

C RAMACHANDRAN MEMORIAL LECTURE 2006

RETRIEVAL OF THE APPROACH OF PHC IN PUBLIC HEALTH

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Introduction

This lecture is in the memory of C Ramachandran. He was a highly talented and bright young man. I pay my homage to his memory. The term, PHC (PHC), has long been wiped out from the radar screen of public health practice by certain powerful international and national social and political forces, to make space for promoting their agendas. This leads me to my oft-repeated quotation from the Czech author, Milan Kundera: "Man's struggle against oppression is a struggle between memory and forgetfulness". We are all beholden to Dr Gopalan and the Nutrition Foundation of India for joining the fight and use their considerable stature in retrieving the "memory" of PHC in an attempt to give a new direction to promoting health and health services in India and elsewhere.

I also fondly recall how Dr Gopalan unhesitatingly called into question the research findings (fashionably called "evidence based") claiming value of administration of vitamin A in the growth of children¹. Dr Gopalan had gone on to explore the political economy of such manipulation of research to subserve interests of the drug industry. He had been equally forthright in questioning the decision of UNICEF to import very expensive weighing machines from abroad for India's programme of growth monitoring of children. At the time of opening of the impressive building of the Nutrition Foundation of India, he had remarked that he had refused to accept any financial support from the industry, governments in India and from international agencies to ensure autonomy of NFI. The October 2006 issue of the *International Journal of Health Services* carries an article from me with a title: "Serious Crisis in the Practice of International Health by the World Health Organization: The Commission on Social Determinants of Health"².

PHC: A watershed in public health

The concept of PHC, which was approved by the World Health Assembly in 1977³ and endorsed at the International Conference on PHC at Alma Ata in 1978⁴, marks a watershed in the discipline of public health. It had virtually turned the discipline up side down, as it were; technological and administrative practices were subordinated to the needs of the people.

Halfdan Mahler, the then Director-General of WHO, had rightly labeled it as a revolution. He had also acknowledged that the earlier work done in India had substantially contributed to the development of the concept of PHC⁵.

According to the declaration of the International conference on PHC: “It is essential health care based on practical, scientifically sound and socially acceptable methods and technology universally made accessible to individuals and families in the community through their full participation and at a cost the community and the country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part of a country’s health system, of which it is the central function and main focus, and of the overall social and economic development of the country. It is the first level of contact of individuals, family and the community with the national health system, bringing health care as close as possible to where people live and work and constitutes the first of the continuing health care process.” It is a superb piece of abstraction of the many-fold characteristics of PHC; almost every, phrase, if not word, carries profound meaning, never before attained by any single document of public health.

The Alma-Ata conference on PHC had asserted that PHC was the “key to attaining” the target of health for all by the year 2000 (HFA-2000/PHC). Some of the outstanding elements of the declaration are:

- The conference strongly reaffirms that health is a fundamental human right and that the attainment of the highest level of human health is the most important social goal and whose realization requires action in many other social and economic sectors in addition to the health sector.
- The existing gross inequality in health status of the people particularly, between developed and developing countries and as well as within countries is politically, socially and economically unacceptable and is, therefore, of common concern to all countries.
- Economic and social development is of basic importance to the fullest attainment of health for all and to the reduction of the gap between developing and developed countries. The promotion and protection of the health of the people is essential for sustained social and economic development and contributes to better quality of life and to world peace.
- The people have the right and duty to participate individually and collectively in the planning and implementation of their health care.

- Governments have a responsibility for the health of their people which can only be fulfilled by the provision of adequate health and social measures. A main social target of governments, international organizations and the whole world community in the coming decades should be attainment by all the people of the world by the year 2000 of a level of health that will permit them to live a socially and economically productive life. PHC is the key to attaining this target as a part of development in the spirit of social justice.
- Choice of western medical technology should conform to the cultural, social, economic and epidemiological conditions. Particular care is to be taken to use only essential drugs in generic forms.

Ivan Illich, in his book, "Limits to Medicine"⁶, had stated (perhaps a little exaggeratedly) how even in the rich countries "medicine had become a threat to the health of the people", through what he called medicalisation of life, mystification of medicine, professionalisation of medicine, increasing incidence of medical, social and cultural autogeneses, among others. Later⁷, studying the rapid market driven technological developments, he had pointed out the powerful trends in making practice of medicine as a mere component of a much larger "system" (systematisation), which later turned into even bigger organisations in the form of "conglomerates" (conglomeratisation). More recently, noting that the doctors in the US have lost so much of their say in the market driven medical practice that John McKinlay and Lisa Marceau⁸, have pronounced the "end of the golden age of doctoring". At least theoretically, implementation of the PHC approach requires that such anomalies in the practice of medicine and public health are rolled back. Confronting the powerful political and economic powers that sustain the market is a most formidable task. However, HFA-2000-PHC can be used to contain its spread to the poor countries of the world.

PHC reflects and evolved from economic conditions and socio-cultural and political characteristics of a country and its communities. It addresses the main health problems in the community, at the first level of contact, providing promotive, preventive, curative and rehabilitative services. At this level of first contact in the community, it includes at least: education concerning prevailing health problems and the methods of preventing and controlling them; promotion of food supply and proper nutrition; and adequate supply of safe water and basic sanitation; maternal and child health care, including family planning; immunization against major infectious diseases; prevention and control of locally endemic diseases; appropriate treatment of common diseases and injuries; and provision of essential drugs⁴.

According to the same declaration, PHC must become the central function and main focus of a country's health system. The whole health system must form mutually supportive network of closely-knit institutions and workers, leading to progressive improvement of comprehensive health care for all and, through this, to health for all. As health development extends well beyond the health services and the roots of health lie largely outside the health sector, there is, in addition, a need for close cooperation among different sectors of development. Inter- sectoral cooperation, and community participation, are therefore basic characteristics of the PHC approach.

It may be emphasized that PHC is a *process*. It provides a road map for developing health service in different countries of the world. Thus, this approach can be used in any country in the world. Even the most rudimentary forms of home remedies or a village bonesetter could form the starting point of development of PHC. During the anti-colonial struggle, Mahatma Gandhi had^{9,10} (as had Mao Tse Tung during the Long March¹¹) recognised that the deprived sections of the population have very limited access to health services. In his programme of "constructive work", he had included very simple but effective methods of rural sanitation and use of naturopathy to protect and promote the health of rural people¹⁰. Extent of democratisation and self-reliance within a community determines issues such as the degree of social orientation of medical technology and the degree to which the health system provides back-up support to community efforts to cope with its health problems.

The awesome implications of implementing PHC called for a qualitatively different form of competence in public health practice and research. Naturally, WHO was required to undertake considerable capacity building within its extensive organizational network and in the member states to shoulder the responsibility for undertaking this task. WHO set up meetings of two of its expert committees, to define new approaches to health education and the type of health manpower development.

The expert committee on new approaches to health education for PHC¹² advocated radical changes in the approach. It pointed out that the conventional paternal approaches, and making decisions for others, are seldom effective. People themselves need to fully understand the problems and fully collaborate with health care providers to make an impact on the situation. Earlier, inaugurating the XI International conference on health education (1982), Halfdan Mahler had observed: "I sincerely hope this conference will write an obituary to that type of health education which was concerned with telling people how to act and that instead it will taking due consideration to social forces which bring them to act as they do " ¹³.

The task of manpower development (as it was called then) for implementing PHC in the very diverse countries of the world was even more challenging. The expert committee on health manpower requirements for achieving health for all by the year 2000 through PHC¹⁴, had spelled out the way health manpower development could be used to meet the requirements of various categories of health workers for implementation of PHC, both quantitatively and qualitatively,

However, problems soon began to emerge and the debit side started to expand. The ideas of PHC failed to trickle down even to the regional and country offices of WHO. Indeed, even at the WHO headquarters it was not possible to build a “critical mass” that could provide the leadership for promoting the philosophy of PHC within its own organizational network and in the member states, particularly the most needy ones. This was manifested in the failure of its ambitious global programme for leadership development for the cause. The initiators of the global programme themselves were not adequately equipped to provide the leadership. Understandably, the impact on the poor countries of the world was even more limited. “Health for all by 2000AD” soon degenerated into a hollow slogan of opportunistic political leaders and health workers.

Political economy of PHC

Overthrow of colonial rule and rising aspirations of the liberated people, first steps in initiation of democratic forms of government in some of the newly independent countries, initiation of the cold war and formation of the non aligned movement (NAM), have been some of the major factors which contributed to creation of conditions which tended to impel the new rulers in these countries and the newly formed international organisations to pay attention to some of the urgently needed problems facing them. International organisations such as WHO and UNICEF and many bilateral agencies came forward to contribute to improvement of health status of the people in the needy countries. Availability of the so-called silver bullets tempted these organisations to launch special “vertical” or “categorical” programmes against some of the major scourges such as malaria¹⁵ (DDT and synthetic anti-malarials), tuberculosis¹⁶ (BCG vaccination), smallpox¹⁷, leprosy¹⁸ (dapsone), oncherciosis¹⁹, trachoma²⁰ (aureomycin) and bilharzias²¹. It took them quite some time to realise that these vertical programmes were not only very expensive but they also failed to yield the expected results.

These programmes also hindered the growth of integrated health services. This impelled WHO to shift to advocating integration of health services²², then to promotion of basic health services²³, then going to individual countries to promote country health planning²⁴ and later, to actually work with the authorities in country health programming²⁵. In the mid-1970s

WHO, together with the World Bank, attempted to link health activities with poverty reduction programmes²⁶.

Reference to the term, PHC, is made in the Director-General's report to the 53rd meeting of the WHO executive board as early as in January 1975. Chastened by the disappointing experiences with the vertical programmes and the key relevance of basic health services in an integrated form, Dr. Mahler declared that "PHC services at the community level is seen as the only way in which the health services can develop rapidly and effectively". He had enunciated seven guiding principles for this purpose:

- to shape PHC "around the life pattern of the population";
- for involvement of the local population;
- for "maximum reliance on the available community resources", while remaining within cost limitations;
- for an "integrated approach to preventive, curative and promotive services for both community and for the individual";
- for all interventions to be undertaken "at the most peripheral practicable level of the health services by the worker most simply trained for this activity";
- for other echelons of services to be designed in support of the needs of the peripheral level; and,
- for PHC services to be "fully integrated with the services of the other sectors involved in community development".

A World Health Assembly resolution in 1977⁴, aiming for a programme of health for all through PHC by 2000AD, set the stage for the calling the International conference for PHC at Alma Ata in 1978.

Early moves towards the approach to PHC in India

Apparently responding to the popular movements and also to their own colonial interests, the British had already developed a rudimentary health organisation in the country, which provided services to a tiny fraction of the people. It had also to develop a skeletal structure for health human resources development and research to support the administration and its army. Only some highlights are considered sufficient to elaborate how the fledgling democratic forces exerted pressure on this rudimentary set up, to provide much wider and better services to the population of the country²⁶.

Social and political churning of the anti-colonial struggle led, among other major events, to the establishment of a Sub-committee (Sokhey Committee) on National Health of the National Planning Committee of the Indian National Congress, which, in 1938²⁷, recommended that persons chosen from villages be given some basic training to enhance the capacity of villagers to cope with their health problems themselves — “people’s health in people’s hands”. The pro-people ambience on the eve of independence and the pressure for post-war reconstruction led the British Indian Government to set up the health survey and development (Bhore) committee in 1943, as an Indian counterpart of the Beveridge committee of the UK²⁸.

The report of the Bhore committee, submitted in 1946, is to this day regarded as an authoritative document, not only because of its distinguished authorship but because many of its proposals and recommendations continue to be valid even today. It contains many “seeds of hope”. It was guided by such lofty principles as “nobody should be denied access to health services for his inability to pay” and that the focus should be on rural areas, with emphasis on preventive measures and training of what it called “social physicians”.

After independence, the “political soil” had dramatically changed because of change in the power structure in the country. Those who wielded political power belonged to a thin upper crust of the population – the elite class. It was not adequate to nurture the seeds of hope that took shape during the freedom struggle. However, during the early years, the new rulers were impelled to carry over some of the democratic processes in making decisions concerning health of the masses. Taken as a whole, these decisions gave a perspective to public health principles and practices in the country, which was markedly different from the ones preached in the conventional schools of public health in western countries or elsewhere^{29, 30}. Despite considerable difficulties and shortcomings, India could develop an endogenous, alternative body of knowledge that was more suited to the social, cultural, economic and epidemiological conditions prevailing in the country. This led to the emergence of an alternative approach to education, practice and research in public health^{29, 30}.

Following the acceptance of the report of the Bhore committee by rulers of the newly independent country, a start was made in 1952 to set up primary health centres³¹ to provide integrated promotive, preventive, curative and rehabilitative services to entire rural populations, as an integral component of a wider community development programme (CDP)³² – it sought to be an integrated health services as a component of inter- sectoral action, as was envisaged much later in the Alma Ata

declaration on PHC⁴. (A primary health centre ought to be clearly distinguished from PHC).

Departments of social and preventive medicine in medical colleges were upgraded to give social orientation to medical education^{33, 34, 35}. Apart from the then already existing highly rated institutions like the All India Institute of Hygiene and Public Health³⁶ and the Malaria Institute of India³⁷, institutes such as the National Institute of Communicable Diseases³⁸, National Institute of Health Administration and Education (NIHAE)³⁹ and the National Tuberculosis Institute (NTI)^{40, 41} were established in the 1960s, to provide support to education, training and research to the budding health service system of the country.

During 1961-64, interdisciplinary research work done at NTI received worldwide attention⁴¹. Perhaps the most remarkable feature of its work was to give primacy to people^{42,43}, and the workers at NTI actively resisted imposition of a prefabricated technological package on them (countrywide use of mass miniature radiography, for example) from the west as a way to deal with tuberculosis as a public health problem in the country⁴⁴. Imparting sociological dimensions to epidemiological issues^{45, 46}, developing people oriented technologies⁴³ and formulation and use of an operational research approach in public health^{47, 48, 49, 50} can be cited as instances of some other features which laid the foundation of India's National Tuberculosis Programme (NTP) developed at NTI⁴³. NTP was designed to sink or sail with the general health services⁴³. As hinted earlier, Halfdan Mahler⁵ had pointed out how some of the ideas generated at NTI contributed to the formulation of the concept of PHC within WHO.

By 1977, in the aftermath of the declaration of National Emergency (1955-1977), the new central government that took over from the previous one, took steps to make an effort on entrust "people's health in people's hands", as envisaged by the Sokhey committee²⁷, by training villagers selected by every 1000 of the population as community health volunteers and by training the one traditional birth attendant for a similar population⁵¹. With the rapid expansion of the health service system to cover the entire rural population of the country, at least on paper, India had developed a network of health services, which compared favourably with any country in the world with similar socio-economic situation. There was a community health worker and a trained birth attendant for every 1000 population; a sub-centre with a male and a female multipurpose health worker for 5000 people; a primary health centre for every 30,000 people; and a community health centre for 100,000 persons, with referral and supervisory and supportive echelons which went right up to the national level. As providing health services to the population was considered a responsibility of the government, these services were offered free of charge.

The ideas developed in the country were subsequently consolidated to develop a new approach to study of public health, which is specially tailored for a country such as India³¹. Development of new concepts (e.g. social orientation of medical education and practice and interrelatedness of cultural perception and meaning of health, access to services, and community health behaviour)^{52, 53, 54} in-depth analyses (e.g. political economy of health, health services, nutrition and population control and family planning)^{55, 56, 57} field surveys (e.g. health behaviour of people)⁵² operational research and systems analysis (e.g. optimising health systems)^{47, 48, 49, 50} are instance of some of the distinguishing features of the formal academic programmes of studies leading to degrees of Master of Community Health and Master of Philosophy in Health Social Sciences and subsequent doctoral work⁵⁸. Sciences basic to these programmes, such as epidemiology, social sciences and health administration provided the foundation. These “seeds” are preserved in the form of textbooks^{59, 60, 61}. They can be used by concerned persons to “remind” the rulers about the health problems of the “forgotten” masses. They can also flourish wherever or whenever the soil becomes conducive to them. By 1978, India thus came quite close to the concept of PHC that was adopted at Alma Ata – commitment of governments to health as a right; primacy to expressed health needs; community self-reliance and community involvement; inter-sectoral action in health; integration of health services; coverage of the entire population; choice of appropriate technology; services provided free of cost.

Indeed, the country incorporated most of the ideas on PHC in its National Health Policy of 1982, which called for jettisoning of what it termed as “health manpower policies and establishment of curative centres based on western models, which are inappropriate and irrelevant to the real needs of the people and the socio-economic conditions prevailing in the country”⁶².

Expectedly, there were gaping holes between the policy commitments and their implementation. However, the reasonably correct commitments made in the initial phase could have been used as a springboard for more effective implementation of PHC in India. The political economy of the failure to do so will be taken up later.

Resurrection of vertical programmes: The antitheses of PHC

There were exponential changes in the power equations between and within the countries of the world from the early 1980s⁶³. Events such as impending end of the cold war, enfeebling of the NAM and rapidly increasing influence of the Bretten Woods institutions, brought about a sea change in the national and international commitment to HFA-2000/PHC. Then, there were the far-reaching consequences of the responses of the

rich countries to the proposed declaration of self-reliance and self-determination by the poor people of the world at Alma Ata. Their response was swift and sharp. Knowingly or otherwise, they betrayed profound lack of understanding of the basic philosophy of the Alma Ata Declaration of entrusting “people’s health in people’s hands”, by contending that most of the developing countries were too poor to undertake what they called “comprehensive PHC”⁶⁴. The alternative suggested by them was called the approach of Selective PHC (SPHC), which limited the focus of action to single or a few diseases. This is the very antithesis of the concept of PHC^{64, 65, 66, 67}. The rich countries launched the SPHC in 1979 on the basis of virtually no scientific data^{65, 66}.

Under the substantially changed political equations between and within countries, the poor were left with no alternative but to give up some of the key elements of PHC in their rudimentary health services. As if to rub in the power of the syndicate of the rich countries and the ruling elite of the poor countries⁶⁸, the two sponsors of the Alma Ata conference - WHO and UNICEF - were made to tow the line laid down by it. An active effort was made to thoroughly wash out the ideas generated by the declaration to make “space” for patently unscientific, market driven agenda for health for the poor countries of the world. It was a massive assault on the intellect of public health workers all over the world; those who conformed to the laid down line were rewarded and those who dared to disagree were simply ostracised⁶⁹. Vicente Navarro, who had undergone such forms of intellectual ostracisation during the McCarthy era in the 1950s in the USA, has rightly called this as “intellectual fascism”⁶⁹. Sadly, the “above down” approach to public health was once again brought back, with people once again becoming hapless recipients of pre-fabricated, market driven, techno-centric and scientifically untenable programmes imposed by international agencies, with full support from many of the rich countries^{65, 66}.

The rich countries mobilised enormous resources of organisations such as the WHO, UNICEF and the World Bank to promote their agenda of SPHC^{70, 71, 72, 73, 74, 75}. Substituting scientific reasoning and well researched conclusions for use of brute political power, the syndicate let loose a virtual torrent of what they called “International Initiatives” on the poor countries^{71, 73, 74}. The Universal Immunization Programme, the Global Programme for AIDS, the Global Tuberculosis Control Programme, the Global Programme for Eradication of Poliomyelitis and the Leprosy “Elimination” Programme, are examples of the major initiatives taken during the last decade and a half⁷⁵.

One of the most astonishing features of taking such global initiatives is that WHO and other international organizations and scholars of international health in public health schools in western countries missed

the very obvious fact of steep differences among the countries of this world. Even if comparison is confined to the lowest fourth of the poor countries, one can easily discern very wide differences among them in terms of such critical issues as epidemiological situation, history of public health practice, political conditions, geographical conditions, racial characteristics, religious factors, and so on. It is therefore not surprising that each one of these uniformly designed programmes was also shown to be seriously faulty in the policy formulation and programme content⁷⁶. These were persistently ignored by the concerned authorities, despite being brought to their notice^{77, 78}. Not unexpectedly, despite massive investment into these programmes on a global scale, running into billions of UD dollars, they have fallen far short of the forecasts made about their achievements at the time of their launching⁷⁶. In the bargain, they inflicted further damage to the already battered general health services of the member states, particularly those of the very poor countries. This had been an awe-inspiring demonstration of power of the rich to impose their will on the poor. The power elites ensured that nobody or organization is held to account for such massive blunders.

In what has turned out to be a desperate bid to regain some credibility for itself, WHO managed to interest some of the top economists of the world to join a Commission on Macroeconomics and Health (CMH) to study macroeconomic implications of investment in health services for the poor people of the world and make its recommendations⁷⁶. Interestingly, it included the former finance minister of India and at that time the leader of the opposition in the upper house of the Parliament, Manmohan Singh and also the President of the Mitsubishi Bank. The report is being analysed at some length as it provides a documentary evidence of the poor level of the scholarship of the members of the commission and the WHO secretariat⁷⁹.

The report of the commission is historical, driven by political motivation and theoretical. It has adopted a selective approach to conform to a preconceived ideology. It has ignored the earlier work done in this field. It has pointedly ignored such major developments in the health services as the Alma Ata declaration. This attitude of developing massive blind spots in their vision has brought the quality scholastic work to almost the rock-bottom level. It is not surprising that the CMH has developed a tube vision in making recommendations on so important a subject. Their emphatic recommendation for perpetuating the second time discredited and proven very expensive vertical programmes against major communicable diseases like tuberculosis, AIDS and malaria on the grounds that vertical programmes have proved to be convenient in a number of ways to the “donors”, lets out the real motivations for undertaking such an almost openly ideology driven agenda (with the approval of Manmohan Singh and Isher Judge Ahluwalia). This is a serious danger signal for scholars of the world who would like to have a scientific attitude towards policy and

programme formulations for the poor to get the maximum returns from the limited resources – actually an issue of health economics!

The Commission on Social Determinants of Health (CSDH) is the latest effort by the WHO “to improve health and narrow health inequalities through action on social determinants”⁷⁸. After what happened to the WHO-UNICEF sponsored Alma Ata declaration, such expectations look patently untenable, if not downright hypocritical. Those involved in the formulation of the mandate for setting up the CSDH did not note that much work had already been done on this subject, does not make a sufficient attempt to analyze why earlier efforts failed to yield the desired results, and does not seem to have devised approaches to ensure that it will be more successful this time. The CSDH intends to complement the work of the earlier WHO CMH, which itself has not had the desired impact. It is unclear how the CSDH can complement work that suffers from such serious infirmities.

Inadequacies of both commissions reflect a crisis in the practice of international health at the WHO, stemming from a combination of unsatisfactory administrative practices and lack of technical competence to provide insights into the problems afflicting the most needy countries. Often the WHO has ended up distorting the already rudimentary health systems of the poor countries, by pressuring them into accepting health policies, plans, and programmes that lack sound scientific bases. The WHO no longer seems to take into account historical and political factors when it sets out to improve the health situation in low-income countries, which is supposed to be the focus of the CSDH.

Apart from having WHO betray the carefully nurtured trust of the poor of the world, during the post-Alma Ata period at the instance of the rich countries, (which are contributors of most of its budget), as will be mentioned in the case of India, the power elites also mobilized other international agencies such as the International Monetary Fund (IMF), the World Bank and the World Trade Organisation to advocate and facilitate the expansion of the private medical care sector and actively restrict the recovery of the battered public health sector⁷⁷.

The IMF demanded and got compliance for fundamental structural adjustments in the economy of dependent countries. Its impact on health and health services for the poor was devastating. It meant drastic cuts on the already pathetically inadequate public supported health budgets⁷⁵. They created space for rapid growth of the private sector in the medical care sector. There was also pressure for cost recovery for services provided by some of the publicly funded health agencies. Their pressure to globalise poor countries on grossly unequal and iniquitous terms turned

these countries into bonded labourers in the global village dominated by the kulaks formed by the rich.

Rapid deterioration of the Indian health service system

The seeds of a retreat from the promising start were sown in India as early as in 1967^{80, 81}. A virtual mass hysteria was worked up by the ruling elite and their mentors from foreign countries about the perils of imminent population explosion. Nicholas Demerath's (Sr) has given a very disturbing account of the pressure exerted by the US government and many of its other agencies and non-governmental organizations in shaping it into a coercive organization^{82, 83}. A common refrain those days were to exclaim, "the fruits of development are being eaten away by the exponential growth of population". It was obviously inconvenient for the proponents of population control to ask the simple question: who had been eating away the so-called fruits of development during the earlier two decades? As Gunnar Myrdal had pointed out, the then existing power relations did not allow sharing of the "fruits" with the poor⁸⁴. Not complying with the constitutional requirements of providing compulsory primary education for all the children between six and fourteen years by 1960, or taking steps to "protect and promote health and nutrition of the people" or enforcing land reforms, are examples⁸⁵. It was thus inevitable – it was deterministic - that the political leadership from the elite class stooped to take coercive measures on its own people to stop population growth.

To get this hatchet work done, they preferred generalist administrator's bureaucrats, who still carried the colonial tradition of serving as an instrument for imposing the will of their masters on more vulnerable sections of the people. Another "qualification" of bureaucrats is that they are a historical -- they have short memories, as they frequently hop from one ministry to another. Politicians of all hues, bureaucrats and foreign agencies formed a formidable nexus a powerful syndicate, which backed the coercive "pogrom" of population control.

The Union Ministry of Health was crudely "partitioned" into departments of health and family planning. Family planning was accorded overriding priority by the government⁸¹. People became the "targets" of their own government^{83, 84}. Most of the political parties within or outside the legislatures, intellectuals and social activists were mute spectators, if not active promoters, of this gross violation of human rights of the masses of people for three decades⁸¹. However, despite almost astronomical allocation of funds to family planning, as compared to other health programmes, the population of the country shot up from 351 millions in 1951 to over a billion in 2001 "greater the allocation, the greater is the decennial rise in population growth!" In addition, preoccupation with family planning led to gross neglect of the health services, which were so

painstakingly built over the first two decades after independence. The historical bureaucrats could not care less about these seminal achievements in their fanatic zeal to achieve the targets of catching hapless poor people for sterilization, to please their superiors. Nobody was held accountable for the colossal blunders; there were few to “remind” them as can be seen from hindsight, the blunders were simply “forgotten”⁸⁵.

In addition to the far reaching consequences of more than three decades of implementation of a target oriented, time bound programme of family planning, the health service system of India had also to take its share of the consequences of the imposition of the international initiatives in the form of the several vertical programmes. The rulers in the country actually welcomed these initiatives, which led to even further neglect of the health services.

It took the bureaucrats more than a decade and a half to realize the considerable damage done by such vertical programmes. In the bureaucrat crafted National Health Policy document of 2002⁸⁶, the government of India has belatedly recognised that these were not only *not* cost-effective and non-sustainable, but they also inflict major damage to the growth and development of the health services of the country. It now says:

“Over the last decade or so, the government has relied upon a ‘vertical’ implementation (sic) structure for the major disease control programmes. Through this, the system has been able to make a substantial dent in reducing the burden of specific diseases. However, such an organisational structure, which requires independent manpower for each disease programme, is extremely expensive and difficult to sustain. Over a long time range, ‘vertical’ structures may only be affordable for those diseases which offer a reasonable possibility of elimination or eradication in a foreseeable time frame⁸⁶.”

The document goes on to state: “It is a widespread perception that over the last decade and a half, the rural health staff has become a vertical structure exclusively for the implementation of the family welfare activities. As a result where there is no separate vertical structure, there is no identifiable service delivery system at all. The policy will address this distortion in the public health system”. What had the government been doing over the last decade and a half?

Ironically, the very decimation of the infrastructure of the health services has made it very difficult to implement the international initiatives. A very brief mention will be made below of the fates of five of such major initiatives in the country.

Universal Immunization Programme

In 1984, a task force⁸⁷ of mainly bureaucrats, which obviously did not have the public health competence needed to understand the highly technical and complicated issues involved in ensuring protection of infants against the six immunisable diseases, strongly recommended to the government of India to undertake the Universal Immunization Programme (UIP). It was perhaps their lack of understanding of the technical aspects of the UIP, which helped them to faithfully echo the wisdom of their not so informed foreign consultants; the task force solemnly declared, “immunization is the most cost-effective method known to mankind”. Now the same government declares, “vertical programmes are most expensive and not sustainable”. It did not strike them that there had been numerous flaws in the programme design handed down by the international organizations. It is pity that the bureaucrats could not anticipate that even the logistic problems of ensuring that efficacious and still viable vaccines are delivered to at least 85 % of the infants for five successive years (1985-90) were most formidable⁸⁸.

Expectedly, the coverage of the UIP fell far short of the requirements and there was large scale doctoring of data^{66, 76, 89}. Despite the long period that has elapsed since the deadline for completion of the programme (by 1990), it lingers on, relying on what the National Health Policy of 2002⁶³ had termed as “vertical implementational structure”. From the recent two field reports by Patralekha Chatterjee, for the *Lancet* group of journals, one about polio eradication programme in the Moradabad district of Uttar Pradesh and the other about the virtually “non-existent” Kajra primary health centre in Rajasthan^{89, 90}, which will be referred to below, it is not surprising that the vaccination coverage figures are so abysmally low, even if one makes the almost absurd presumption that the data sent by the health workers are reliable⁸⁹. There is no question of its having any epidemiological impact, as envisaged by the task force.

It did not occur to the task force that the six diseases included for the immunization drive constituted only a tiny fraction of the load of diseases in the country the enormous problems of child malnutrition, anemia in mothers and children and maternal mortality and morbidity. Furthermore, the inclusion of BCG among the vaccines does not carry scientific sanction. A classical experimental epidemiological study of the BCG in India, which, till then, was being used in most of the rich countries almost with religious fervour, carried out at NTI, proved conclusively that it does not provide protection at least to adults⁹¹. Till then BCG vaccination was being used in most of the western countries extensively. No evidence is available to prove its efficacy among infants and children. Besides, the incidence, prevalence of childhood tuberculosis is relatively low and it is much less life threatening than the adult variety. However, possibly as a

hangover from their earlier enchantment with BCG, its insertion in the UIP is justified because it is claimed, without any evidence, to prevent tuberculosis a good test of their adherence to what they call evidenced based medicine.

National AIDS Control Programme

The first case of AIDS was detected in India in 1986. After a somewhat wayward approach to the problem by the Indian Council of Medical Research (ICMR) and the Directorate-General of Health Services (DGHS)⁹², in 1991, the World Bank started providing massive assistance for India's AIDS control programme, apparently on condition that it is set up under a separate National AIDS Control Organization (NACO)^{92, 93} designed and guided by it. Having a bureaucrat of a rank of Additional secretary to head NACO was a part of the package. Audit of the finances of NACO in the report of the Comptroller and Auditor General (CAG) of India up to the end March 2003⁹³, provides some obviously limited information about the functioning of NACO. Within these limitations, the CAG paints a dismal picture: Rs 3836.6 million had been spent till then; it could utilize only 48 % of the aid from the World Bank during the first four years of the five-year period of the phase II; "it has achieved limited success mainly due to failure in generating awareness among the masses and the slow pace of implementation of the programme".

Perhaps the most outstanding technical flaw in the programme is that even after a decade and a half, NACO has not come forward with such basic prerequisites about a disease control programme as reasonably reliable epidemiological data on the prevalence, incidence, the course of the disease, extent of mother- child transmission, its cultural and social dimensions and a control strategy based on health systems research. The bureaucrat-headed organization, with many consultants from abroad, could only produce a scientifically very suspect surveillance system and pathetic, if not comical, figures of cumulative totals of the infections and deaths reported to it since 1986: 111,508 infectious cases and 8534 deaths⁹⁴. How do these tally with calculations made by NACO officials more than ten years ago that there were five million cases in the country? If that were so, these five millions would have all been dead by now. NACO hastens to defend such obviously outrageous figures by pleading that, "The statistics for AIDS cases may be a poor guide to the severity of the epidemic, as in many situations a patient will die without HIV having been diagnosed and with the cause of death attributed to an opportunistic infection, such as tuberculosis". If that indeed is the situation, what steps did NACO take to rectify such obviously absurd figures? It is a reflection of near paralysis of the organization. Considered in the other way, how could we directly observe huge numbers of people literally melting into death due to AIDS and the hundreds of the thousands of AIDS orphans in the

high-endemic countries of Africa, while the World Bank led, bureaucrat implemented NACP can make only wild conjectures “opportunistic infections like tuberculosis”? Could they have not at least collected data on these so-called opportunistic infections killing millions of Indians?

Rather belatedly, NACO has arranged to get HIV tests done on more than 100,000 men and women as a component of the NFHS-III, the results of which are going to come out soon⁹⁵. That might throw some light on NACO and the problem of AIDS in India. If the epidemiological pattern seen in Sub-Saharan Africa is presumed to be also replicated in India, the country would have simply been swamped by hundreds of thousands of AIDS orphans. Can NACO show that it has indeed happened? India had offered to make available free anti-retroviral drugs to one hundred thousand of AIDS more than three years back. That quota is yet to be filled. At least these should have served as wake up calls to the authorities concerned. Some indications of spread of the disease over the past 17 years show that the disease may be becoming self-limiting on its own, as was seen in the case of syphilis earlier in the last century^{92, 96, 97}.

Apparently because of its intrinsic infirmities, the World Bank-led NACO has generated very limited information regarding its function. This has made it very difficult to access them for this discussion. Apart from the very limited information available at its website and the CAG Report, we had to invoke the Right to Information Act of 2006 to obtain key data on time series of state- and sex-wise surveillance, whatever details that are available on the quality of data on infection and deaths due to HIV/AIDS and the regularity and scientific validity of the evaluation and research undertaken by it, as it was mandated to do in the middle and end of each of its three phases. An apparent reason for this tendency to secrecy is that there is so much to hide and, may be as a safety device, so little information is generated. This applied to one mid-phase evolution; another was not carried on at all; Phases II and III were launched without even the formality of carrying out the mandated end phase assessment.

Revised National Tuberculosis Control Programme

It is a profound irony that after being instrumental in causing so much of damage to the health service infrastructure, international agencies should have sought to replace the pre-existing National Tuberculosis Programme of India with uniformly structured Global Programme of Tuberculosis Control fabricated by it on a very fragile data base⁹⁸. As mentioned in the foregoing, the National Tuberculosis Programme of 1963 was designed to “sink or sail” with the general health services. A logical line of action would have been to take steps to stem the disintegration of the general health services and then rejuvenate the NTP as a part of its rejuvenation. This

did not impress the world level tuberculosis experts. The agenda of action was probably already fabricated.

The proponents of SPHC and the Global Programme on Tuberculosis had to make the sociologically astonishing hypothesis that even if people are offered services as envisaged in the NTP of 1963, they would still court death or continue to suffer due to their “non-complaint” or “defaulting” behaviour – a classical case of victim blaming^{99, 100, 101, 102, 103, 76, 44, 45}. It has now dawned on the global authorities and their Indian camp followers that, till recently, majority of the cases were diagnosed as cases of pulmonary tuberculosis on the basis of radiological examination alone^{100, 101}. It is now claimed that much as 75 % of them are now considered as not cases of tuberculosis at all – they were wrongly branded due to over-diagnosis¹⁰³.

The global programme envisaged, in effect, that the people should be “saved” from death or suffering by ensuring that they take the prescribed medicines under direct observation in health institutions – Directly Observed Treatment with Short-course chemotherapy (DOTS). Furthermore, although the global programme, called the Revised National Tuberculosis Control Programme (RNTCP) in India, was launched with the express purpose of *controlling* the disease, a recent monograph on RNTCP by the government of India¹⁰³ has failed to provide any epidemiological evidence to show that it has made any epidemiological impact even more than nine years after its launching. In fact, the Director has observed that RNTCP could climb up to be among the more effective of the global programmes because it had inherited the NTI tradition of having a reasonably sound infrastructure for tuberculosis work and facilities for team training and setting up a reasonably reliable information system on the programme performance. An approach of PHC would have considered actions against tuberculosis and other diseases as integral components of a people oriented health service, which is meant primarily to deal with it as a problem of suffering (as was the case with the NTP), with the added advantage of having an epidemiological impact, if the natural trends in the disease had not already brought down the incidence, as had happened in most of the western countries.

Global Poliomyelitis Eradication Initiative

The Global Poliomyelitis Eradication Initiative (GPEI) denotes the latest level of programme initiatives of UNICEF, WHO and World Bank^{74, 75, 76}. As a new “convert” from PHC to SPHC, UNICEF had sought to launch what it grandiosely called Child Survival and Development Revolution⁷⁴. Then it settled for a combination of programmes on Growth Monitoring, Oral Rehydration, Breast Feeding and Immunization (GOBI). Then it launched the ambitious UIP of 1985-1990. Even before the UIP could

reach the completion year, it launched the single disease programme of GPEI in 1988¹⁰⁴.

Epidemiologically, the problem of poliomyelitis forms a miniscule proportion of the disease load of the country. The reason so much of resources were poured into this programme was that the eradication of the disease would enable the rich nations to save billions of dollars when they will no longer have to give the routine poliomyelitis immunization to their children. Did this occur to the political leadership and the hordes of clinical pediatricians and the NGO hangers on when the proposal for GPEI came up in the World Health Assembly in 1987? Did the UN Secretary-General and the Director-General of WHO dare to oppose the patently irrational move, as this would distract resources and priority for other crying needs of the children of the world – in the form of malnutrition and water-borne diseases, for instance. In fact, Go Harlem Bruntland, a former DG of WHO, has been a strong exponent of the what has come to be known as Public-Private Partnership (PPP)¹⁰⁵. The Rotary International and some industrial houses in the rich countries had been the moving spirit behind the launching of the GPEI¹⁰⁶.

Proponents of the GPEI in India¹⁰⁷ face the same dilemma of weak general health services⁸⁷. Apparently because of weakness of health infrastructure in some “backward” but in thickly populated states of the country, there have been repeated failures of their strategy, thus repeatedly missing the target dates fixed for attaining eradication of the disease. Without realizing its vital limitations, the *Lancet* came up with a news report¹⁰⁸ in a patently uninformed attempt to rescue the GPEI missionaries. Deodhar had predicted the demise of the Indian programme as early as in 2003¹⁰⁹. Sathyamala and her colleagues have made an insightful critique of the way the programme has been implemented in the country¹¹⁰.

A report on a field visit in October 2006 by Patralekha Chatterjee of the *Lancet Infectious Diseases*⁹⁰ gives a vivid account of the problems involved:

“In November, Uttar Pradesh, India, will be gearing up for another sub national immunisation day - a targeted approach in selected high-risk states in the country to immunise children that were missed out during the routine, nationwide polio vaccination drives. But this year, the stakes are higher than ever.

“As of Oct 3, 2006, India recorded 352 polio virus cases up from 66 in 2005. Out of the total, Uttar Pradesh's contribution was 312, according to officials at India's National Polio Surveillance Project. Public health analysts fear that other states in India as well as other countries could be increasingly at risk from the flare-up of the poliovirus in Uttar Pradesh --

the most populous state in the country, characterised by endemic poverty, low levels of literacy, and weak health indicators.

“Official explanations attribute the sudden spurt of polio cases in Uttar Pradesh to rumours and fear among the muslim minority. However, a visit to Moradabad, one of the worst affected districts in Uttar Pradesh, provides valuable insights into the reality of traditionally disadvantaged communities that have little contact with the health-care system. Grievances accumulated over years, now being exploited by rumour-mongers, are proving to be formidable hurdles in the global battle against polio”⁹⁰.

More recent data of the polio-spreading “season” (up to November 11.2006), the total has shot up to 522, with UP adding during the week an additional 23, Bihar coming with a disturbing 40 and the relatively affluent and resourceful national capital taking a step backward with 6. There are still eight more weeks to go in the year. As an epithet on GPEI, a pediatrician, Yash Paul¹¹¹, has now come to the lamentable conclusion that India’s Polio Eradication Programme has been a failure. “Polio eradication in the near future is not possible; we will have to acknowledge that fact”, he opines.

Leprosy Elimination Programme

The World Bank and WHO had been assisting India for quite sometime in eradicating leprosy from the country by the year 2000. Later, the goal posts were shifted and the term, “eradication” was replaced by the epidemiologically confusing term, “elimination”. Even the task of “elimination” will still take some more years. While delving so extensively about the stigma against the disease among the people, it is not adequately realized that the leprosy programme in India suffers from additional stigmata – stigma against those working in the field of leprosy and stigma against leprosy units in health directorates¹¹². Long ago, Gandhi declined a request to open a new leprosy hospital, saying he would be glad to perform the closing ceremony, when it will not get patients to fill its beds¹¹².

Mention of functioning the five of the international initiatives presents a vivid account of how pre-occupation with their implementation has led to the steep decline of the health service system of the country from the hay days of 1977, when the country took the first tentative steps to entrust “people’s health in people’s hands”⁵⁰.

Implementation of internationally promoted economic reforms and access of the people to health services

In addition to the imposition of the international initiatives, the IMF had imposed conditionality in return for extending loans to bail out the

government of India from the financial morass of the early 1990s. Their Structural Adjustment Programme (SAP) enabled the IMF entry into most vital elements of the governance of the country in the form of influencing budgetary allocations. Indeed, the present Deputy-Chairman of the planning commission catapulted to his key position straight from the IMF. By virtue of his nominated position he attends meetings of the union Cabinet. Dutifully submitting to their dictates, the then union finance minister Manmohan Singh inflicted a 20 per cent cut in the health budget of 1992-93, excluding the rise due to inflation. The impact on the state health budgets was even more devastating. The decimation of the state funded health service system enormously expanded the space for private initiative. Indeed, the state extended assistance to the private sector in the form of various types of duty exemptions, land subsidies and incentives. The governments were also made to undertake a most unimaginative regime of “cost recovery” from the pitiably meagre allocations made for the government funded health services^{84, 85, 86}. The breakdown of the public health system rapidly expanded the “market” for the private sector.

The government’s moves towards globalization further extenuated this trend of commodification of medical services. There has been a mushrooming growth of numerous unregulated profiteering private hospitals, nursing homes, diagnostic centres and other ancillaries of the medical industry. With unabashed political support, unregulated institutions for education of physicians and other health personnel such as dentists, nurses, homeopaths and *vaids* rapidly expanded in the private sector, as they became a lucrative field for making profits.

The present state of Indian health services

The political leaderships, both at the central and state levels have chosen personnel from the Indian Administrative Service (IAS) cadre of generalist administrators and the clinician dominated cadres of the central and state health services to run health service systems of the country. As pointed out earlier, these officials’ inadequate or distorted understanding of some of the basic principles of public health practice, such as developing an epidemiological approach in solving a community health problem, choice of appropriate technology and optimization of health service systems, has had very deleterious effect on the health service system. They also have become vulnerable to manipulation by personnel from international agencies, WHO also have questionable public health credentials, to create space for imposition of their agenda. To get such obviously faulty agendas adopted, the officials have to be historical, obedience to their political masters and theoretical and willing to indulge in misinformation, disinformation and suppression and manipulation of information¹¹³.

It is not difficult to get an idea of the very poor state of the public health services from the foregoing analyses of different phases and facets of the health services development in the country. It is considered sufficient to refer only to a few major findings here.

An Independent Commission on Health in India (ICHI)¹¹⁴, set up by the Voluntary Health Association of India, which submitted its report to Prime Minister Vajpayee in 1997, had pointed out that the health services “are in an advanced stage of decay”, with decay of key public health institutions, frequent outbreaks of virtual “epidemic of epidemics” and neglect of the “forgotten people” those who live “on the other side of the moon”. There was the usual promise of a politician, but no significant action followed.

Documents from the planning commission also paint an equally gloomy picture^{115, 116}. A study of a national sample of community health centres by the programme evaluation organisation of the planning commission¹¹⁷ has revealed that virtually none of them was working at its optimal level. The 1992 and 1998 rounds of the Family Health Survey (FHS) revealed that India is among the countries having the highest rates of maternal mortality^{118, 119}. Results of the 2006 round of FHS are just started coming in⁹⁵; some preliminary data from a group of five states show encouraging improvements in some health parameters. A survey conducted by the National Council of Applied Economic Research revealed that, among the poor, expenditure incurred to meet the medical needs is the second most important cause of rural indebtedness¹²⁰.

Data from the Union Ministry of Health and Family Welfare paint an equally grim picture¹²⁰: the percentage of the gross domestic product (GDP) in public sector investment has fallen from 1.3 in 1990 to a dismal 0.9 in 2005, giving India the unenviable distinction of being among the bottom five countries of the world in this respect; for every rupee spent on the poorest fifth of the population from the public sector, three rupees are spent on the richest fifth; hospitalized Indians spend, on an average, 58% of their total annual expenditure; over 40% of hospitalized Indians borrow heavily or sell assets to meet to cover expenses; 25% of hospitalized Indians fall below the poverty line because of hospital expenses. A coalition of parties came together to form the government at the centre on the basis of a Common Minimum Programme, which vowed to increase the % age of public sector expenditure to “2-3%” of the GDP during its tenure. They adopted what it called a mission approach to deal with the problem.

Yet another questionable promise to improve rural health in India

When coalition politics compelled the present government of India to vow to increase the public sector expenditure in health from the meager 0.9%

to the still modest 2-3% of the GDP in its 5-year term, it exposed the profound public health incompetence of the bureaucrats to come up with a plan of action. They had no clue as to how to proceed to fulfil the political commitment. As those who had been mounting criticisms over the government policies since the 1960s, and offered alternatives, were ruled out, they had to seek out commercial agencies like McKinsey, Fergusson and Chatterjee. This is rank trivialisation of the science of public health. These point to a new low in public health practice in India. The catchy slogan of National Rural Health Mission (NRHM) emerged out of the consultations and the Prime Minister Manmohan Singh, who, in his earlier incarnation as the finance minister, had made a brutal, cut in the health budget in 1992, himself launched the NRHM. As detailed account and analysis of the NRHM are available elsewhere¹²², they would be mentioned only very briefly here.

In the formation of the NRHM^{121, 122} we hear echoes of what Rudolf Virchow¹²³ had said in that fateful year of 1848 that health is politics and politics is health, and people do not matter. Despite making numerous solemn promises to improve the situation since India gained Independence, as pointed out in the foregoing account, the state of the rural health services to this day is extremely unsatisfactory. This is rooted in the politics of health and health services of the past. However, to garner rural votes during the 2004 elections, some political parties expressed “deep concern” over these shortcomings and made yet one more promise to rectify the conditions. The obviously limited political commitment to improving rural health services has confined the NRHM mostly to some superficial issues that have come in the way of development of the rural health services. There are, however, some commendable features of the action plan which may be taken note of at the outset: abolition of a separate department of family welfare to form a composite Ministry of Health; decentralization of the organization and function of the health services; integration of the vertical programmes with the general health services. However, little progress has been made thus far on these commitments, except for formation of a composite Ministry of Health, with a bureaucrat at the head.

As has happened so often in the past, NRHM is based on questionable premises¹²¹. It adopts a simplistic approach to a highly complex problem. The Union Ministry of Health And Family Welfare and its advisors from business fields, either because of ignorance or otherwise, have doggedly refused to learn from the many experiences of the past, both in terms of the efforts to earlier somewhat sincere efforts to develop endogenous mechanisms to offer access to health services to all the people, free of cost, as well as from the devastating impact on the painstakingly built rural health services of the imposition of prefabricated, ill-conceived, ill-formulated, techno-centric vertical programmes on the people of India.

They also ignored some of the basic postulates of public health practice in a country like India. That they did not feel it necessary to provide the “evidence base” to substantiate some of their substantive contentions with scientific data obtained from health systems research, reveals that they are not serious about their promise to rural population. The mission has set for itself ambitious targets of health impact: for example, reduction of the infant mortality rate (IMR) to half that is to 30; maternal mortality rate to be reduced from around 475 to 100 (per 100,000 live births) and reduction of malaria mortality rate by 50% in 2010¹²². From the track record of performance of the mission since the Prime Minister inaugurated it in March 2005, the targets set are patently Utopian, meant more as a political propaganda and gimmick.

A recent report on a field visit (in October 2006) by Chitraloka Chatterjee of the *Lancet* presents a graphic account of the state of affairs mid-way through the term of the present government⁹⁰: “But for the vast majority of people living in rural India, these impressive statistics are little comfort because in the functioning public health-care system they remain elusive. At 5 pm on a weekday afternoon, the primary health centre at Kajra village, Rajasthan, in northwestern India offers a sorry but all too familiar sight. There is no one inside the centre except a nurse and a security guard. The outpatient department does not have electricity or water supply. The skeleton staff manages with a bucket of water. The centre is short of medicines. There are five cots in the outpatient department but no patients. The accommodation provided to the medical officer could pass for wreckage in a bombed city. The doctor is on leave. ‘In the last 6 months, only one delivery has taken place in the health centre. Why should anyone come here? We have no facilities’ says nurse Rajbala. The depressing scenario at Kajra is replicated across the country, underscoring the enormity of the task ahead of India’s NRHM”. Hopefully, yet another betrayal of the long suffering rural population will generate greater political power among the ‘*aam admi*’ (common man) to instill greater urgency and sincerity within the intrinsically reluctant political leadership.

The Public Health Foundation Of India (PHFI)

A registered body – the PHFI – plans to tackle the formidable problems relating to public health education, research and standardisation, when it takes its final form. It is simply a mind-boggling venture. The charter of PHFI reads¹²⁴:

- establish new institutes of public health.
- assist the existing institutes to enhance their capacity and their output.

- promote research in prioritized areas of public health, to inform policies and empower programmes.
- facilitate policy development, programme evaluation & advocacy on public health related issues.
- enable development of standards & adoption of a credible accreditation system for public health courses.

It is most astonishing that the foundation was inaugurated by the Prime Minister of India in the presence of speakers and audience carefully chosen by the organizers of the Foundation. This amounts to a public admission by the government of India that it was unable to cope with the problem, notwithstanding all the commitments made in the Common Minimum Programme of the ruling alliance to pull the country up from the unenviable position of being among the lowest five countries of the world in terms of the percentage of GDP expenditure on health services. It was as if the Prime Minister throws up his hands in despair, and entreats the private sector to join it in a private public partnership to overcome a critical problem in the health service system of the country.

Even if the strong protestations by the authorities about their being fully transparent in reporting on decisions concerning its growth and development of PHFI is taken at its face value, very much more information and clarity about the foundation will be required to comprehend how it is going to work on the lines laid down in its charter. Conflicting and confusing reports appearing in top English newspapers will be ignored. Only reports of the address delivered at the inauguration ceremony by the Prime Minister on March 28 2006 and dialogues in academic journals will be taken into account to discuss the genesis of setting up the foundation and its ambitious agenda of work.

Rajat Gupta of McKinsey and Purnendu Chatterjee of the Chatterjee Consultants have been the moving spirits behind the idea of the PHFI. They got this from some top public health academics from the Schools of Public Health at Harvard and Johns Hopkins and many office bearers and individual members of the Association of American Schools of Public Health. As pointed out by Mohan Rao and K R Nayar¹²⁵, Gupta and Chatterjee did not realize that the USA does not offer a particularly attractive model of institutions of public health practice, research and training. The record of the institutions in Europe and elsewhere is only marginally less inappropriate^{30, 126}.

Apart from the dismal outcome of the very expensive Khanna Study¹²⁷ referred to by Rao and Nayar, there has been an earlier failed Harvard study, called Communication Action Research Study on Environmental

Sanitation at Najafgarh in 1957¹²⁸ and the still more extensive and long term study of rural health and medical education at Narangwal by Carl Taylor and his group from Johns Hopkins, with its final report coming in 1978¹²⁹. As mentioned earlier in his book, *Birth Control and the Foreign Policy: The Alternative to Family Planning*, Nicholas Demerath Sr, had laid bare an extensive network of cloak and dagger activities of major US government agencies and NGOs then involved in influencing India's Family Planning Programme⁸¹. In the true McCarthy style of intellectual fascism, Harper and Row had to hastily withdraw the unsold copies from the market.

Very few still remember, least of all the Prime Ministers and Health Ministers of India that under President Truman's Point Four Programme, a large number of public health personnel in medical colleges and health administration from India were taken to the US for education in its schools of public health. This made little impact on public health practice in India. This has an uncanny resemblance with one of the key first steps that had already been taken by the PHFI sponsoring selected students from India to get educated in public health in schools in US. What are the academic credentials of the self-styled India specialists in the US? It has to be brought home to the globalisation and GDP driven political leadership in India that they should act to find Indian solutions to Indian public health problems, as has so often been done in the past.

Typically, the PHFI found a square peg for a round hole in choosing an erstwhile head of the department of cardiology at the prestigious AIIMS, who obtained a Master's degree in Public Health from Canada, K S Reddy, to head the army of "knights in shining armour" to find a solution for the predicament of the Prime Minister and his team. This included, apart from opening four or five brand new institutes of public health, for which the sites are yet to be finalized, intention to resuscitate the long comatose All India Institute of Hygiene and Public Health, National Institute of Health and Family Welfare, 150-odd almost invisible departments of social and preventive medicine in medical colleges and the paralytic public health research agendas of the ICMR and the National Institute of Communicable Diseases. It is clearly a doomed venture; a quixotic venture.

Public health scholars like C Sathyamala¹³⁰ have sent a message to the Prime Minister that despite what amounts to a long neglect and at times their systemic "McCarthy" ostracisation, there are still public health scholars in the country who could be instrumental in rejuvenation of the moribund public health system. Sathyamala was prompt in calling into question the political and scientific premises of PHFI. She has rightly pointed out: "PHFI and its institutions albeit located in India with blessings of the Indian government will in effect function as an extension of

American interests. It is to be governed by technocrats/bureaucrats and nominated NGOs and will be subjected to little or no accountability/scrutiny by the Indian polity". In an earlier contribution, taking strong exception to the way the leadership has given in to the power brokers, Imrana Qadeer, professor at the Centre of Social Medicine and Community Health of Jawaharlal Nehru University¹³¹, has wryly observed "PHFI seems to be important to both American and Indian governments, one needing the markets and the other needing more resources to increase the middle-class consumption patterns".

In responding to the criticisms, Reddy has exposed his public health professional limitations in confronting the formidable challenge undertaken by the foundation^{132, 133, 134}. The Prime Minister and the PHFI have been deafeningly silent over the critical question of competence and suitability of the bureaucrats and high officials from the central health service and other state cadres who occupy key public health positions throughout the country. It is intriguing that Reddy calls for creation of more public health posts in the government health system. If one goes by the definition of public health by pioneers like WEA Winslow (1920)¹³⁵, John Grant¹³⁶, Hugh Leavell¹³⁷ and Edward McGovern¹³⁸ (all Americans!), personnel of the entire health system of the country -- from the Director General of Health Services down to the Auxiliary Nurse Midwife, including those in hospital administration and medical care, are public health workers. It did not strike Reddy that public health posts at higher levels at the Centre have been filled by unsuitable bureaucrats from the IAS and clinicians from the CHS.

Had Reddy made a deeper study of the process of setting up a nationwide network by pioneer officers of the erstwhile Indian Medical Service (IMS)³¹, he would have discovered that each state had an "orientation training centre" like the once famous ones at Singur, Ramanagaram, Poonamallee and Najafgarh, where the entire team of primary health centres were given in-service training, before their postings^{32, 31}. Indeed, there was a tradition in the IMS that prior to succeeding as the as the Director General of the IMS, the officer spends two years a Director of the All India Institute of Hygiene and Public Health¹⁴⁰. The National Institute of Health Administration and Education (NIHAE) tried to revive that tradition through a resolution at the Central Health Council to encourage officers at the centre and in the states to attend a specially designed three-month Staff College Course³⁹, before they are allowed to take up key positions in health administration. What a far cry it is from the ministry hopping bureaucrats of IAS and hospital bound clinicians of the CHS.

Incidentally, one of the many critical shortcomings of the NRHM is that it has totally ignored the vital question of the human resources needed for fulfilling the mission objectives. The PHFI documents too do not mention it has any link with meeting the public health professional needs of the

NRHM; in any case, the gestation period of the PHFI is too long, even assuming that there will be no abortions or stillbirths.

The long and difficult path of return to PHC

Thirty-five years after rule by the same party, the government of India had to confess in its National Health Policy of 1982⁶² that the then existing unsatisfactory situation “had been engendered by wholesale adoption of health manpower development policies and establishment of curative centres based on western models, which are inappropriate and irrelevant to the real needs of the people and the socio-economic conditions prevailing in the country”. It goes on to observe that it provides benefits to the upper crusts residing in urban areas. It stated: “proliferation of such an approach has been at the cost of providing comprehensive PHC services to the entire population. Instead of building self-reliance, it has tended to enhance dependence and weakened the community’s capacity to cope with its problems. It has resulted in the development of cultural gap between the people and the personnel providing care”. The ultimate goal of achieving health status of all the people, it went on to say, can not be secured without involving the community in the identification of their health needs as well as in the implementation and management of the various health and related programmes⁸⁶.

At that time, such far-reaching policy commitments on the part of the government, however belated, sounded encouraging. But the lapse thirty-five years to make such an analysis and sweeping recommendations left lingering doubts whether these were mere empty rhetoric to buy more time from the long suffering people. Unfortunately, the fear came true. Twenty years later, in 2002⁸⁶, the government of India came up with yet another health policy document. It made yet another confession that the “1982 policy was too ambitious”. This is of considerable social and political significance. So, the poor people will have to carry on with the same health service structure, which the government had itself condemned in such strong terms – almost wholesale adoption of health manpower policies and curative institutions that are irrelevant and inappropriate to the real needs of our people. Of equal significance is that the same political party once again dared to play the same game of shedding copious tears for the “*aam admī*”, swearing its abiding commitment to their cause and drawing up the Common Minimum Programme and in presenting its NRHM. Such rank deception of the people seems to be built into the character of the small elite class that has been ruling the country since Independence.

One can draw some consolation from the fact that democratic forces in the country had compelled the rulers to make confessions, however insincere, about their lapses and make at least some amends – merging the family planning and health departments; promising once again to integrate the

vertical programmes with the general health services; and, decentralising the health services. The ruling class will not give in so easily: the deprived have to wrest their rights from the rulers. That will be a long, grinding struggle.

The dispossessed will have to generate much more powerful political movements to throw up much more dedicated political leaderships. Concern for the problems of the hitherto deprived people ought to haunt the leadership at the highest levels the Prime Minister, the cabinet and the Parliament. Unfortunately, the leadership provided by the long chain of health ministers since Independence has been far from reassuring. They are eminently forgettable. Ironically, the fact that Shri Raj Narain stands out among them for his daring to launch the Community Health Workers Scheme⁵¹, shows the level of political leadership in health in independent India. Till a much more powerful leadership is thrown up by the people, one has to contend with marginal changes in the process which has led not only to the persistent fall in the GDP percentage of public investment in health, but also to have one rupee of the pathetically inadequate public money for the poorest fifth for every three rupees for the richest fifth. For using health action as a lever for giving momentum to the social and political movement for greater democratisation and for defining the task of the political leadership to bring back the spirit of PHC, some of the key steps that ought to be taken are:

- Rejuvenation of the existing institutions for research, education and training of public health workers and building new ones and producing an elite corps of managerial physicians, who possess high levels of epidemiological, managerial, political and social competence to deal with public health problems^{140, 141}.
- Removing the square pegs in round holes and inserting the round ones in their places. This will require rolling back of the bureaucrats of the IAS and clinicians of the CHS from positions for which they have no competence.
- Formulation of a totally different cadre structure to attract highly competent public health personnel in the services. The cadre ought to allow selected, highly competent managerial physicians to attain the same status as their counterparts in the IAS, as was the case when the country had the Indian Medical Service as a counterpart of the Indian Civil Service. Political leadership must realise that historical, uninformed, ministry hopping IAS officers are incapable providing leadership for meeting crying health services needs of the poor.
- Implementing the already taken decision to integrate the discredited vertical programmes with the general health services.

- Inability to pay should not come in the way of the people to have access to health services.
- Promoting interdisciplinary health systems research to formulate optimised health systems.
- Ensuring foreign funding agencies are not allowed to impose their agendas on the country. “Doors and windows of our rooms ought to be kept wide open for fresh winds to come in, but it should not sweep us off our feet”. Work at NTI and the Tuberculosis Chemotherapy Centre at Madras^{43, 141} provides examples of such collaborative work.
- Considering increase in allocations for investment in proven cost-effective programmes.

The Alma Ata declaration on PHC provides the pathway for health action. It reaffirms that health is a fundamental human right and that the attainment of the highest level of human health is the most important social goal and whose realization requires action in many other social and economic sectors, in addition to the health sector. It also asserts that governments, and not private public partnerships of the PHFI model, have a responsibility for the health of their people, which can only be fulfilled by the provision of adequate health and social measures. PHC is the key to attaining this target as a part of development in the spirit of social justice. As has been stressed earlier, PHC is a *process*; it cannot be realized overnight.

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C RAMACHANDRAN MEMORIAL LECTURE

RETRIEVAL OF THE APPROACH OF PRIMARY HEALTH CARE IN PUBLIC HEALTH

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Primary health care : a watershed in Public health

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

ALMA-ATA DECLARATION

- Health is a fundamental human right and attainment of the highest level of human health is the most important social goal;
- Existing gross inequality in health status of the people is politically, socially and economically unacceptable;
- Economic and social development is of basic importance to the fullest attainment of health for all. The promotion and protection of the health of the people is essential for sustained social and economic development;
- People have right and duty to participate individually and collectively in planning and implementation health care;
- Governments have responsibility for attaining health, of their people by 2000, of a level that will permit them to live a socially and economically productive life. Primary health care is the key to attaining this target;
- Only essential drugs in generic forms are to be used.

WHAT IS PRIMARY HEALTH CARE

Primary health care reflects and is evolved from economic conditions and socio-cultural and political characteristics of a country. It addresses the main health problems in the community, at the first level of contact, providing promotive, preventive, curative and rehabilitative services.

COMPONENTS OF PRIMARY HEALTH CARE

IT INCLUDES

- HEALTH EDUCATION FOR DISEASE PREVENTION AND CONTROL
- PROMOTION OF FOOD SUPPLY AND PROPER NUTRITION; AND ADEQUATE SUPPLY OF SAFE WATER AND BASIC SANITATION
- MATERNAL AND CHILD HEALTH CARE, INCLUDING FAMILY PLANNING; IMMUNIZATION
- PREVENTION AND CONTROL OF LOCALLY ENDEMIC DISEASES
- TREATMENT OF COMMON DISEASES AND INJURIES
- PROVISION OF ESSENTIAL DRUGS

PROBLEMS IN IMPLEMENTING PRIMARY HEALTH CARE

- **IDEAS OF PHC FAILED TO TRICKLE DOWN EVEN TO THE REGIONAL AND COUNTRY WHO OFFICES**
- **ITS AMBITIOUS GLOBAL PROGRAMME FOR LEADERSHIP DEVELOPMENT FAILED TO DEVELOP**
- **IMPACT ON THE POOR COUNTRIES OF THE WORLD WAS LIMITED**
- **“HEALTH FOR ALL BY 2000AD” - BECAME A HOLLOW SLOGAN OF OPPORTUNISTIC POLITICAL LEADERS**

EMERGENCE OF VERTICAL PROGRAMMES

INTERNATIONAL ORGANISATIONS LAUNCHED SPECIAL “VERTICAL” PROGRAMMES AGAINST

- MALARIA (DDT AND SYNTHETIC ANTI-MALARIALS),
- TUBERCULOSIS (BCG VACCINATION),
- SMALLPOX,
- LEPROSY (DAPSONE),
- FILARIAE (DIETHYL CARBAMAZOLE),
- TRACHOMA (AUREOMYCIN) AND
- BILHARZIASIS.

BUT THESE PROGRAMMES WERE

- VERY EXPENSIVE;
- FAILED TO YIELD THE EXPECTED RESULTS;
- HINDERED GROWTH OF INTEGRATED HEALTH SERVICES

SHIFT IN WHO STAND

WHO SHIFTED ITS STRATEGY TO

- TO ADVOCATING INTEGRATION OF HEALTH SERVICES
- PROMOTION OF BASIC HEALTH SERVICES
- PROMOTING COUNTRY HEALTH PLANNING
- WORK WITH THE AUTHORITIES IN COUNTRY HEALTH PROGRAMMING
- TO LINK HEALTH ACTIVITIES WITH POVERTY REDUCTION PROGRAMMES

WHO DECLARED “PRIMARY HEALTH CARE SERVICES IS THE ONLY WAY IN WHICH THE HEALTH SERVICES CAN DEVELOP RAPIDLY AND EFFECTIVELY.”

PRIMARY HEALTH CARE IN INDEPENDENT INDIA

- IN 1952, PRIMARY HEALTH CENTRES WERE SETUP TO
- PROVIDE “INTEGRATED PROMOTIVE, PREVENTIVE, CURATIVE AND REHABILITATIVE SERVICES’ TO THE ENTIRE RURAL POPULATION, AS AN INTEGRAL COMPONENT OF A WIDER COMMUNITY DEVELOPMENT PROGRAMME.
- DEPARTMENTS OF SOCIAL AND PREVENTIVE MEDICINE IN MEDICAL COLLEGES WERE UPGRADED TO GIVE SOCIAL ORIENTATION TO MEDICAL EDUCATION.
- SEVERAL NEW INSTITUTIONS WERE ESTABLISHED TO SUPPORT EDUCATION, TRAINING AND RESEARCH TO THE BUDDING HEALTH SERVICE SYSTEM OF THE COUNTRY.

NATIONAL TUBERCULOSIS INSTITUTE AND PRIMARY HEALTH CARE

- **INTERDISCIPLINARY RESEARCH WORK DONE AT NTI - GAVE PRIMACY TO PEOPLE - WORKERS AT NTI ACTIVELY RESISTED IMPOSITION OF A PREFABRICATED TECHNOLOGICAL PACKAGE**
- **NTP FEATURES - IMPARTING SOCIOLOGICAL DIMENSIONS TO EPIDEMIOLOGICAL ISSUES, DEVELOPING PEOPLE ORIENTED TECHNOLOGIES, FORMULATION AND USE OF AN OPERATIONAL RESEARCH APPROACH IN PUBLIC HEALTH**
- **NTP WAS DESIGNED TO SINK OR SAIL WITH THE GENERAL HEALTH SERVICES**
- **IDEAS GENERATED AT NTI CONTRIBUTED TO THE FORMULATION OF THE CONCEPT OF PRIMARY HEALTH CARE WITHIN WHO**

INDIA IN 1977

INDIA CAME QUITE CLOSE TO THE CONCEPT OF PHC ADOPTED AT ALMA ATA –

- **COMMITMENT OF GOVERNMENTS TO HEALTH AS A RIGHT; PRIMACY TO EXPRESSED HEALTH NEEDS;**
- **COMMUNITY SELF-RELIANCE AND COMMUNITY INVOLVEMENT;**
- **INTER-SECTORAL ACTION IN HEALTH;**
- **INTEGRATION OF HEALTH SERVICES;**
- **COVERAGE OF THE ENTIRE POPULATION;**
- **CHOICE OF APPROPRIATE TECHNOLOGY;**
- **SERVICES PROVIDED FREE OF COST .**

RESURRECTION OF VERTICAL PROGRAMMES

- DEVELOPED COUNTRIES FELT THAT MOST OF THE DEVELOPING COUNTRIES WERE TOO POOR TO UNDERTAKE “COMPREHENSIVE PRIMARY HEALTH CARE”. THE ALTERNATIVE SUGGESTED BY THEM WAS CALLED THE APPROACH OF SELECTIVE PRIMARY HEALTH CARE (SPHC), WHICH LIMITED THE FOCUS OF ACTION TO SINGLE OR A FEW DISEASES.
- “ABOVE DOWN” APPROACH TO PUBLIC HEALTH WAS ONCE AGAIN BROUGHT BACK, WITH PEOPLE ONCE AGAIN BECOMING HAPLESS RECIPIENTS OF PRE-FABRICATED, MARKET DRIVEN, TECHNO-CENTRIC AND SCIENTIFICALLY UNTENABLE PROGRAMMES IMPOSED BY INTERNATIONAL AGENCIES

EXAMPLES :

UNIVERSAL IMMUNIZATION PROGRAMME,
GLOBAL PROGRAMME FOR AIDS,
GLOBAL TUBERCULOSIS CONTROL PROGRAMME,
GLOBAL PROGRAMME FOR ERADICATION OF POLIOMYELITIS,
LEPROSY “ELIMINATION” PROGRAMME

PROBLEMS WITH VERTICAL PROGRAM

DESPITE MASSIVE INVESTMENT INTO THESE PROGRAMMES ON A GLOBAL SCALE, THEY HAVE FALLEN FAR SHORT OF THE FORECASTS MADE ABOUT THEIR ACHIEVEMENTS.

THEY INFLICTED FURTHER DAMAGE TO THE ALREADY BATTERED GENERAL HEALTH SERVICES.

MACROECONOMIC COMMISSION AND HEALTH

**PERPETUATING THE SECOND TIME DISCREDITED AND
PROVEN VERY EXPENSIVE VERTICAL PROGRAMMES
AGAINST MAJOR COMMUNICABLE DISEASES LIKE
TUBERCULOSIS, AIDS AND MALARIA**

COMMISSION ON SOCIAL DETERMINANTS OF HEALTH

**THE LATEST EFFORT BY WHO “TO IMPROVE HEALTH AND
NARROW HEALTH INEQUALITIES THROUGH ACTION
ON SOCIAL DETERMINANTS”**

RAPID DETERIORATION OF THE INDIAN HEALTH SERVICE SYSTEM

IN LATE SIXTIES CONCERN WAS EXPRESSED ABOUT PERILS OF POPULATION EXPLOSION AND THE NEED FOR POPULATION CONTROL MEASURES TO ENSURE THAT THE FRUITS OF DEVELOPMENT ARE NOT EATEN AWAY BY EXPONENTIAL GROWTH OF POPULATION

NO ATTEMPT WAS MADE TO COMPLY WITH CONSTITUTIONAL REQUIREMENTS TO PROTECT & PROMOTE HEALTH & NUTRITION OF THE PEOPLE

UNION MINISTRY OF HEALTH WAS CRUDELY "PARTITIONED" INTO DEPARTMENTS OF HEALTH AND FAMILY PLANNING PEOPLE BECAME THE "TARGETS" OF THEIR OWN GOVERNMENT

DESPITE ALMOST ASTRONOMICAL ALLOCATION OF FUNDS TO FAMILY PLANNING, AS COMPARED TO OTHER HEALTH PROGRAMMES, THE POPULATION OF THE COUNTRY SHOT UP FROM 351 MILLIONS IN 1951 TO OVER A BILLION IN 2001 - "GREATER THE ALLOCATION, THE GREATER IS THE DECENNIAL RISE IN POPULATION GROWTH!"

ADVERSE CONSEQUENCES OF VERTICAL PROGRAMMES

**IT TOOK OVER FIFTEEN YEARS FOR THE
BEAUROCRATS TO RECOGNISE THE DAMAGE
DONE BY VERTICAL DISEASE CONTROL
PROGRAMMES**

**THEY HAVE INDICATED IN THE NATIONAL
HEALTH POLICY 2002 THAT VERTICAL
PROGREMMES ARE NOT COST EFFECTIVE ,
NOT SUSTAINALBE AND HAVE INFLICTED
MAJOR DAMAMGEON THE GROWHT AND
DEVELOPMENT OF HEALTH SERVICES**

NATIONAL HEALTH POLICY DOCUMENT (2002)

- **‘VERTICAL PROGRAMMES FOR MAJOR DISEASE CONTROL HAVE BEEN ABLE TO MAKE A SUBSTANTIAL DENT IN REDUCING THE BURDEN OF SPECIFIC DISEASES.**
- **OVER A LONG TIME RANGE, ‘VERTICAL’ STRUCTURES MAY ONLY BE AFFORDABLE FOR THOSE DISEASES WHICH OFFER A REASONABLE POSSIBILITY OF ELIMINATION OR ERADICATION IN A FORESEEABLE TIME FRAME.”**

“IT IS A WIDESPREAD PERCEPTION THAT OVER THE LAST DECADE AND A HALF, THE RURAL HEALTH STAFF HAS BECOME A VERTICAL STRUCTURE EXCLUSIVELY FOR THE IMPLEMENTATION OF THE FAMILY WELFARE ACTIVITIES. AS A RESULT WHERE THERE IS NO SEPARATE VERTICAL STRUCTURE, THERE IS NO IDENTIFIABLE SERVICE DELIVERY SYSTEM AT ALL. THE POLICY WILL ADDRESS THIS DISTORTION IN THE PUBLIC HEALTH SYSTEM”.

UNIVERSAL IMMUNIZATION PROGRAMME

- THE TASK FORCE CLAIMED “IMMUNIZATION IS THE MOST COST-EFFECTIVE METHOD KNOWN TO MANKIND”.
- COVERAGE OF THE UIP FELL FAR SHORT OF THE REQUIREMENTS
- VACCINATION COVERAGE FIGURES ARE SO ABYSMALLY LOW
- THERE IS NO QUESTION OF ITS HAVING ANY EPIDEMIOLOGICAL IMPACT
- SIX DISEASES INCLUDED FOR THE IMMUNIZATION DRIVE CONSTITUTED ONLY A TINY FRACTION OF THE LOAD OF DISEASES IN THE COUNTRY
- INCLUSION OF BCG AMONG THE VACCINES DOES NOT CARRY SCIENTIFIC SANCTION. A CLASSICAL EXPERIMENTAL EPIDEMIOLOGICAL STUDY OF THE BCG IN INDIA, CARRIED OUT AT NTI, PROVED CONCLUSIVELY THAT IT DOES NOT PROVIDE PROTECTION

NATIONAL AIDS CONTROL PROGRAMME

- **IT HAS ACHIEVED LIMITED SUCCESS MAINLY DUE TO FAILURE IN GENERATING AWARENESS AMONG THE MASSES AND THE SLOW PACE OF IMPLEMENTATION OF THE PROGRAMME**
- **NACO HAS NOT COME FORWARD WITH SUCH BASIC PREREQUISITES ABOUT A DISEASE CONTROL PROGRAMME AS REASONABLY RELIABLE EPIDEMIOLOGICAL DATA ON THE PREVALENCE, INCIDENCE, THE COURSE OF THE DISEASE, EXTENT OF MOTHER- CHILD TRANSMISSION, ITS CULTURAL AND SOCIAL DIMENSIONS AND A CONTROL STRATEGY BASED ON HEALTH SYSTEMS RESEARCH**

GLOBAL PROGRAMME OF TUBERCULOSIS CONTROL

- **NATIONAL TUBERCULOSIS PROGRAMME OF 1963 WAS DESIGNED TO “SINK OR SAIL” WITH THE GENERAL HEALTH SERVICES**
- **THE GLOBAL PROGRAMME ENVISAGED DIRECTLY OBSERVED TREATMENT WITH SHORT-COURSE CHEMOTHERAPY (DOTS).**
- **REVISED NATIONAL TUBERCULOSIS PROGRAMME (RNTCP) COULD CLAIM TO BE AMONG THE MORE EFFECTIVE OF THE GLOBAL PROGRAMMES BECAUSE IT HAD INHERITED THE NTI TRADITION OF HAVING A REASONABLY SOUND INFRASTRUCTURE FOR TUBERCULOSIS WORK AND FACILITIES FOR TEAM TRAINING AND SETTING UP A REASONABLY RELIABLE INFORMATION SYSTEM ON THE PROGRAMME PERFORMANCE**

THE GLOBAL POLIOMYELITIS ERADICATION INITIATIVE (GPEI)

- **POLIOMYELITIS FORMS A MINISCULE PROPORTION OF THE DISEASE LOAD OF THE COUNTRY**
- **PATENTLY IRRATIONAL MOVE, AS THIS WOULD DISTRACT RESOURCES AND PRIORITY FOR OTHER CRYING NEEDS OF THE CHILDREN OF THE WORLD – IN THE FORM OF MALNUTRITION AND WATER-BORNE DISEASES**
- **BECAUSE OF WEAKNESS OF HEALTH INFRASTRUCTURE IN SOME “BACKWARD” BUT IN THICKLY POPULATED STATES OF THE COUNTRY, THERE HAVE BEEN REPEATED FAILURES OF THEIR STRATEGY**
- **AS OF OCT 3, 2006, INDIA RECORDED 352 POLIO VIRUS CASES**
- **PUBLIC HEALTH ANALYSTS FEAR THAT OTHER STATES IN INDIA AS WELL AS OTHER COUNTRIES COULD BE INCREASINGLY AT RISK FROM THE FLARE-UP OF THE POLIOVIRUS IN UTTAR PRADESH**

LEPROSY ERADICATION

- THE WORLD BANK AND WHO HAD BEEN ASSISTING INDIA FOR QUITE SOMETIME IN “ERADICATING” LEPROSY FROM THE COUNTRY BY THE YEAR 2000.
- THE GOAL POSTS WERE SHIFTED AND THE TERM, “ERADICATION” WAS REPLACED BY THE EPIDEMIOLOGICALLY CONFUSING TERM, “ELIMINATION”.

ECONOMIC REFORMS AND ACCESS TO HEALTH SERVICES

- **GOVERNMENT EXPENDITURE ON HEALTH IS 0-9 %, GDP;IT IS QUITE LOW**
- **THERE IS EXPANSION OF THE SPACE FOR PRIVATE INITIATIVE.**
- **THE STATE EXTENDED ASSISTANCE TO THE PRIVATE SECTOR IN THE FORM OF VARIOUS TYPES OF DUTY EXEMPTIONS, LAND SUBSIDIES AND INCENTIVES.**
- **THE GOVERNMENTS UNDERLOOK “COST RECOVERY” FROM PATIENTS**
- **THE BREAKDOWN OF THE PUBLIC HEALTH SYSTEM RAPIDLY EXPANDED THE “MARKET” FOR THE PRIVATE SECTOR**

REPORT ON INDEPENDENT COMMISSION ON HEALTH

- **HEALTH SERVICES “ARE IN AN ADVANCED STAGE OF DECAY WITH DECAY OF KEY PUBLIC HEALTH INSTITUTIONS, FREQUENT OUTBREAKS OF VIRTUAL “EPIDEMIC OF EPIDEMICS” AND NEGLECT OF THE “FORGOTTEN PEOPLE”**
- **INDIA IS AMONG THE COUNTRIES HAVING THE HIGHEST RATES OF MATERNAL MORTALITY (1992 & 1998 ROUNDS OF FAMILY HEALTH SURVEY)**
- **AMONG THE POOR, EXPENDITURE INCURRED TO MEET THE MEDICAL NEEDS IS THE SECOND MOST IMPORTANT CAUSE OF RURAL INDEBTEDNESS.**

MISSION DOCUMENT – NATIONAL RURAL HEALTH MISSION

PUBLIC SECTOR INVESTMENT HAS FALLEN FROM 1.3 IN 1990 TO A DISMAL 0.9 IN 2005

FOR EVERY RUPEE SPENT ON THE POOREST FIFTH OF THE POPULATION FROM THE PUBLIC SECTOR, THREE RUPEES ARE SPENT ON THE RICHEST FIFTH;

HOSPITALIZED INDIANS SPEND, ON AN AVERAGE, 58% OF THEIR TOTAL ANNUAL EXPENDITURE;

OVER 40% OF HOSPITALIZED INDIANS BORROW HEAVILY OR SELL ASSETS TO MEET TO COVER EXPENSES;

25% OF HOSPITALIZED INDIANS FALL BELOW THE POVERTY LINE BECAUSE OF HOSPITAL EXPENSES.

NATIONAL RURAL HEALTH MISSION

- **ABOLITION OF A SEPARATE DEPARTMENT OF FAMILY WELFARE TO FORM A COMPOSITE MINISTRY OF HEALTH**
- **DECENTRALIZATION OF THE ORGANIZATION AND FUNCTION OF THE HEALTH SERVICES**
- **INTEGRATION OF THE VERTICAL PROGRAMMES WITH THE GENERAL HEALTH SERVICES.**
- **THE MISSION HAS SET FOR ITSELF AMBITIOUS TARGETS OF HEALTH IMPACT: FOR EXAMPLE, REDUCTION OF THE INFANT MORTALITY RATE (IMR) TO HALF – THAT IS TO 30; MATERNAL MORTALITY RATE TO BE REDUCED FROM AROUND 475 TO 100 (PER 100,000 LIVE BIRTHS) AND REDUCTION OF MALARIA MORTALITY RATE BY 50% IN 2010 .**

THE PUBLIC HEALTH FOUNDATION OF INDIA

- **ESTABLISH NEW INSTITUTES OF PUBLIC HEALTH**
- **ASSIST THE EXISTING INSTITUTES TO ENHANCE THEIR CAPACITY AND THEIR OUTPUT.**
- **PROMOTE RESEARCH IN PRIORITIZED AREAS OF PUBLIC HEALTH, TO INFORM POLICIES AND EMPOWER PROGRAMMES**
- **FACILITATE POLICY DEVELOPMENT, PROGRAMME EVALUATION & ADVOCACY ON PUBLIC HEALTH RELATED ISSUES**
- **ENABLE DEVELOPMENT OF STANDARDS & ADOPTION OF A CREDIBLE ACCREDITATION SYSTEM FOR PUBLIC HEALTH COURSES.**

THE LONG AND DIFFICULT PATH OF RETURN TO PRIMARY HEALTH CARE

- **NATIONAL HEALTH POLICY OF 1982 (62) THAT THE THEN EXISTING UNSATISFACTORY SITUATION “HAD BEEN ENGENDERED BY WHOLESALE ADOPTION OF HEALTH MANPOWER DEVELOPMENT POLICIES AND ESTABLISHMENT OF CURATIVE CENTRES BASED ON WESTERN MODELS, WHICH ARE INAPPROPRIATE AND IRRELEVANT TO THE REAL NEEDS OF THE PEOPLE AND THE SOCIO-ECONOMIC CONDITIONS PREVAILING IN THE COUNTRY”.**
- **“PROLIFERATION OF SUCH AN APPROACH HAS BEEN AT THE COST OF PROVIDING COMPREHENSIVE PRIMARY HEALTH CARE SERVICES TO THE ENTIRE POPULATION. INSTEAD OF BUILDING SELF-RELIANCE, IT HAS TENDED TO ENHANCE DEPENDENCE AND WEAKENED THE COMMUNITY’S CAPACITY TO COPE WITH ITS PROBLEMS. IT HAS RESULTED IN THE DEVELOPMENT OF CULTURAL GAP BETWEEN THE PEOPLE AND THE PERSONNEL PROVIDING CARE”**

THE WAY FORWARD

- Rejuvenation of the existing institutions for research, education and training of public health workers and building new ones and producing an elite corps of managerial physicians
- Removing the square pegs in round holes and inserting the round ones in their places.
- Formulation of a totally different cadre structure to attract highly competent public health personnel in the services.
- Implementing the already taken decision to integrate the discredited vertical programmes with the general health services

THE WAY FORWARD

- **Inability to pay should not come in the way of the people to have access to health services.**
- **Promoting interdisciplinary health systems research to formulate optimised health systems.**
- **Ensuring foreign funding agencies are not allowed to impose their agendas on the country.**
- **Considering increase in allocations for investment in proven cost-effective programmes**

**“DOORS AND WINDOWS OF OUR ROOMS
OUGHT TO BE KEPT WIDE OPEN FOR
FRESH WINDS TO COME IN, BUT WIND
SHOULD NOT SWEEP US OFF OUR FEET”.**

Thank You

The text 'Thank You' is rendered in a bold, sans-serif font. Each letter is filled with a different color from a rainbow spectrum: 'T' is magenta, 'h' is red, 'a' is orange, 'n' is yellow, 'k' is light green, 'Y' is blue, and 'o' is purple. The letters are slightly raised from the white background, casting a soft, grey shadow to their left and slightly forward, giving them a three-dimensional appearance.