sciences at Pune was also set up with the idea of bringing in an integrative approach to the teaching of medicine.

In this note, we would focus on the academic programmes of CSMCH at JNU, which had a vision and a dream to bring together bio-medical and social science perspectives for a critical Public Health. While the value of the Centre's efforts has been appreciated, its very success is seen to pose challenges to its impacting on the mainstream– "While these suggestions (for a public health curriculum) are very relevant, it is somewhat unfortunate that the JNU department has become somewhat marginalized because of its 'critical questioning' and overall 'radical' image…" (Narayan, R. 1991). A brief profile of the Centre is given in Appendix 1.

Mandate of CSMCH

It is a challenging task when a vision based on interdisciplinary linkages between bio-medical and social sciences have to be operationalised. In the fifties, when there was a rethinking on including social sciences in the medical curriculum, the general attitude was "they are young, somewhat inexact, and often pretentious. Their findings are presented in a horrible jargon which obstructs clear thinking" (Simey, 1954). Social sciences are not a single, united field of enquiry; it contains a number of disciplines with varying perspectives and theoretical orientations. It is difficult to visualize one social science and therefore it is all the more difficult to identify a core area or the concepts necessary to work in public health.

One of the major objectives of CSMCH, as visualized by the working group for setting-up the centre, was to investigate health problems within the context of social, cultural and behavioral aspects of the community. Social Science was considered as having a major role in this, especially considering realistic planning of community health services. It was therefore proposed that the centre would be located in the School of Social Sciences. In fact, this is the only public health academic centre located in a school of social sciences with a view to bridge the gap between available knowledge and its social application. This was also thought to be a way to provide a meeting ground for medical and

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social sciences with a common focus of making health services meaningful to the society.

Thirty five years of experience in offering academic programmes, undertaking research, providing consultancies and engaging with the State and civil society has given us rich insights regarding the nature of public health education suitable to our context. We have increasingly realized that a bio-medically and statistically oriented public health academic programme alone will not be able to capture the 'health culture' of the community (Banerji, 1986). In fact, one of the strong points of CSMCH is the integration of the people's viewpoint with the bio-medical components and epidemiology into the teaching programmes of the centre. One of the remarkable achievements is that it has been able to give a new direction to the concepts and knowledge of public health by developing a body of knowledge through use of social science in general and political economy approach in particular in the study of community health problems and programmes in India.

Approach to Community Health/Epidemiology

Public health as visualized by CSMCH uses a "holistic epidemiology that examines society not as a cohesive outcome of the working of its institutions but as a social structure with its inherent processes which are not dependent upon internal institutions or external stimuli, which operate dialectically and influence disease and health patterns" (Qadeer, undated). According to Qadeer, this potential in classical epidemiology was lost due to decontextualisation. The reductionist approach and the so-called thrust for universality failed to capture contextual complexities and denied epidemiology the opportunity to become a science which could best serve public health. In addition, it did not attempt to study collectivities and instead focused on the individual, the family and the immediate environment (Priya, 1987). Epidemiology as envisioned in the discourse of CSMCH is holistic which cover the varied and complex social, economic and political dimensions of the human environment. This is why the epidemiological vision of the centre is closely linked to political economy and social sciences.

Approach to Social Sciences

In recent years there is a proliferation of social science studies on health-related themes. largely as a result of renewed interest in the area, and change in the funding strategies, mainly of international agencies. Several universities and research institutes have initiated study programmes and research in this field and substantial contributions have been made in a number of social science disciplines such as sociology, psychology, anthropology, political science, history and the favorite of the funding agencies –economics. The consequence is that the problem of health which requires a multi-dimensional social analysis is approached more or less similar to the six blind men examining an elephant (Nayar, 1993). An entirely different trajectory is the one adopted by what can be called as the fact-finding approach which is largely outside the academic system especially by non-governmental agencies undertaking research. Thus, there are two broad categories of health social sciences, one which is still predominantly academic in orientation and the other, practised outside the academic institutions which are essentially fact-finding in it approach.

CSMCH has adopted a paradigm which follows the epistemology of interdisciplinary approach wherein the core is defined and dictated by the needs of health and health services. It is for this reason that issues of social inequalities and social stratification including gender, caste, class etc. have been part of the social science discourse in the centre. These are then continuously fed into the teaching programmes of the centre keeping in mind the need to synthesize them with the existing approaches in epidemiology.

Pedagogy and the Logic of Course Structure

The centre has two separate programmes, M.Phil in social sciences in health for social scientists and an M.P.H programme for doctors/nurses. The course structure in the centre is a dynamic entity which is constantly evolving and changing depending on the addition of new knowledge and based on the review undertaken by the faculty themselves and the student feedback. There is an internal logic in the structure of courses in the centre. The common binding course for M.Phil and M.P.H is the one which focuses on the fundamental concepts of health and service planning interwoven with the organization of health services in the country. Through this course students get an opportunity to understand the evolution of health services in the country and the social, programmatic and epidemiological issues with regard to the general health services and various national programmes. This is followed by the M.P.H students undergoing some common sessions in social sciences with the M.Phil students. This kind of a synergy is intended to bridge the gap between social sciences and bio-medicine. For social sciences, there is a problem of dissimilarity as we get students from varied backgrounds. Therefore,

there is an additional challenge of bringing students belonging to various social science disciplines into one common platform. This is the rationale for having bridge courses such as "Social Sciences: Towards an integrated approach" for social scientists wherein the theories and concepts needed to work in the area of community health are delineated. M.P.H students go through the same course in social science although they are not expected to cover the course as extensively as the social scientists. This is followed by courses which focus on the social science issues in community health and research methodology. The M.P.H. students also go through a course on Epidemiology in which they learn to understand the different perspectives within the discipline itself, to view it as a science rather than merely as a set of methods, and to use its approaches and methods for interdisciplinary research and health planning. The course structure with areas dealt within optional courses can be seen in the appendix.

From the students' point of view, the perspective and the courses that the centre offers denote a shift from the earlier disciplinary backgrounds. This may be equally applicable to doctors and social scientists. For the doctors it is more a process of re-examining their perspectives and becoming consciously aware of the social, cultural and political role of health, the health sciences, health services and health personnel. A brief note is appended on the students' background, fee structure and democratic mechanisms for students' involvement in evolution of the academic programme and institutional ethos.

The students' research also evolves out of the teaching programme to a large extent through assignments (such as writing a synopsis on a research topic for the course on research methodology), independent seminars based on the interests of the students, fieldwork etc. The student's own past exposure to health and development issues, links with health institutions and understanding of community problems also influence the themes they choose to study.

Team Work for Public Health

One of the important hallmarks of public health academic work is the need for teamwork. Teamwork helps in transcending the limitations of disciplinary boundaries of faculty involved in teaching and research at the centre. Teamwork is practiced primarily in teaching individual courses. Most core courses are organized along these lines wherein more than one faculty member is involved in teaching courses. Often, it has involved faculty with medical and social science backgrounds working together on a course.

In research, there is an effort to pursue the same spirit of teamwork. This is reflected in the many publications of the faculty over these years. One of the great opportunities to demonstrate the teamwork in research was made possible in a large multi-centric project on "Monitoring shifts in health sector policies in South Asia". The entire faculty of the centre was involved in the various stages of planning and operationalisation of this project which examined the shifts that had taken place in the health sector in India after the implementation of Structural Adjustment Programmes in terms of changes in the health status of the population, shifts in the delivery and utilization of health services and the process of decentralization as a part of reforms. At least two major publications which evolved out of this team work laid the foundations of the critique of structural adjustment and health sector reforms in India (Rao, 1999; Qadeer et al., 2001)

Concluding Observations

It is indeed challenging to develop a public health academic programme which needs to overcome the limitations of a decontextualized epidemiology and the heterogenous nature of social science disciplines. Our experience shows that it is possible to delineate the minimum core areas of social sciences which can establish the synergy with epidemiology and community health. The political economy perspective offers a bridge to establish such a synergy within which health and health services and programmes including family planning can be understood and analysed in a holistic way. The strength of CSMCH lies in the development and continuous rethinking of such a holistic perspective which may fall within the realm of 'critical public health' while utilizing the science of epidemiology.

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Appendix 1

Profile of CSMCH

The Centre of Social Medicine and Community Health was started in 1972, as one of the problem-oriented centers located in the School of Social Sciences. Its mandate was to develop the contours of public health as a discipline suited to address the needs of the country, with a special focus on the needs of the underprivileged sections. Over the years its work has focussed on Health Systems Research and Public Policy Analysis with an interdisciplinary perspective. While engaging in universal public health issues and debates, the Centre keeps a context specific approach. While it relates to global developments in health and health services, the South Asian, Indian and within India the state-specific contexts get greater emphasis.

Courses offered are an M.Phil/Ph.D. in Social Sciences in Health for social scientists and a Masters in Community Health/Public Health (a pre-Ph.D. programme equivalent to the M.Phil) as well as a Ph.D. for doctors and nurses. The M.Phil and MPH are covered over 1.5-2 years. The programmes equip the students with an interdisciplinary perspective for studying the societal dynamics of health and the modes of dealing with health problems, for analyzing policy approaches relevant to health and for conducting health systems research contributing to policy and programme formulation. The M.Phil students come with a post-graduation in sociology, psychology, economics, history, social work, public administration and other allied subjects. The doctors are required a minimum of a medical graduation with one year experience in community health and the nurses a M.Sc. with Community Nursing. The admission intake is of about 20-25 students each year, with 14-18 social scientists and 6-8 doctors /nurses. At any time there are over 50 students actively pursuing their research after having completed the course work. A majority of the students have found employment in various universities, research institutes, state and para-statal health services, NGOs and UN agencies.

The Centre has a faculty strength of ten with an equal number having medical and social science backgrounds. Prof. D. Banerji continues to be associated as Professor Emeritus. The faculty research interests include history of health services development, international and national health policies and service systems, the political economy of health, health culture, epidemiology, nutrition and communicable diseases, population policies, health manpower development, worker’s health, environment and health, women’s health, urban health as well as methodologies for health systems research and health policy and programme formulation. Faculty members have been playing an advisory role for research and planning to the Ministry of Health & Family Welfare, State Governments, WHO, UNAIDS, other universities, research organisations and non-governmental organisations.

The Centre has organised a number of international and national conferences and seminars. Over the last decade these have been on themes related to the transitions in international and national policy environment, World Bank prescriptions on Investing in Health, protecting folk and tribal herbal medicinal knowledge and practice in the context of the Bio-diversity Convention and Intellectual Property Rights, Impact of Structural Adjustment Policies on Health, Reproductive Health in Primary Health Care, Societal Concerns and AIDS Control Strategies in India, Challenges in Policy and Implementation for Making Essential Drugs Available for the Poor in India. The thrust of these has been to analyse the implications of current policy trends on the health status and access to health services of the underprivileged sections. There was also some effort to search for spaces that allow for protecting and enhancing the entitlements of these sections in the given context. These have been variously organised in collaboration with and financial support from the Indira Gandhi Rashtriya Manav Sanghrahalya, the UNFPA, UNICEF, the European Commission, RIAGG (Maastricht), Department of Public Policy (Cambridge), STAKES (Finland), Centre for the Study of Developing Societies (Delhi), Coalition for Women, Population and Environment, Coalition for Environment and Development (Finland).

Several books, monographs and reports have been published as outcomes of these efforts.

The Centre faculty has jointly coordinated a collaborative project over the past 3 years on Monitoring Shifts in Health System Policies in South Asia. The collaborating partners are health research institutions from Sri Lanka, Bangladesh, Nepal, Pakistan, Kerala and Andhra Pradesh in India, Belgium, Finland and England. This is funded by the European Commission and is in the process of completion. It has attempted to analyse national data sets of the region to bring together evidence on the impact of structural adjustment and Health Sector Reforms on health status, health services and health planning processes in the region. Collaborative linkages have been formalised for faculty exchange, sharing of information, and joint research with the Global Social Policy Programme based at the University of Sheffield and with the University of Heidelberg.

Appendix 2

Course Structure

Master of Philosophy (M.Phil) in Social Sciences in Health

Core Courses

1. Community Health and Its Organisation in India
2. Research Methodology
3. Social Science Issues in Community Health
4. Social Sciences: Towards an Integrated Approach
5. Review of the Current Issues in Social Sciences in Health

Master of Public Health (MPH)

Core Courses

1.Community Health and Its Organisation in India
2.Epidemiology
3.Health Services and the Community
4.Research Methodology
5. Review of Current Issues in Community Health

Optional Courses

1. Population Problem and Family Planning Programme in India
2. Communicable Diseases
3. Nutrition and Maternal and Child Health
4. Rural Health Services
6. Comparative Studies in Health Systems
7. Operational Research and Systems Analy sis in Community Health Research
8. Political Economy of Health
9. Application of Anthropology in Health
10. Application of Sociology in Health
11. Workers' Health in India
12. Women and Health
13. Urbanisation and Health
14. Communication and Health
15. Environment and Health
16. Gender, Development & Health
17. Current Trends in Sociology
18. Social Psychology and National Development Programmes
19. Psychology in Community Health
20. Vital Statistics & Health and Information System
21. Health Manpower Planning in India
22. Health Planning and Health Economics
23. Community Health Nursing Education and Administration
24.Hospital Administration and Medical Care Services in India
25. Education and Training of Health Workers

* Optional courses are common for M.Phil and MPH

Appendix 3

An Inclusive & Democratic Ethos:
A Note on Institutional Characteristics

The JNU campus is a microcosm of the Indian nation, drawing students from every nook and corner of the country and from every group and stratum of society. To make sure that this is so, annual admission tests are simultaneously held at 37 centres spread across the length and breadth of the country, and special care is taken to draw students from the underprivileged castes and ethnic groups by reserving 22.5 per cent of seats for them. Candidates belonging to backward regions of the country are also given deprivation points in the entrance examinations. 3 % of the seats are reserved for the physically challenged students. Apart from this, deprivation points are given to other backward classes where women candidates are awarded 10 points as against 5 for the men. Overseas students form some 10 percent of the annual intake. Students' hostels and blocks of faculty residences are interspersed with one another, underlining the vision of a large Indian family. (For details please see http://www.jnu.ac.in).

Participation in student union activities and other elected representative bodies is viewed as an important part of the students' life on campus. Healthy norms of student politics have been developed by the student body, with support from the faculty.

One of the important features of JNU is the democratization of decision-making in academic affairs. Academic matters pertaining to the centres are discussed in the Student Faculty Committees (SFC) with equal representation of teachers and students. Students also give continuous feedback on the courses through the SFCs. Students are also involved in the board of studies which approve the courses for each of the centres as well as represented in the Academic Council of the university.

Apart from a large number of Merit cum Means scholarships offered to deserving students based on parents' income, the university has also instituted a number of scholarships and fellowships for the weaker sections and others. The fee structure of the university is as follows:

Tution fee Annual: Rs. 240
Other fees Annual: Rs. 154
Room rent in hostels Rs. 240 (annual).

Annual Meet 2006 Paper

Can Public Health open up to the AYUSH Systems... and give space for People's Views of Health and Disease?

Some thoughts to add to the debate in MFC at NTI, Bangalore, 28-29 December 2006

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The double issue of the *Medico Friend Circle Bulletin* (December 2006 – March 2007) carried an array of background articles and matter to support serious debate on 'The Public Health System and Public Health Education' at the MFC Annual Meet on 28-29 December 2006 at Bangalore. Our effort in this article is to point out a major lacuna that we see in the debate so far, that is, the need to genuinely include India's non-allopathic systems and people's local 'health and healing' cultures within the Public health system. Blindness to the issue, if one goes by the articles collected in the *Bulletin*, appears virtually total at this point. It is not an easy issue – it is fraught with contradictions and unaddressed questions. But we find it untenable for us to go on with our debates without facing it. Our expectation is that friends gathered here will give serious attention to this and open up to looking for how we can move towards 'mainstreaming' the non-allopathic or so-called AYUSH systems in the public health system in our country. In fact, whether we talk about it or not, somehow it is a stated goal in the Indian Government's 11th Five Year Plan (2007-2012)!

It is our contention, while exact figures are not at hand, that the vast majority of our billion-plus population share cultural bases and even ethnic resonances with the non-allopathic healing systems [1]. *So it should seem odd to all of us,* we think, that western medicine or 'allopathy' persists in dominating the public health services system long past the 'British times'. True, in recent years a proportion of qualified non-Allopathic practitioners (with degrees like BAMS and BHMS, etc.) have been appointed within the primary health care system, but they operate within the all-Allopathic framework.

Only in recent years – for both right and wrong reasons – have the non-allopathic systems been drawing a measure of serious official attention. In 2003 a full-fledged Department of AYUSH was set up in the Ministry of Health and Family Welfare. The term 'AYUSH' includes 'Ayurveda, Yoga, Unani, Siddha and Homeopathy' – the formal or codified non-allopathic systems. The term is now being coaxed to include the vast and diverse local folk healing traditions of India, as well as the codified trans-Himalayan system of *sowa-rigpa* in Ladakh (akin to Tibetan or 'amchi' medicine). The WHO, by the way, recognises the significant role in public health of both 'formal' and 'folk' traditional healing systems.

In calling for 'mainstreaming of the AYUSH systems in Government health policies and programmes' in the 11th Plan, the Planning Commission sees the National Rural Health Mission (NRHM) as the main field for operationalising this aim. Here we enter an area of public health where little data and scant research-based analysis exists and so much is to be worked out... First, what is meant by 'mainstreaming' itself? Does it mean employing AYUSH physicians in the PHC system? It is already happening, for example, in Gujarat where we hear that now most doctors at PHC level have AYUSH degrees but are expected to practice allopathy, a phenomenon that has been in existence for some years and needs to be studied. Or by mainstreaming is it meant that the various systems of health and healing – allopathic and 'alternative' – will be brought on par? Will there be parity and equity between all the systems? The prospect is mind-boggling. Yet in China parity was adopted at the outset of the PRC (1949), so that Chinese and western medicine function on par to the present day – we need to study that experience. The question is:

How could the Public Health system and P H education evolve if it were to be adequately informed by the ISMs and become consistent with people's 'health' cultures?

Let us first look at some background regarding the philosophy and history of public health, and the contrasting natures of the allopathic and non-allopathic systems.

Background

While the origins of a 'sense of public health' can be traced to antiquity, western-style 'public health' today has its roots in training programs begun in Munich in 1881, at Harvard-MIT in 1913, and by Johns Hopkins

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in 1916 (Badgley). Historically public health has been defined in terms of governmental action, but voluntarism played a role (Porter). (While then voluntarism represented action and funding by people or organizations, today we call it 'community participation'. Also, there has always been a private sector with a hand in medical care.) The services were generally limited to the non-personal, e.g. public sanitation and preventive health education geared to control problems in vulnerable populations (Frenk).

The history of western medicine gives insight into the development of public health, where public medical services are directed towards groups of individuals while clinical services are directed towards isolated individuals known as 'patients'. So while public medical services differ from classic medicine in this respect, public medicine has shared the outlook and history of allopathic medical care. Hence it partakes of the many problems of allopathy historically epitomised in a mechanistic, reductionist, medicalising, techno-centric and elitist approach to health.

In India, as in the West, the formal systems of medicine have usually been available to the wealthy exclusively. The Greek forefathers Hippocrates and Galen served whoever could pay their fees. While ancient Egyptian medical texts do mention diseases of the poor including occupational diseases, nothing was done to protect workers (Sigerist). In India, the mythical Ashwinis were the ones who roamed about healing the common people, while Charak was court physician. The surgeon Sushrut is said to have learned his nasal plastic surgery from barbers in Maharashtra, but once codified it became the privilege of kings. Often, as in Babylon and Greece, priests were the earliest physicians. From the 16th century onwards physicians in Europe recruited themselves from the middle class (Sigerist). Ironically it was christianity that instituted the view of everyone deserving medical care, but it also led the witch hunts that eliminated lakhs of women and men folk healers! Thus the history of medical care is a story of elite professionalisation that excluded the folk healing systems and acquired an officially sanctioned monopoly over the definition of health and illness.

The story in India has unfolded and is still unfolding in similar manner. Public health in British India was enclavist – it lacked interest in needs beyond those of the army and the white community (Ramasubban). While pluralism in treatment-seeking behavior in the population existed, allopathic doctors, British and Indian alike, never appreciated it. On the contrary, European medical caregivers worried about having to 'gain ground and diminish the influence of ignorant hakims and Hindu practitioners'. Interestingly, though they doubted the efficacy of indigenous medicine, even in the 1900s they were obliged to make some room for the *vaidya* and the *hakim.* (Arnold) However a result of this attitude since the British period has been that allopathy has dominated and turned a blind eye to the AYUSH systems, stultifying their development. Arnold also points out that,

In the end the future of western medicine lay not with the colonizers but with India's emerging elite. In the years after 1914 they were able to take up Western medicine as part of their own hegemonic project.

To accommodate to this domination, the AYUSH medical colleges have modeled themselves after the department categories of Allopathic colleges. The pedagogical content is often couched in western medical terms or includes facts grafted without comment from western medical science into the classical knowledge base. Research is conceived within western medical frameworks and based upon those criteria instead of referring to existing indigenous knowledge frameworks.

And what is the understanding of health and illness that this Western system holds?

In Hippocrates' time environment, diet, activities of daily life and so on were understood as factors in health or illness, but this view was replaced in the 19th century by the theory of 'germs' (or living micro-organisms) being the prime factor for illness. The human body was already being regarded with the mechanistic eye of the industrial revolution, and this redirection of medicine towards biology gave importance to technology for eradicating disease. Thus it accelerated the process of medicalisation, subsuming all the other ways to understand health and illness, and blinding generations after that to the crucial insight that health is politically, socially and economically determined. Consequently, even today the discourse on medical and public health care tends to get limited to the organization and distribution of services.

Undoubtedly, these latter concerns are critical to insure quality of care and its equitable availability to all – as such, public health systems management is a corner stone for health services development. But it is equally important to be clear and equitable with regard to the kinds of medical care to be delivered by the health services system.

Do we approve of a public health system that fails to take into account the intelligent perceptions of the poorest? ...that doesn't acknowledge their livelihood struggles? ...that falls short of valuing the traditional healing systems evolved from generations of their life-times? ...that discredits all other knowledge systems other than its own, a system blind to its own arrogance?

Do we want a system that medicalises all aspects of our lives and takes away our power over decisions about our own health and gives it to medical professionals?

Simple home remedies and local healing traditions evolved over time have been communities' way of resolving issues of health and illness in their lives. Similarities found in the use of plants and herbs, and different cultures using similar plants for corresponding conditions indicates a people's knowledge base evolved with experience over time, not to be dismissed lightly. Similarly, methods of care practiced by dais (traditional midwives) do not deserve the discredit pronounced by allopathy standing in judgment. Dais understand pregnancy and childbirth and even the women themselves differently, as a part of life and thus affected by aspects of life like nutrition, rest and stress. This contrasts with the doctors' view that all pregnancies are 'at risk' and need medical management.

It is slowly being accepted that the view held by doctors is not necessarily correct. However, whatever acceptance of traditional elements of care that occurs within allopathy is piecemeal, insofar as it can be taken into and adjusted within the allopathic world-view. In general a deeper, more genuine grasp of non-allopathic patterns of thought is resisted. It is good that some of the allopathic regimens, particularly some obstetric practices, are being recognised as unscientific. They have persisted for years because the male 'fathers of obstetrics' had flawed and sexist notions about women. For example, in childbirth the 'lithotomy position' is now widely replaced by a semi-sitting posture in which the womb contractions are enhanced by the direction of gravity. Thus, the use of traditional birthing stools or bearing down in squatting position during labour, as taught worldwide by traditional midwives, is at last validated. It is remarkable that doctors could discard these methods so easily as being the practices of 'illiterate uncouth women', rather than acknowledging them as techniques evolved through women's long experience. Incidentally, Victorian era doctors adopted the lithotomy position (meant for urinary stone surgery) so they could curtain themselves off from women's sight while viewing and handling their 'private parts'.

Such major errors have occurred because modern allopathy, developed in the wake of the industrial revolution, is a 'reductionist' system that looks firstly at parts and how they function in the human body as if it were a 'wonderful machine', generally without referring to either the natural or the social environment.

In contrast, the non-allopathic or AYUSH systems are found to be 'holistic' in that they take reference from the wide natural universe in which human bodies and minds function or mal-function, and they see all parts and workings of the body intimately related to each other. They are premised upon interdependent processes and energy flows. Thus, in Ayurveda the human body is a microcosm within the macrocosmic universe composed of the five energetic elements, the *panch mahaabhoot*. So humankind is not opposed to nature and rather needs to keep in balance with it. The finest physicians in these systems have cultivated special sensitivities to mind-body states, like the ancient physician and surgeon Sushrut who describes subtle internal changes in pregnancy perceivable by a woman as *do-hridayni* or 'being with two heart-beats'.

Being reductionist in nature has given allopathy (and western science in general) a particular advantage, however, and that is the capacity to focus practically on the minutest of physical details and mechanisms in body function. Thus having generated the germ theory and fueled by capitalist interests, it could come up with precisely attributable, measurable therapeutic interventions like antibiotics for treating communicable diseases. Today it astonishes us by technical feats unimaginable earlier such as coronary artery 'by-pass' surgery that is now almost routine in the upper social class... and heart valve replacements, etc. even for members of populations depending on the public hospital system. Or stem-cell research that promises intervention to correct even genetic disorders. But allopathy's excessive dependence on technology sometimes definitely leads in the wrong direction, for example, the unchecked worldwide trend of unnecessary cesarean section operations.

Various observers have pointed out that a prominent feature characterising the health culture of Indian people is *pluralism* in seeking treatment and relief of ailments. People make choices to draw from the various healing systems and sets of practices, including allopathy.[3] In a sense, this pluralism may be even more characteristic of women than of men. Another less

commonly made observation especially for women, is that rather than being helpless about their own health care there is a strong element of *agency* in making health choices. Women choose despite their restricted access to health care and their tendency to look after others first.

Generally speaking, women in India find more resonance in the AYUSH systems and local health traditions as compared to allopathy. This is because of their pattern of social and cultural relationships, their power or lack of it within each system, and the way most Indian women relate to their bodies and to nature. Contrary to what most analysts have argued, it is probably not their powerlessness (economic weakness, poor educational status) that "drives" women (as it is said) to a *vaidya* or *hakim.* As regards mental and emotional health, too, there is more resonance. In the allopathic view there is a sharp mind/body distinction or split, hence a dichotomy of mind and emotions. The male mind (supposedly not emotional) is seen as the standard "sound mind", and so women's mental and emotional health issues tend to get discounted. But in the traditional views, in general found throughout India, a person's *"man"* (roughly translating as "mind" but located closer to the heart, in the upper chest) is a combination of both mental and emotional facets. This is not to say that women's mental health issues are not neglected by practitioners of Ayurveda, Unani or Homeopathy. It is only to suggest that the AYUSH systems and local health traditions may provide relatively more space for women's mental health issues to be addressed.

Patriarchy or dominance by male-structured values is very much a part of all the medical systems. Patriarchy is present in traditional systems of care as well and the males have more power than the women. Women may be healers of smaller ailments but it is usually men who are the shamans etc. At global level, allopathy has been more exposed to criticism and pressures from the women's movement, and today there are many more women physicians in that system than there were forty years ago. Much of feminist critique concerns health issues as seen by women, in particular women's health both including reproductive health and beyond it. However, the AYUSH systems on the whole have not been exposed to this discourse. In these systems there are a lot of unfounded unquestioned biases about women's bodies. Furthermore, in the local traditions some blatant taboos still work against women even today. While the codified texts and the practitioners of each system carry a number of sexist ideas and gender-based prejudices, most AYUSH practitioners are unaware of these drawbacks. In Ayurveda caste prejudice is another negative feature that does crop up.

Because of allopathy's pre-occupation with the technical location of a pathology, it tends to ignore many ailments that women experience, considering them not "serious" or not amounting to "disease". For example, common anaemia and weakness, vaginal irritations, menstrual disorders, all kinds of pains, etc. typically receive scant or no attention. At the same time allopathy tends to medicalise natural aspects of health like menstruation, pregnancy, childbirth and menopause.

On the other hand, the AYUSH systems and LHTs are more concerned with correcting imbalances in health and sustaining it. Subtle signs indicate states of humoral balance or imbalance that would be helped by various types of correction, not merely by medicines, such as modifying diet content, regulating timing and amount of meals, fasting and yogic posturing or movements. Moreover, perhaps surprisingly, in AYUSH systems male and female *bodies* are not as opposed or dichotomised as in allopathy and western culture. In Ayurveda differences in individual make-up or nature (*prakriti*) are more important than biologically distinct reproductive organs and hormones.

Nutrition is another distinct area of expertise in the AYUSH systems, particularly in the ISMs. Although the Ayurvedic system of nutrition contrasts starkly with the protein-carbohydrate-fat framework of allopathy, its elaborate schema is rational no doubt. The same would hold for Unani principles of nutrition, which we hear have been applied with proven success in improving child nutrition through ICDS in a Block in Tamilnadu by a Unani Medical College.[3]

Questions of 'How?'

Given that 'parity and equity' of systems is an objective, there are fundamental questions of how AYUSH (with or without the LHTs) is going to be 'mainstreamed' at par with allopathy in the public health system – questions of fundamental conceptual nature and questions of specific application. The most basic is the difficulty of interfacing fundamentally different knowledge systems. The non-allopathic systems are based on entirely different conceptual principles and assumptions that generally contrast with the western medical world-view.

Allopathy is accustomed to interpreting the non-

allopathic systems on its own terms and up to the present time in the field of public health this has been allowed because allopathy is dominant. But what if allopathy were 'brought onto on par' with ayurveda and unani, or with homeopathy? To many of us it raises the basic question of *'What is science?'* More practically speaking, we need to know the answers to the questions:

How is the validation of medicines or therapeutic procedures to be done and accepted? How will physicians resolve issues of interacting therapeutics, side-effects, counter-indications? Will there be a change in the way of looking at health and disease taking a wider view beyond the germ theory and individual-based causes?

Without a live and strong internal tradition of critique and development, the potential of the AYUSH systems to address women's health needs and public health issues is restricted and unrealised.

Moreover, in these days of LPG (liberalisation-privatisation-globalisation) we are seeing the allopathisation and commodification of AYUSH systems on a massive scale. Already from past years of subordination, the AYUSH colleges mimic the form of Allopathic colleges in terms of department categories, structuring of text-books, etc. Ayurvedic medicines are researched by allopathic criteria. But the scale on which Ayurveda is being globally marketted and sold, and the price tags on its newly-celebrated therapies, is unprecedented. Not only is there no concern for public health, it is also drawing off the graduates of AYUSH colleges. The majority of graduates of Unani colleges today and many from Ayurveda colleges are going into cosmetics manufacture and beauty parlours. And ironically globalisation is bringing Ayurveda therapies back to us in new expensive garbs geared for tourist consumption.

Even looking at management of medical services the problems are immense. If mutually acceptable standards for therapeutics, medicine interactions and so on are achieved, then what will be the mechanism for regulation? Who will carry out inspection? What kind of criteria will be evolved for quality of care and cure? Which kind of health problems will by attended to by whom? What about immunisation, which certain non-allopathic disciplines don't accept, like homoeopathy? Will we continue to insist on vaccination as a mainstay of public health? Where will there be the 'choice' for users and how are they going to decide? Who makes the decisions, healers or the people they treat?

As of now, it is hard to imagine a lack of systems hierarchy in actual PHC settings. And, are there enough AYUSH doctors in India for Primary Health? As one of our friends suggested, would it be feasible at PHC-level to think of a kind of trained "Healers' Group" (including various systems' physicians and specific therapists), adept at dealing with 30-40 commonly occurring health disorders or conditions? In Gujarat now there is experience of some special 'Ayurvedic PHCs' (also called 'healing centres'); what can we learn from this? What will be the role of specific therapies, such as *marma/varma chikitsa* (indigenous acupressure system) and 'nature cure'?

Apart from the 'medical' issues like those, don't we really need a new framework to give precedence to fulfilling the essential demands like food, decent work conditions, fair wages which, in people's perception, is how to achieve good health?

Some Conceptual Lacunae from a Public Health Perspective

In the allopathic sphere, a certain discourse exists on the 'political economy of hunger and healing' and the interaction of malnutrition and therapeutics. Behind it is a half-century of concern about calorie-protein deficiency and an evidence-based notion of 'body mass index' (BMI) from a data base built up over decades. Research has now found a linkage between nutrition and drug interactions. For instance, in case of the anti-TB drug Rifampicin, drug metabolism is grossly abnormal when body weight is lower than 35 kgs in adult women... and between 60-80% of Indian women on average are irrefutably anaemic.

There is a need to pursue this kind of discourse and awareness within the AYUSH sphere, where it seems the nutritional norm of a 'middle class adult who has two adequate meals a day' is unchallenged, unacceptably low BMI in women appears to be a non-issue, and there is no acknowledgment by systems of the imperative of feeding populations exposed to starvation. As we speak of developing this discourse in AYUSH sphere, we watch with dismay that much of the world tries to flee from reality into mythical media-lands of 'Shining Progress'.

As demands are made of Public Health professionals (in the allopathic sphere as of now), there is a need for professionals in other systems to take stands on issues such as intellectual property rights (IPRs), and

protection of biodiversity, public (community) property and public health. Despite these strong concerns that might even be envisioned as intrinsic in the non-allopathic and indigenous systems, the massive pressures to commodify these systems are pulling them in the wrong direction. Hence, here is an area where sincere professionals of all systems can draw strength and clarity from each other.

The non-Allopathic healing systems, diverse and less organised among themselves as compared to the allopathic system, must undergo deep conscientisation about the issues. This can come to pass only if 'tradition' begins to be known among them as something to be made and re-made appropriately according to needs of the time for the fulfillment of human rights, the most fundamental right of which is right to health and health care. Without a live and strong internal tradition of critique and development, the potential of the AYUSH systems to address public health issues will be restricted and unrealised.

In this paper we have tried to lay out the issues that we see and the challenges and contradictions. We don't claim to have the answers, but are raising the questions to begin a collective process of thinking and seeking of solutions.

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We are thankful to Chinu Srinivasan and Manisha Gupte for thoughtful feedback in the early and final stages of writing this paper. – Mira, Alpana

Endnotes

[1] *The non-allopathic systems are also known as 'Indian Systems of Medicine (ISMs) and Homeopathy, and by the new official acronym 'AYUSH'. Many people refer to them as 'alternative' medical systems. In this paper 'western medicine' and 'allopathy' are used synonymously.*

[2] *See Leena Abraham, 'Indian Systems of Medicine and Public Health Care' (Chapter) in Review of Health Care in India. Mumbai: Cehat, 2005.*

[3] *Source: Prof. Hakim Syed Khaleefatullah, Chennai (Member of AYUSH Steering Committee,11th FYP).*

'Dais' (indigenous midwives or 'birth attendants') in South Asia...

...represent a long line of women's experience, mainly of non-literate and low-caste women. They have attended to women in childbirth for thousands of years. Lack of mention of their knowledge and skills in the Ayurvedic texts is only testimony to that system's deeply etched upper-caste bias.

At present some of us are chalking out an investigation into a traditional child-birthing practice of theirs that we believe holds untold significance – the practice of reviving an apparently lifeless newborn by heating the placenta (still attached to the infant by the umbilical cord). The practice is found to be widespread in the sub-continent and nowhere else in the world. It is reported so far from Indian States as diverse as AP, Bihar, Gujarat, Jharkhand, MP, Maharashtra, Punjab, Tamilnadu, UP, and from Bangladesh. Yet doctors know nothing about it – this practice has 'flown below the radar screen' so to speak, and few 'educated' persons have witnessed it being done. One field report estimates that local dais are doing it to revive newborns in "one in twenty" births – a frequency vastly significant for infant survival that also raises the question of whether dais are facing the neonatal consequences of oxytocin misuse by quacks to hasten childbirth.

How this traditional technique might be 'working' at physiological level is a scientific question to be addressed by bio-medicine. Of first importance to us is that this marginalised diverse group of women 'indigenous health providers' appear to have preserved and carried a life-saving tradition since deep antiquity. This very fact may validate an indigenous world-view totally different from our medical paradigm which we blindly impose on these women through 'dai training'. We invite serious participation in this investigation.

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Annual Meet 2006 Paper

State Institutes of Health & Family Welfare and Growth of Public Health in India

-Shiv Chandra Mathur[1]

Medicine to the study and application of biology in a matrix that is at once historical, social, political, economic and cultural. The practice of Medicine is a part of sociology and a product of sociological factors.
-Henry Siegerist

1.0 Introduction

This write-up is an attempt to draw the attention of public health activists towards the process of institution building of state level institutions in our federal polity. There are a dozen State Institutes of Health and Family Welfare in India. Almost all large states have an apex level health training (and research!) institute at the State level! All these institutes were started as a project activity with World Bank support under the banner of 'India Population Project'. These projects were popularly designated as IPP. They had a life span of five to seven years in each State. These projects were essentially to provide strengthening support to Family Welfare Program in collaboration with Government of India. Eventually during the life time of IPP's in the respective states, SIHFWs were brought up energetically. This entailed not only large scale civil works often in sprawling campus, but recruiting the faculty and inducing a culture of streamlining the in-service trainings for large health systems. Since the World Bank projects have a mechanism of continuous dialogue between the three parties during the implementation phase - GOI, respective State Government and World Bank Review Mission - continuous improvements in the training process occurred as long as the projects were in vogue. But once the IPP was winded up from a given State, the process of institution building of SIHFW in that State has gone haywire.

Following text is a brief account of extent of ownership of SIHFW by the States, their impact on the growth of public health in India, context of health sector reform in this process, brief on couple of cases of SIHFW and possibilities of their revival in the light of Public Health Foundation of India and lately a proposal to start State Health System Resource Centre under National Rural Health Mission in all the (erstwhile!) States clubbed under Empowered Action Group.

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2.0 Health and Family Welfare Training Centres

Training Institutions to take care of in-service training in health sector were initially started as Regional Health and Family Welfare Training Centers (RFPTC). This momentum started in late fifties, reached to its pinnacle by 1978 when the number of RFPTC's in India rose to 47. The staff provided in these training centers was based on the recommendations of Mukherjee Committee Report. Since multi-disciplinary professionals were expected to organize training activities in these centers in coordinated and cooperative manner, varieties of disciplines such as Bio-medics, Social Science, Health Education, Public Health Nursing and Statistics were converged in these training centers. The main functions of RFPTCs identified were:

- To plan, conduct, evaluate and follow up training programs including refresher courses, seminars, workshops, conferences for health professionals in the training centre and in the attached districts as a technical resource for a given region;
- To develop urban/ rural field practice and demonstration areas;
- To develop guides and manuals for training and to provide consultative services on family planning and training to other voluntary and allied agencies;
- To promote and coordinate teaching and training in family planning in the training curricula and programs of other organizations.

These training centers were established with a norm of one for 10 million populations. They were exclusively FP training centers to begin with, subsequently widening their horizon to health. RFPTC,s contributed substantially in developing the capacities of health systems in seventies and eighties. Their ubiquitous presence was proved during reorientation of health professionals to multipurpose scheme. Shift in management approach from program to project mode might have led to weakening of their potency. RFPTCs under the new jargon of HFWTC's around the country

are now surviving with funds made available under centrally sponsored schemes of FP program. HFWTC's have huge buildings, large manpower and sufficient training hardware, most of which remains underutilized. Latest addition to the network of these regional institutes was HFWTC, Jodhpur. It was established specially for ten desert districts of western Rajasthan under IPP-IX project. Way back in 1996-97, it entailed civil work of Rs. 2.5 crore, to construct this huge training institute with a large hostel and staff quarters. Staff was collected and institute functioned for five years. As soon as IPP-IX terminated, this beautifully created HFWTC was dissolved and the assets so created were handed over to another department of the State!

3.1 SIHFW Andhra Pradesh

Established in 1992 under IPP-VI, it functions as an autonomous body. Governance is through a board chaired by the chief secretary of the state. It has a faculty of 3 Professors, 3 Readers and two lecturers. They cover the disciplines of Epidemiology, Communication, Management and RCH. During 2003-04, all faculty members were sent to different European Institutes under a Institution Development Program of Health sector reforms supported by European Commission. While services for Mess, Hostel, garden etc are hired on contract; ancillary support of 17 persons is there. Beside a 155 seat auditorium and a lecture theatre, institute has four training halls which more often are given on rent to other agencies to conduct training program, thus bringing revenue to the institute. It has a hostel with 44 rooms and four VIP suites, seven computers and a fairly .large library. State government is regularly giving them a grant-in-aids to the order of Rs. 80 lakh per annum. Institute has been able to undertake several projects and earn a substantial savings. This led to the creation of a corpus which gave confidence and sustainability. Thus it boasted by re-designating itself as Indian Institute of Health and Family Welfare! It can be said with certainty that SIHFW, Hyderabad could create a niche as an autonomous institute in health sector. . Although led by a full time technical director for seven continuous years, this is third occasion of fairly long duration when SIHFW is under additional charge of Commissioner FW, Govt. of A.P.

3.2 SIHFW, Rajasthan

World Bank could persuade the Government of Rajasthan to follow the example of AP. Thus another SIHFW as an autonomous body was established in yet another large state i.e. Rajasthan. Governing Board of the institute is chaired by Health Minister. It has a full time technical director selected through open competition. Between 1995 and 2001, SIHFW, Rajasthan functioned well but came to a grinding halt in January, 2002 when IPP-IX was terminated. World Bank project could leave behind a legacy of huge building in a sprawling campus and disillusionment for the State as to how to carry it on? Virtually for earlier half of 2002, it was kept gasping.

Fortunately efforts to revive it were started soon. Bringing back a full time technical director and exploiting the opportunity of clubbing the HRD component of erstwhile projects in the State i.e. IPD, EC-SIP, RCH-1, RHSDP etc could infuse life into it. Physical asset of a large unfurnished building could soon be changed into a throbbing institute by the component of "Strengthening SIHFW" under European Commission supported sector reforms program. Equipping the 24 double occupancy rooms in the hostel, a library with more than 3000 books, four training halls and an auditorium with 100 seats brought life to the campus.. There are six faculty positions covering the area of Community Health, Communication and Management. Additionally, support staff of ten persons and subsequently, a contingent of Consultants as CTI in RCH-2 were also made available.

Thus SIHFW restarted working on its mission to help the Medical and Health Department of Government of Rajasthan in continuously improving the quality of services provided through variety of public facilities. Thus institute's involvement in organizational development through concurrent conduct of in-service trainings and operational research started creating a dent. Managing more than a dozen trainings in RCH-2 Project throughout the state now seems to be it's routine. Beside holding flagship for a network of HFWTC's and ANMTC's and guiding them in implementing the training strategy of RCH-1 and 2, it has oriented all the Project Management Units created in 32 districts of the State under NRHM. It has also set the ball rolling for orienting ASHA through a cascade approach. Short term research projects undertaken by the SIHFW provided consultancy for mid-course corrections in national health program and projects on one hand and provided a feel on training needs of the department on the other hand. Of course, this phenomena set ball rolling for Institute to earn consultancy. Institute has hardly received any financial support from State Government over last four years. But it has demonstrated that a self-sufficient autonomy can be created even within public system!

3.3 SIHFW, Uttar Pradesh

World Bank has supported three IPP's in Uttar Pradesh between 1973 and 1996, viz, IPP-1, IPP-2 and IPP-6.

Establishment of SIHFW, UP is part of implementation of these projects. Its current shape was finalized in IPP-VI. It is an integral part of department of health and family welfare of the state government. It is led by a full time technical director who is selected through open competition. There are 2 positions of Professors, 3 Associate Professors and ten Assistant Professors in the faculty. Disciplines covered include Education and Training, Communication, Statistics and Demography, Social Science, Organization Behaviour, Community Health and Epidemiology. Research staff is being additionally provided which includes 1 Joint Director, 1 Assistant Director, 4 Research Officers and 15 Research Assistants. Paraphernalia includes strength of 57 persons. This SIHFW has two hostels with 35 rooms and one guest house with four suites, 100 seat auditorium and four training halls. It maintains a convoy of five vehicles and eight Pentium Computers. Its annual budget for 2004-05 was Rs. 1.37 crores. SIHFW, UP conducts foundation courses, RCH-ToT, Nurses training and HIV counseling program. Institute is collaborative training institute for RCH-2 Project for Uttar Pradesh. It has published couple of research studies in last three years which remained restricted between SIHFW, Lucknow and Government of U.P.

3.4 SRC, Chattisgarh

With the carving out of Chattisgarh from Madhya Pradesh, two major projects i.e. cultivating Mitanins as a community Health Worker and attempts to begin a consolidated course to create a band of paramedical professionals led to the creation of State Health Resource Center. Basically this is a research support to the health system of the State. The experience of Chattisgarh Health System Resource Center is said to be very positive in the opinion of Government of India in pushing reforms and building capacity for improving health systems delivery at all levels. Government of India has directed all the states under NRHM to establish similar health system resource centers albeit the SHRC, Raipur is now being upgraded as SIHFW by the government of Chattisgarh.

4.0 Health Sector Reforms and Professional Development Courses

"That for the general promotion of the means necessary to prevent disease it would be good economy to appoint a district medical officer, independent of private practice, and with the security of special qualifications with responsibility to initiate sanitary measures and reclaim the execution of law – their task was to be essentially with prevention."

Edwin Chadwick

Another major component of health sector reforms at country level is beginning of Professional Development Courses (PDC) for district level Medical Officers. It was around the beginning of new millennium that MOHFW in collaboration with NIHFW evolved a 12 week long professional development course (PDC). It was primarily addressed to Doctors who are already District Medical Officers, and secondarily to the potential candidates who are soon expected to take charge of districts. NIHFW piloted this program for two years. Subsequently at the behest of European Commission, MOHFW delegated the responsibility of conducting PDC to SIHFWs around the country. This has been an appreciative beginning on the way to revitalize the SIHFWs where state institutes in Punjab, Gujarat, Andhra and Orissa have proved their worth.

In Madhya Pradesh, during the implementation of IPP-VI, state level institute was created under the banner of State Institute of Health Management and Communication at Gwalior. For almost a decade, this unconventionally jargoned state level health institute has remained under the charge of Divisional Commissioner of Gwalior! Naturally, its resources were exploited more often for activities not related to development of health services. Substantial evidence of this fact is reflected in the decision to delegate PDC by GoI to HFWTC, Indore for the State of Madhya Pradesh. Epilogue of this episode is that HFWTCs if supported can deliver the goods! After all every black cloud has a silver lining.

In Rajasthan, PDC was assigned to IIHMR, Jaipur in place of SIHFW with the pretext that at two places these prestigious training programs were assigned to private institutions. Other private institute identified was in Kerala where PDC never took off, while in IIHMR, over a period of two years only two programs with 16 participants at each time could be conducted. Had it been SIHFW of the State in implementing PDC, the identification of participants could have been of the order where worthy utilization of trainee after training could be possible! After all a private institutes do not feel as much concerned on the profile of a participant as a institute of state having allegiance to the health system of the respective state.

Overview of initiating PDC in India seems to be a good beginning in terms of making provision for well oriented district level Medical Officers, since the later in our country manage the health services for as large a population as two million. Nominating right candidates has remained a challenge with the Health Directorates of respective states in view of duration of ten continuous weeks. Officers who are already in service for 20-25 years charged with responsible portfolio have

many stakes when they are supposed to be away for two and half months.

5.0 SHSRC and NRHM

Framework for implementation of National Rural Health Mission (NRHM) has proposed the setting up of State Health System Resource Centre (SHSRC) in EAG States to begin with. It is expected that the SHSRC will work very closely with existing SIHFWs, PRCs and HFWTCs. At this juncture, there is again a need to take stock of SIHFWs and HFWTCs in various states. Exploiting the opportunity created within the frame of NRHM may further pave the way to enhance the capacity of state's own institutes. It would further link up the research and in-service training. In fact, quality training can be delivered only when traiers are consistently fed with on-going strengths and weaknesses of the system. This has been a firm experience of SIHFW of AP and Rajasthan. While in Raipu, SHRC is remolding itself as SIHFW- Chattisgarh, SIHFW- Rajasthan has initiated the steps to demonstrate that as an already established autonomous body, it can play effectively as SHSRC.

6.0 PHFI and SIHFWs

Public Health Foundation of India launched in March 2006 plans to set up a chain of Indian Institutes of Public Health (IIPH). Government of India has requested all the State Governments at the time of launch of PHFI to come forward with the proposals for the foundation to establish IIPH in their states. Incidentally the States having SIHFWs with sufficient physical and manpower resources have expressed the interest from a new end. Thus they have overlooked the presence of Institutes which their own Government created within last decade or at the most 15 years. Since the basic premise of Public Health is optimization of resources, MOHFW and state governments owe a responsibility to converge the movement of building up new institutions with strengthening the one's which are government's own creation. Alternately a huge investments in HFWTCs and select SIHFWs through central sponsored scheme funds needs a thorough review.

7.0 Conclusion

Thus, we are passing through a dilemma. We observe the sustaining of HFWTC's at regional level and indifference for State level institutes created in recent past! We see unproductive HFWTC's larger than the much criticized SIHFW of their respective states! SIHFW's to begin with babies of central and respective state governments were marginalized by the same creators. Ministries themselves could not ungrip themselves from the overwhelming presence of IIHMR here, ASCI there and IIM boasting of their Health Schools elsewhere! Eventually the bowel of nourishment from States which could go to their own creations (SIHFW), also reached to the well established institutes (a natural corollary of privatization). And State health burecracies are now nurturing the ambition to establish yet another set of health training institutions under the garb of public-private partnership! What is required is to advocate and persuade the decision makers to carry on the growth of health systems on proper track. When Public Health has many patrons around, Governance owes the onerous responsibility to regulate the sponsor's support effectively.

Further Reading

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Table 1: SIHFW in India

Name & AddressPhone No.	Leader as of	Oct. – Dec. 2006
Indian Institute of Health and Family Welfare, Govt. of A.P. Vengalrao Nagar, Hyderabad-500038 website:<www.iihfw.org>	040-23810400	Commissioner, FW
Govt. of A.P. State Institute of Health & Family Welfare, Khanapara, P/O Assam Sachivalaya, Guwahati- 781006	0361-2261605	Commissioner & Secr. of Hlth & FW
State Institute of Health and Family Welfare Sheikhpura, Patna-80014	0612-2286148	Acting Director
State Institute of Health and Family Welfare, Near Sola Civil Hospital, Sarkhej- Gandhinagar Highway, Ahmedabad-380060	079-27462811	Fulltime Technical Director
State Institute of Health and Family Welfare Behind Tapori Park, Sect-6, Panchkula-145109, Haryana	0172-2584549	-
State Institute of Health and FW, Karnataka 1st Cross Magadi Road, Bangalore-560023 SIHFW, Thycaud, Thiruvananthapuram, Kerala- 695014	080-23206125 0471-2336743	Director Incharge -
State Institute of Health Management and Communication City Centre, Gwalior-474002, M.P.	0751-2340229	-
State Institute of Health & Family Welfare Nayapali, Bhubaneswar-751012, Orissa	0674-2402032	Fulltime Technical Director
SIHFW, Punjab New Civil Hospital, Sector 34, Mohali, Chandigarh, Punjab	0172-2624353	Commissioner Health System Corporation
SIHFW, Rajasthan Jhalana Institutional Area, Jaipur-302004	0141-2706534	Fulltime Technical Director
SIHFW, UP C-Block, Indira Nagar, Lucknow-226001, UP State Institute of Health & Family Welfare, 29-G.N. Block, Sector-V, Bidhan Nagar, Kolkata- 700091 033-23574531	0522-2340597 033-23578870 -	Director I/c

Annual Meet 2006 Paper

Public Health Education Needs as Seen from Grassroots

-Narendra Gupta[1]

Public health education is an important element in changing people's beliefs, mindset and behaviour to move towards healthy life. Therefore, it is seen as an important aspect for attaining the objective of health promotion. Globally, a substantial mass of human resource is created to carry out the work of public health education and various strategies are adopted to do it effectively depending upon the context. However, most of the public health education related activities are carried out by the Government system only.

Undoubtedly, public health is a big challenge for health personnel in India, because a large number of people especially those residing in rural areas still have deep beliefs in myths and superstitions. Coupled with this is the dispossession of resources required to maintain good health, viz, full nutrition, clean water, secure dwelling and safe working conditions. Strong traditional practices also act as block in operationalising public health. 'Health' including public health is a state subject in India, therefore many states have different methods of health care systems in terms of infrastructure and personnel. Health education in the governmental sector is performed by several categories of functionaries in our country. Some of the designations for public health personnel in different provinces are health education officer, health extension education officer, health education instructor, extension educator, block extension educator, block family extension educator, block family welfare officer, extension training officer, health extension education worker, demonstrator, assistant professor, reader, professor, medical officer, social worker, social welfare officer, public health assistant, nutrition assistant, sanitary inspector, case worker, district extension educator, district family welfare officer, district family welfare extension officer, mass education and media officer, deputy health education officer, media education officer, education and information officer, education and publicity officer, district health education and information officer, deputy mass education and information officer, state health education officer, project leader, and regional health educator. All these categories of people are placed at different positions. However, amongst these the most important cadre is of the people engaged straight into primary health care delivery because most of the time, it is these who interact and work directly with community on subjects of public health.

Public Health Education in the Context of Primary Health

India has a well conceptualized network of outreach health delivery services with the mandate to make health care available, accessible and affordable to all citizens irrespective of caste, religion, gender, income and geographic location. To attain it, primary health care institutions have been created based on population norms and postings of health personnel is being done accordingly.

Health care personnel in primary health care can broadly be categorized into two sections. One segment is of medical officers and other is of paramedics. Within paramedics there are many categories, viz,. female and male multipurpose health workers and general duty nurses. Medical Officers could be simple graduate or postgraduate in any discipline of medicine. The female and health multipurpose workers undergo one year training while nurses have at least three years training. Public health is taught in all health courses, but not taken earnestly and taught in very indifferent manner. In fact this is the biggest weakness as far as public health teaching is concerned. Though there has been continuous change in public health teaching. There is an attempt to make it more interactive, experiential and challenging but in the absence of supportive milieu, these remain only paper dreams.

One and rather important activity of the personnel in primary health care is to render preventive services which are essentially non-clinical. These include health and nutrition education, disease surveillance, disinfection of drinking water sources and issues relating to maternal, reproductive and child health. *Most of the preventive health activities require sound knowledge about the public health principles & issues, skills to use the knowledge in the local context and above all a sensitivity and attitude to do it in effective manner.* Knowledge source to health workers are basically their training schools and later continuing education is possible through in service training, workshops and literature. However, if the knowledge, skills and attitude about public health amongst health care providers in primary health care system is examined, we find that it is invariably incomplete and full of several

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gaps. These gaps are perhaps for the reasons public health is taught in the medical and nursing schools to doctors and paramedical staff. Some of the glaring gaps in public health education amongst male health workers and also the doctors engaged in delivery of primary health care from the way they function as providers are discussed below:

Knowledge

Prevention of any disease can be advocated or operationalised only if there is clear grasp of facts of the distribution and determinants of causation of disease in a particular area. But often it is seen that peripheral health workers posted in community settings have imperfect clarity about these aspects of the health and diseases. Therefore, mostly they look for to receive instructions and their actions are mostly limited to carrying out the messages and directions received from their higher officers and senior persons. On many occasions, these instructions and messages are ambiguous and in the absence of any sound public health knowledge, activities are conducted in perfunctory manner. A very important aspect of public health education is connected to knowledge about collection of accurate health information especially of the vital events like births, deaths and morbidity through setting up appropriate surveillance system. Sound knowledge is also required to collect information on prevalence of various diseases, their periodicity, case fatality and the treatment seeking behaviour of the community for these diseases within different social segments. Curriculum of the nursing and medical schools do show that these aspects of health are taught to students but the approach of teaching remains very technical and deprived of any social context. As a consequence, health personnel pass out from schools with flawed knowledge on health issues. This gets further perpetuated by the system of unethical clinical practice with over emphasis on clinical activity. In the words of a Chief Medical Officer of one district in Rajasthan *"My surveillance system operates through newspapers…the first thing in morning I do is, open newspapers and look for any epidemics or outbreaks reported within district and based on it, I plan my activity."* This kind of statement clearly reflects that there is hardly any surveillance system and emphasis is on containment after an outbreak rather than on prevention.

An important function of the health personnel engaged in primary health care is to implement national health programmes of all kinds viz. vector borne control, anti malaria, tuberculosis control, blindness prevention, reproductive & child health to name a few. Public health action related aspects to most of these programmes keep changing regularly and require updating on frequent intervals. Attempts are made to enhance knowledge and skills through organizing short term training and orientation courses of field level health functionaries. But most of the time these training programmes are done in very ritualistic manners through one prescribed format that necessarily may not be relevant in the local context. The trainers themselves many a times are not convinced with the usefulness of the training. Experience and anecdotal information shows that most of the workshops and training organized for to upgrade knowledge of the peripheral health functionaries are not conducted with seriousness. Day long training workshops are finished in few hours and a lot of time is spent in gossiping. In most training programmes, the gap between persons nominated to attend and actual attendance is grossly different. One often cited reason by the nominated persons to not attend the training/workshops is that they are conducted in boring manner and there is no space for interaction. However above all the paramount reason for not participating into such programmes is loss of income that health personnel make through indulging into private practice. In most states of India including in the state of Rajasthan, health personnel are allowed to do private practice after duty hours at their homes. The passion to earn money through private practice is so intense amongst health care providers that it has led to not only avoiding duty completely or partially but also indulge into unethical or irrational therapeutic practice.

Skills

A skill can be defined as an ability that is usually learnt and obtained through training to perform activities to achieve desired outcomes. It implies that skill can be acquired by practically doing activities. A skill can be best utilized if it is contextualized especially in instances of social interventions such as public health. However, there is a universal pattern for public health education in India. With the mushrooming of medical and nursing schools in private sector, a lot of human resource movement takes place in terms of education. More influx is towards the states where more private institutions are set up. Since the knowledge of public health imparted in all the institutions is generic, emphasis is always on teachings theories from text books and with very little practical work. The application of the knowledge in the local context and above all how should the local context be analyzed and understood from the point of view of health

completely lacks in the curriculums of public health courses. Therefore, health care providers get into service without much of skills to work in community setting. As a result there are ANMs posted in the health sub centres and PHCs whose one important job is to conduct safe deliveries but they have had no previous experience of doing it. A large number of health workers would not know, how to estimate haemoglobin, measure foetal growth and identify at risk factors in pregnant women. Medical Officers also most of their times are engaged in treating patients and never use principles of public health or for that matter try to understand the health profile of their area. Though there is scope to enhance their skills through in service training but these are again conducted without sincerity and no advancement in skills happen for most of the participants. Most medical officers are unwilling to carry out public health work. They perceive it as work of an inferior category and believe that those who can not be good in clinical skills will opt for public health positions. Therefore public health related skills amongst medical officers are lowest. Most medical and paramedical health personnel when it comes to getting into public health related work try to avoid doing it or if compelled then do it very carelessly.

Sensitivity and Attitude

Knowledge and skills are important requisite for carrying out appropriate health activity, but it's the 'sensitivity' which determines whether these will be applied appropriately amongst those persons who require it. Therefore, sensitivity is a very important attribute required to deliver health services. Sensitivity is very intimately linked to ethics. A sensitive person would always try to be ethical and fair in work. There are different ways by which people become sensitive and motivated. It is a lot related to the mindsets which may be influenced by different role models struck to individuals. Belief in different spiritual, religious and political philosophies also factor in shaping sensitivity of individuals. Sensitivity is the product of socio-economic analysis and vice versa.

Building of sensitivity and motivation is least looked into public health education. In the name of sensitivity only lectures are delivered which are mostly alien to the reality. Social determinants often miss from public health education curriculums. The determinants include unemployment, unsafe workplaces & housing, urban slums, corporate led market controlled globalization, gender based discrimination and lack of access to health systems. Thereby, public health personnel while working with rural and especially the poor community mostly act in very mechanical way. They rarely look at the socio-cultural, geographical, economic, occupational and gender based segments of them and in particular how these segments lead to inequities which finally result to act as barrier in accessing health to certain categories of people. Non-contextualization of the public health work restrains local people to participate. Insensitive health care provider point finger towards community for their non-participation and hold people themselves to be responsible for their poor health. This happens more so with women especially with regard to their reproductive and mental health problems. In the absence of gender sensitization, most health providers accuse women for their problems and owing to non-availability of right information, women get more confused and depressed. Socially excluded groups such as dalits, adivasis, religious minorities etc. also experience denial of health care and health education because of insensitive attitude of the providers.

What is to be done?

The notion that public health is a low skill work in comparison to clinical work has to be changed and its importance in managing the burgeoning health challenges is required to be established. While teaching public health, a lot of emphasis is required to be given on social and economic determinants of health, so that the public health practitioners get into the causes of causes of ill-health and plan their action to remove fundamental barriers of health.

Awareness and sensitivity on different patterns of inequities is an equally important characteristic to be generated among public health practitioners. This will form the basis of effective, rational and ethical public health approach. Above all, the field level health personnel are required to be competent enough to analyse the public health issues and act on them. This can happen only through continuous up gradation in their knowledge and skills.

In memoriam

N.H. Antia 1922-2007

***-Padma Prakash*[1]**

Dr. N.H. Antia, plastic surgeon, community health lobbyist and health care policy-maker recently passed away after a brief illness. Even as we await more considered assessments of his many contributions to improving our public health system, offered here is a profile in tribute.

Noshir Antia ventured on his first plane ride when he was a small boy in a town in south western India. It was a joy-ride on a small plane at a time when aircrafts were beyond the ken of ordinary people. The ride isn't important. But his memory of what struck him on his trip into the skies is a pointer to what moved him into the different paths he traversed in his lifespan of 85 years. He said he was struck most by the underlying unity of the landscape – the school, the temple, the *dhobi ghat*, the hospital and the liquor shop all had a place in the scheme of things. One just had to make an effort to see that larger design.

Years later he recognized the hidden linkages of economic status, living conditions and health in a small postwar industrial town in rural England, and the futility of techno-medical solutions. Writing in *The Lancet* he pointed out, 'The workers' plight, despite the wealth derived from the industrial revolution and the colonies over 250 years, was revealed by the gross manifestation of rickets… Its elimination by vitamin-enriched butter was an equally dramatic manifestation of a medical solution to what was essentially a socioeconomic problem.' All through his life he chased that ideal of a well-balanced and integrated community that would take care of all its welfare needs. It was only late in life that he came close to realizing the dream in Parinche near Pune.

When I met Dr. Antia he was, one might say, on the threshold of his second career, in health care. His days as a surgeon were by no means past, but something else increasingly took precedence over his first love. It is not surprising that he set up the first office of the Foundation for Research in Community Health (FRCH) in Mumbai in an unused anteroom of the operating theatres of the Tata Department of Plastic Surgery, which too he had begun in 1959 and nurtured to great acclaim. This was 1977. Antia had some years back launched a health project in Mandwa near Mumbai, centred on locally trained health workers. This gave the impetus for him to take on the somewhat thankless task of anchoring the secretariat of the recently set up Committee on Health and Medical Services under the tutelage and blessing of the redoubtable educationist, intellectual and social activist, J.P. Naik.

The committee had an ambitious objective to produce a comprehensive strategy for the development of health care for the Sixth Plan, a plan that would follow up on the Bhore Committee's radical recommendations of 1947, many of which had been shelved over the decades. The secretariat had to willy-nilly contend with brilliant, if sometimes intractable experts in medical and public health disciplines. Antia was undoubtedly the right person for the task.

Even though many of those who worked under him often found him autocratic, among his peers he could be very persuasive. In the numerous meetings of the committee, formally he spoke little. It was at the lunch table and post dinner discussions that he engaged the well-known and well-lettered public health specialists, including the controversial Dr. Carl Taylor from Johns Hopkins School of International Health, a sometime invitee.

Quite ignoring the past histories of several other reports, the ICSSR-ICMR Committee with V. Ramalingaswami as its chairperson, dared to look at out of the ordinary solutions towards a plan that would ground itself on the newly revived panchayati raj institutions and incorporate a 'for the people by the people' philosophy. Health for All: An Alternative Strategy turned out to be a path-breaking document. Indeed many of the recommendations of the committee were incorporated in the Sixth Plan document and Antia fought a quiet battle for decades after trying to push this agenda through.

Antia's journeys in community and public health had just begun. He plunged into pioneering health care research at a time when few institutions were going that way. The core group of the secretariat underwent a metamorphosis to draw in more young people, in dialoguing and working with whom he probably grew as much as his young colleagues did. Among the early studies of FRCH in that first decade were an analytical study of the NGO institutions in health in Maharashtra, an independently researched companion volume to the HFA document, and a path-breaking study on health expenditure that for the first time estimated the huge out of pocket expenditure that had so far escaped critical scrutiny. For Antia, the crowning achievement of these different labours perhaps was the setting up of a comprehensive development model in Parinche in 2002 towards whose success he devoted his energies and resources.

Although Antia's public image in recent years is associated with his activities in public health, his singular achievements in plastic surgery can hardly be forgotten. After his graduation in medicine, Antia chose to specialize in plastic surgery, a field that was only then taking big strides in England. He trained under Sir Harold Gillies, a skilled and intrepid surgeon whose name is synonymous with major developments in plastic surgery. Antia and Gillies had a lifelong association and Antia facilitated the latter's visits to India which helped to put plastic surgery on a firm footing. Perhaps it is those early years with Gillies that prompted him into venturing out from safe harbours. He was among the earliest of surgeons to innovate and perfect skills in reconstructive surgery for rehabilitation of burns and leprosy patients. At a time when the disease was much feared, this young surgeon chose to treat those afflicted, much to the consternation of his family, his community and his friends. Some of his innovative techniques are now textbook procedures and awards and honours came from many quarters.

[1] *Reproduced from* Seminar, *August 2007*

(contd.)

Antia was a vocal advocate of a people-oriented health policy and a severe critic of what he saw as a West-influenced pro high-tech curative care-oriented health programme. He actively participated in the evolution of the National Rural Health Mission and it is indeed sad that he is gone just when the NRHM is beginning to be implemented.

Antia Saab was by no means an easy person to work with – in the early days he was irascible and many of his juniors and colleagues in plastic surgery will recount his tantrums. And although he somewhat mellowed when he began to work in health care, there were many who would not escape his sharp temper. Notwithstanding this, his outstanding legacy is in the many that he inspired to 'go where no man has gone'. NHA wasn't himself a great institution builder, but it is significant that FRCH spawned many institutions, notably MASUM, a women's cooperative in Pune, and the Centre for Enquiry into Health and Allied Themes (CEHAT) in Mumbai established by those whose formative years were spent with him. The Medico Friends Circle and the Jan Swasthya Abhiyan too have acknowledged Antia's support and encouragement.

This, in the final analysis, is the measure of the man: that he led so many into discovering in themselves the drive to pursue public spirited missions with zeal, enthusiasm and passion despite the odds.

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