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PRIMARY HEALTH CARE

Politics of Primary Health Care

SINCE the seventies, in many national and international circuits of health bureaucracies, Primary Health Care (PHC) has become a panacea for all the evils of the poorer nations. The WHO has projected it with all its convictions and the member nations have accepted it with equal vigour. According to the Alma Ata declaration:

> Primary Health Care is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and 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 both of the country's health system of which it is the central function and main focus, and of the overall social and economic development of the community.

Today when this strategy has been accepted by such a large number of countries, there is a need to examine its potential strengths and weaknesses.

The idea that health is closely related to people's living and working conditions and that it is an outcome of their socio-economic environment was vocalised by men in different fields like John Snow, Engels and later Virchow in the West. It manifested itself in the sanitary movement of the 19th century. In India and other parts of the East it had much deeper roots, visible in the method of ancient medical science itself and in the cultures of Harappa and Mohenjodaro. In India during the struggle for Independence, a demand for comprehensive health care was a part of the national movement. Why then this sudden fervour now for projecting PHC as a new concept by international and national official circles?

To understand the politics of PHC one has to understand the role that UN and WHO have played in the overall politics of the world. Always supporting the interests of the imperialist nations, these organisations have used the liberal tools of aid, support and providing consultancy to diffuse, control and direct crisis situations. The effort to develop an alternative World Economic Order in the 70s was one such spurious exercise and as a part of it, was proposed the notion of alternative health care for the third world.

The motives behind it were to check impending destructive and costly reactions from and within third world nations whose poverty, disease and squalor were becoming threats to stability. PHC was the baby of the liberals in the imperialist camp and WHO projected it as the solution to poor nations' health problems—with full promise of help and support, but a clear understanding that the local political structures alone will give shape to the implementation of Primary Health Care! Such an international strategy which offers free help without any political price is obviously seeking change in health situation with or without the political will of the local government. It is interesting that the international terms of trade are in total contradiction to this attitude. Even though one knows that some liberals have their hearts in the right places, this conflict in international strategy needs serious analysis to understand the reasons for this special concession to health.

At the national level the concept of PHC acquires multiple dimensions. Given the particular hue of the government, the implications have varied from Africa to south east Asia and Eastern Mediterranean regions. The issue is what use does a national government make of the concept? Does it use it as the concept is presented by the Alma Ata declaration and make it a part of its effort to develop an integrated strategy for the betterment of its people, as in Angola, Tanzania and Mozambique or does it allow the concept to degenerate into a slogan behind which the same old strategies with some new features continue to be implemented—at a faster rate perhaps with the additional inputs from the international fund givers—as in India and Pakistan?

A grasp on the national politics of PHC requires an understanding of the country's socio-economic and political structure and the nature of its government and health service structures. Only such an understanding allows one to assess the potentialities or limitations of the system to achieve PHC. An example of the interplay between PHC and politics is the level at which it is integrated into the planning process of a country. Thus, the Chinese and Vietnamese incorporated PHC in the very process of national planning right from the period of their independence without giving it a name. In contrast, India made so much fuss and then relegated PHC to the care of the health ministry while the overall planning processes took its own directions. Yet another example is the implementation and outcome of programmes introduced under the banner of PHC. These programmes which may have a potential of providing much needed services are overtaken by the local power elite through their links with the health and administrative bureaucracies. The nature of the latter thus becomes the primary determinant of the outcome. The Community Health Guides scheme and the drinking water supply through borehole hand pumps in India are two such examples.

Another dimension of the PHC efforts at the national level is the setting of priorities and the selection of technology. In India despite the official acceptance of implementing PHC by 2000 AD, the heavy emphasis on urban-based services and curative approach in rural areas continues with heavy dependence on expensive equipment and drugs. The drug policy needed to provide PHC is yet to be formulated. Can issues of priorities and technology be then isolated from politics? A simple but revealing example is the supply of "electrolyte" packets in the Community Health Guides' kits! Does it not show links between the health administrators and the drug industry who know that addition of so many salts to the basic mixture only increases cost and not effectivity?

If the concept of PHC is getting distorted in the hands of the not-so-democratic government and is becoming a tool for creating two types of services, one for the rich and the other for the poor, should it be criticised, rejected, accepted as an unavoidable distortion or used to broaden the base of democratic movements? These are some of the questions which need to be answered by those who are working in the

interest of people's health. Can PHC as a concept become an inspiration for those involved in people's struggle for their rights? If PHC is an outcome of total development then it should be. And what have people's democratic and left movements done about it?

There are many small or regional projects experimenting with implementation of primary health care. What is the role of such projects in focussing upon the issue of PHC or in diluting it?

In academic circles, in the name of professionalism and the need to achieve results, a concept of "selective PHC" has been circulated which means let us not talk of comprehensive development but do what we can without disturbing the existing balances. This is attractive to those who would like to go back to singing praises to powers of technology and managerial competence. There is need to examine such concepts threadbare to show their reactionary ideology as well as non-feasibility.

Are there any lessons that we can draw from the experiences of the socialist countries which have tried to provide health care not in isolation, but as a part of their total developmental processes? These are the major questions which need to be addressed when one is dealing with the bipronged weapon of Primary Health Care.

This issue examines some of the problems raised in the editorial. Guy Poitevin describes his experiences in taking up health issues as a part of larger movement for socio-economic change. Manisha Gupte comments on the ideology and perspective of the maternal and child health programme and points out that without a questioning of the role of the women in society, any such programme would be ineffective. Asha Vohuman reports on the mass immunisation programme which was launched with such fanfare in Bombay in 1983, not so much because of its potential impact on the health of the children but because the minister in charge needed a visibly successful campaign to consolidate her political gains. The reprinted article from *International Journal of Health Services* provides a historical background of the concept of public health and raises some questions about holistic health alternatives emerging in the US. And in the non-theme section we have Jytte Willadsen discussing the question of the sexist bias in medicine. As a doctor herself she also touches upon the problems encountered in bringing about any changes in the very male oriented medical establishment in Denmark.

We have as usual the Update and Dialogue sections. Sujit Das continues the discussion on the role of doctors; Ulhas Jajoo responds to Anant Phadke's review of his book *When the Search Began (RJH, I: 1)* and *AS* questions if drug therapy in psychiatric problems does not have a place in the present socio-political context.

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XIII Annual Meet of MFC

Medico Friend Circle will hold its XIII Annual Meet at Seva Mandir Training Centre, Kaya (near Udaipur), Rajasthan, on 26th and 27th of January 1987.

The theme chosen for discussion this time is *"Family Planning in India: Theoretical Assumptions, Implementation and Alternatives".* Family Planning has generally been considered an important part of Primary Health Care, but over the past two decades, it has come to occupy a key place amongst the country's development strategies. Is its elevation to the level of a panacea, for the problems facing the people, based on well examined theoretical assumptions? What effects has the policy of incentives and coercion had on the performance of other health programmes? Out of the existing contraceptive methods which is the least harmful? Do some of these methods need to be rejected outright? Are there safer alternatives? These are some of the issues to be discussed at the Meet.

As usual there will be no reading of papers. Background papers on related topics will be circulated beforehand to facilitate discussions. They include: (a) Problem of population versus resources (b) Theoretical assumption of FP policy in China (c) Critical examination of the FP policy in the context of the child survival hypothesis (d) Comparative analysis of the dangers of pregnancy and contraception (e) Women as the main targets of FP policy (f) The paradox of higher FP performance in tribal areas (g) Incentives and coercions—effects on Primary Health Care (h) Pattern of resource-allocation in our Five Year Plans (i) Evaluation of the existing FP methods (j) Natural Family Planning methods as safer alternatives.

We invite you to attend the Meet and share your views and experiences. We also invite you to write background papers on any other topic to the theme. Your note/paper should reach the Convenor's office by the **31st November.**

Participants are as usual expected to pay for their own travel. Simple boarding and lodging facilities will be available at the venue, on a payment of Rs. 20/- per day per person. We charge a small registration fee to cover the cost of the cyclostyled background papers. Return reservation facilities are also available. If you wish to attend, please write to: **Dhruv Mankad, Convenor, Medico Friend Circle, 1877, Joshi Galli, Nipani-591 237.** We will then send you the venue details and background papers.

Social Dialectics of Primary Health

guy poitevin

This article presents some socio-psychological observations and conclusions drawn from a social study made of a limited voluntary health programme undertaken by a sinall NGO in remote rural areas of Maharashtra (Sahyadri Range). This qualitative study is concerned with health as a social process. Health practices are examined as components of over-all socio-cultural dynamics and the foundations of a people's health movement sought within the context of a wider attempt of socio-political awakening and people's organisation.

SEVERAL voices raise to draw our attention on primary health issues as components of local socio-cultural dynamics. This perception prevails, for instances, as a conclusion of the assessment of the working of the Rural Health Scheme made by the Population Research Centre of the Institute of Economic Growth: "His (Community Health Volunteer, CHV) role as a public health worker is more social than medical. It would require of him to create health consciousness within the community and to prepare and organise the community effort to carry out all the necessary steps of improving sanitation within the settlement, cleansing up the surrounding areas and imparting health education to all its members. This work within the community is in fact the fundation upon which the whole health care delivery system must rest" (Bose A, 1983: 53-80). P B Desai concludes a general evaluation of the CHV Scheme in India with the following assessment: "The most crucial shortcomings of this kind of approach is the failure to upgrade the capabilities of individuals, families and communities to take upon themselves the responsibility of attaining and maintaining conditions for healthy living within their jurisdictions. In other words, the central issue of the promotion of self-care is left unresolved" (1983: 7). He then stresses the point that the definition of the objectives drawn in the Alma Ata Declaration (1978) to resolve this central issue is 'holistic' in nature, as their formulation insists on a full community participation and a spirit of self-reliance and self-determination (WHO-UNICEF, 1978: 3), and the "task of delivering health care must begin with this non-medical, social endeavour of achieving the necessary social transformation at the grassroot level."

If such is the case, once we have acknowledged and really perceived the social role of the CHV and measured the import of the 'holistic' perspective with which we should approach primary health issues, a corollary immediately follows, that health development schemes should seek the help and the critical insights of social scientists, anthropologists and psychologists. And this is all the more necessary when we are concerned with provision of primary health education and care based on efforts of self-reliance among the most underdeveloped sections of the rural population, whether these efforts be undertaken by government agencies or NGOs. If these efforts are to be "viable, dynamic and positive instruments of social progress" (P B Desai), then primary health schemes should first of all become the subject matter of social science investigation and critical analysis.

We present here below some/socio-psychological observations and conclusions drawn from a social science study of a limited voluntary health programme undertaken by a small NGO in remote rural areas of Maharashtra. The study is not directly concerned with such objectives as the raising of health status, the planning of alternative or integrated health services among deprived rural population and the related welfare, educational or developmental issues, in a more or less static way. Health is examined here as a social process from within a marginalised population, *viz.*, as a dimension of an overall dynamics of socio-cultural and socio-political awakening and people's organisation. The study is concerned with the conditions of a possibility of an effort of health by the people which actually cares for all, based on a critical appraisal by those concerned -i e those deprived of health care facilities—of the present health system and motivated by a will to try out self-reliant ways. This case study is partial contribution towards answering some of the following questions: the need for a strategy for enlisting community participation, the task of generating social health awareness, securing of the cooperation of women more than of men, generating appropriate health practices, organising collective health actions, etc. We may even piously wish or dream that "if we succeed in organising the community for giving to itself-a primary health care system of its own choice, it may become all the more practicable to carry forward this process of self-reliant development into all fields of social and economic progress" (Desai, 1983: 8). But the crucial question remains unanswered beyond the many evaluations of the shortcomings and failures of the CHV Scheme: what does it mean methodologically to "organise the community" for enabling it to wish, to conceive, to experiment, to chalk out and to give itself a health system appropriate to its concrete needs. What does this mean in terms of strategies of social action?

Primary health care as the subject of social science research should therefore be examined and evaluated by focusing on the dialectical relation obtaining between the level of health conciousness and the forms of collective organisation on health issues on the one hand, and on the other, the local socio-cultural, administrative and power structures, including those of the public health care system itself. If health status is rightly considered as an index of social development, health consciousness—as expressed in relevant renewed perceptions and representations and consequent forms of collective action—should be rightly considered as a component and an index of the socio-cultural and politcal awakening of a given population.

The health education and care programme carried out by the voluntary organisation Village Community Development Association (VCDA) in the remote hilly areas of the talukas of Mulshi and Velhe (Sahyadri Range) was considered as providing an adequate field of observation for such a scientific investigation by the Centre for Co-operative Research in Social Sciences, Pune which conducted the study with a grant from the ICSSR. The health programme under study is part

of a wider educational programme (called "School without Walls" and comprising mainly non-conventional programmes of cultural action for children and women directed towards children's and women's organised collective action) which is itself a part of a much wider programme of "conscientisation" and organisation of the deprived sections of the population of several rural talukas around Pune. The health programme is carried out in areas deprived of any medical services. Quite recently, the government made an effort to implement its CHV Scheme. A few private practitioners sometimes visit the area to give injections and to make money from the population. Medical officers of the PHC (Velhe and Paud) do rarely visit the area, except for enlisting "cases" (tubectomy operations). Sanitary conditions are particularly bad. Animals are kept inside the houses. Many villages are cut off by the monsoon rains. In the dry season, very few villages are directly connected by a bus to the taluka centres. The scarcity of land does not permit a sufficient and balanced diet. Traditional representations about diseases and their treatment are generally prevalent.

The main aim of the study was, to document a few possible ways of reciprocal determination, among marginalised rural population deprived of elementary health services, of three series of processes:

(1) The spread of medical knowledge and the consequent improvement of health conditions among marginalised rural population;

(2) The process of socio-cultural and socio-political awakening especially with reference to the representations about health and body and the present disfunctions of the health care system, with the consequent people's collective initiatives of organisational attempts to deal with health problems as well as other related issues;

(3) Autonomous and alternative efforts to promote attitudes and concrete attempts of collective self-help in respect of primary health education and care among the same weaker sections.

The assumption underlying and motivating the study was the conviction of the necessity of such a reciprocal determination: failing this, no health development scheme—be it of a minor scale—can significantly contribute to the radical changes needed in this field. The aim of the qualitative study was to describe and establish the nature, the extent and some forms of this mutual positive correlation.

A second aim was to draw observations and conclusions relating to and bearing upon concepts and procedures of development—and especially of health development— of processes of cultural, social and political awakening and organisation of the marginalised sections of rural population. These latter processes are obviously leading towards redefining the epistemology of development. The case study sheds some light on these theoretical issues with regard to underdeveloped rural masses the health needs of which have been consistently neglected.

Three aspects characterise the methodology: The analysis is jointly and cooperatively carried out at all stages, with those concerned and involved in the scheme, resorting to methods of collective self-analysis and research-action. Such a methodological approach is expected to promote a better critical consciousness and consequently to foster the process of autonomous self-determination as well as develop the theoretical ability of the group of health workers.

The validity of in-depth studies is not to be undermined with regard to the needs of those concerned with macro-planning and large scale policies. Macro-level planning cannot with impunity overlook the conclusions of in-depth analyses. Planning remains a futile exercise whenever it does not take into account the dynamics operating at the grass-root level.

The scheme under study not being a medical care scheme, sampling methods do not suit the objectives of the investigation. The changes occuring in health preceptions, practices and conditions are evaluated by several types of qualitative procedures. One of the most significant is the so-called "sociological intervention": The sociologist and his assistants intervene at the time of seminars and analytical exercises, in-depth interviews of individuals and groups of health workers on a specific theme; personal interviews of villagers; inquiries made by some trained health workers, personnel narratives; minutes and reports of usual meetings and free discussions among the health workers; and role-plays. No questionnaire nor schedules were used; only guide-lines were always carefully prepared for conducting discussions. The study was spread over two and a half years (1983-1986) as a sort of continued analytical effort following and accompanying the evolution of the action programme.

Awareness of Identity among Health Animators (HAs)

The most decisive step consists in generating a basically new approach through a sort of cultural labour prompting the volunteers to discover their identities as HAs in a way quite different from their own expectations obviously modelled after the social patterns and the collective representations shared by the population at large.

After two to three years of health training and practice, HAs unanimously acknowledge their complete unawareness at the beginning of what health might mean. The contrast between the perceptions acquired during many months of continuous training and involvement and the remaining memories of the initial understanding leads to an evaluation of what happened at the begining. First of all, the idea, let alone the wish, of any health activity being undertaken by the population itself, did not emerge of its own from the people concerned or involved as HAs or as beneficiaries. What then was the motivating factor prompting them to undertake health tasks? People from the lower sections volunteered to undertake a health activity on account of the moral authroity that their organisation Garib Dongari Sanghatna (GDS) had acquired and of the trust they had already put on the external social agents who floated the ideal (the main animators acting as catalysts of GDS). It is obvious that without the on-going organisational process such a prompt response, would have been impossible. Without such a collective social support with its components of moral authority and confidence, neither the idea of a health task would have been effectively welcomed by a deprived population nor any man, let alone a woman, from lower sections would have dared to volunteer.

Secondly, in the absence of an awareness of the urgency

of health issues, what representations defined and accompanied the idea of a health task? The possibility of some honorarium was a very strong constituent; the vague desire of some sort of 'employment' was also there; "to become a doctor!" was a widely shared expectation; "to distrubute medicines and pills, to give injections, or to become a dai": such was the most substantial content discretly related to health; some had really no idea of what could be the task expected from them; there was a strong apprehension, especially among illiterate women, about their ability to comprehend; some daring pushed ahead all of them and some liking too. When we compare these initial representations with those brought about after three years of experience, three main shifts appeared to occur in the preceptions. Firstly, from static notions of social status and prestige position associated with the health profession and the expectation of an employment, the approach evolved towards activist attitudes, became action-oriented and conceived in terms of actual achievement. The systemic outlook was altered into a dynamic attitude. Secondly, from self-preceptions in terms of ignorance, fear and inferiority feelings, there was a shift towards self-confidence, boldness. Their ability to assimilate knowledge enhanced the self-image. Inhibition gave way to self-assertion. Thirdly, from an individualistic outlook and wishes of private profit, there was a shift towards a social understanding.

The interest was hence motivated at the start by the hope of a small honorarium (discontinued later on), by the wish to be a 'doctor', by the desire to escape deceptive practices of the private doctors, by the pleasure of getting information "when we realised that we could understand it". The interest of those who had no specific liking for the topic was raised when they learnt something new and delivered a few pills. After two or three years, four main motivations are expressed as follows at the time of health seminars: Let us give information to the people. Let us sit together and educate people. Let us organise the people. Let us be self-reliant. Later new-comers, all women, all illiterate, who joined a scheme which they had observed, give the following reasons for taking up this responsibility: to get a new education and training; if they fall sick, to be able to do something by themselves; the good results of the medicines circulated by the HAs; no money to buy medicines from private doctors, but cheap pills available from the HAs, even on credit; doctors take a lot of money and do not treat unless paid beforehand; interest in this topic; if they now learn, their children can be taught... To the question that such interest may not be sufficiently strong when male pressure is raised against women taking the lead, the answer is that: "We have been selected by a group of people during a meeting. We have the support of people".

As a matter of fact, external support is not sufficient. The female new-comers maintain their involvement out of a strong internal conviction: "We have seen the earlier ones. They committed themselves to this work. They have not eloped or have been taken away by men! The provision of a health education scheme, to succeed or fail for many reasons absolutely alien in nature to the health issues tackled by the scheme. One of them has been suggested above concerning the social factors conditioning the desire for, the access to, the sharing and circulation of medical knowledge among rural lower sections. Secondly, a health scheme is bound in the first instance to be specifically 'recognised' or understood, from a socio-psychologically point of view, through the established patterns of representation concerning doctors, health and therapies. There may be therefore some naivety on the part of action groups to resort to health as an entry point if this means that health, *as such*, on account of its urgency, is expected to easily generate radical social insights. The prevalent unawareness about health as a personal as well as social issue and the deeply imbibed pre-critical and unconscious cognitive structures in this respect make health one of the most deceptive and difficult 'entry points' if one looks forward to it as a lever for radicalising rural populations.

In such circumstances, a main concern of a health scheme consists in defining the role of the HA. This had been and remains one of the main themes of the regular and continuous training programmes of HAs in the VCDA scheme. As a result of discussions among all those concerned by the scheme, doctor, activists and mainly HAs, the following write up was prepared as a basic chart of the HA's role, as an operational model.

Our Health Work: Why and How?

—We and our children fall sick every now and then.
—When we fall sick, we never get medicines soon, nor do we get good medicines.

1. Why do we fall sick so often?

The reasons are that:

1 We do not get enough to eat nor is the food good. Then, as a result, we become weak.

2 We do not get enough of water, nor clean and pure water. As a result in the dry season, scabies increase and in the rainy season, diarrhoeas increase.

3 Our living quarters are small and not clean. We keep our cattle inside our houses.

4 During the rainy season, we work exposed to cold winds and we have not enough clothes to put on.

5 Our work is dangerous, instruments are primitive and insufficient. As a result, accidents occur; we are overworked; we quickly tire and we do not pay attention to our health condtion.

6 Many times, we are overwhelmed by difficulties: as a consequence, our mind does not remain sane. The pressure of the male domination upon women is epecially heavy.

7 The government has no money the government people do not give us information. But it takes great care of a handful of privileged people.

8 Bad habits: alcoholism, tobacco etc.

9 Frequent pregnancies.

10 No vaccination.

If we could get rid of these difficulties, then we would not fall sick so often. But, today, these difficulties cannot be removed. As a consequence, the frequency of diseases cannot immediately come down.

2. Why do we not get proper medicines when we fall sick?

1 There are no doctors in our area; the 'medicine men' are many, they deceive us.

2 The doctors who come into our area, behave like 'medicine men'; for instance, for no reason, they put on a very serious face, use difficult words which they pronounce like mantras and create an atmosphere of mystery. Although there is no need, they give injections and prescribe useless medicines. The medical profession is being converted in to a business like any other business. It is a profession consisting of selling medicines. The more money you give, the better treatment you will receive. A doctor is no different from an agent of a drug company. Doctors behave like dealers: they store the knowledge as shopkeepers

store the commodities and make us more expensive. There is a competition for consumers, (as among dealers) to obtain more consumers and gain more money.
Where is 'humanity'?

3 *What is clear about today's doctors*?

Doctors do just sell treatments. Moreover, on account of the doctors' behaviour, some ideas are firmly embedded in our minds, for example: money is everything; the knowledge of the doctor is very complicated. We shall never be able to understand anything of it; Our health depends upon doctors; Doctors' work is intellectual and of a much higher grade than our labour in the fields.

4 *What is the use of our health work*?

We cannot bring about important changes in our condition, so exposed to diseases with our health activities. The reasons are as follows: Our health condition depends much more on many other factors of our whole environment than on medical factors; the knowledge that we can get about health as health animators is limited. The pills and medicines that we give are simple and not many.
What then is the use of our health work?

We want to bring, at this primary level, a new concrete way of undertaking health work. An example will make it clear. What is the difference in the health work, between the method that is usually followed today, and our method? This will be clearly understood from the following example.

Let us suppose that a lady health animator from our group attends a child suffering from summer diarrhoea, what will she be able to achieve?

Change in the body: We shall be able to win over the disease which affects the body of the child.

Change at the economic level: A good treatment can be given at a very small cost. We can demonstrate it.

At the level of health consciousness: The health animator can change the ideas of the people. What will she/he tell them?

1 Why diarrhoea occurs, what is the treatment, and if it can be prevented. This *techincal* knowledge about diarrhoea will be given.

2 Why diarrhoea occurs much more often among the poor and in the villages. How the proper preventive treatment of diarrhoea depends upon a proper water supply. Why today's doctors and drug companies take pleasure in treating diarrhoea with very expensive medicines. This is *social* knowledge that the health animator is giving.

3 How there is no need for a doctor to treat simple and minor ailments and what is the opposition of the private doctors to this statement:

4 How we can deliver people from the exploitation of private doctors.

5 How in our health work there is no domination of the doctor. We don't give him undue importance.

6 Why, despite so many promises and announcements on the part of the government, this latter cannot seriously undertake genuine health work of that sort.

7 This health work is going on in a nice way, because we are awakened, organised. Our health work will progress to the extent our awakening and our organisation will grow.

8 Still, as long as food, water, shelter, education, cloth, etc. are not available, we shall not stop falling sick time and again.

This definition of the HA's role tries to give a concrete design to a specific concept of health work among and by marginalised rural population. This concept ought to be made explicit. The health work in such a context is conceived as aiming 1) at forging a collective health consciousness based on a critical perception of the relation obtaining between people of lower social strata and their actual physical environment and specific social constraints; 2) at making experimental attempts which constitute *per se* a practical critique of the prevailing methods and structures of the health care system; 3) at projecting in an embryonic form a sort of miniature model revealing the feasibility conditions of alternative values, norms, organisational patterns and practices of medical care; 4) at raising the level of socio-political awareness of the whole population in this respect through health education, self-reliant practices and collective health action as levers, thus contributing, in its own way, to strengthen the overall health movement; 5) at resorting to operational concepts and criteria of evaluation of a social and cultural nature instead of giving priority to and taking only as operative norms the quantitative medical improvements in the health status of a given population, objective that at any rate the NGOs are unable to achieve—particularly the small ones—on a suficiently large scale.

Selection of HAs

A general model remains futile without its operational concepts. The selection of HAs is one of them. With rare exceptions of selection being made by the external main animators of GDS, the HAs of VCDA were regularly selected by local groups of GDS during their meetings (with the 'permission' of the husband or parents for the female HAs). A few women were selected at the start on account of their activity as teachers in a voluntary nursery school of GDS. Sometimes special meetings were called to deal with this issue and several meetings were necessary to make a selection. In the course of time, when new volunteers joined, they were all co-opted by the local groups of GDS. The selection was not a sort of casual appointment but the result of group discussion and exchanges among the assembled people.

When the health workers look back and consider the procedures of their initial selection, they come to the following conclusions.

At the beginning, without any experience of procedures of collective determination, "We had no idea of the method followed, and we did not understand its importance", confess all of them. The cooptation process from within a group for a task to be carried out in the name of a group or mass organisation was a procedure absolutely unknown. They did not realise the meaning of this process. Three years later in 1984, all of them except one woman who dropped out express the firm conviction that it is proper to make the selection from within a group of assembled people taking a common decision.

The reason are the following:

The selection should be made according to the ideas that the people have about it. Their ideas should be taken into consideration; A private selection is a mistake; when there is a decision of a group, the selected person feels responsible to the group and the group responsible to the individual. This is bound to generate a reciprocal questioning of both of them. And such habit should exist; in the case of a private selection, people will not feel like cooperating with the one selected, nor give him/her their support. When a meeting is called, everbody will find an excuse for remaining absent.

The model to be followed in the future is as follows: "In a new village or a hamlet, we shall hold a meeting on health and give some information about it. Then, we should tell the people: "To tackle your problems in this respect you should select your own man/woman for that".

Why should this procedure be followed? This process induces the awareness of a reciprocal responsibility; It avoids the danger of pressures of vested interest and the criticism

or the mockery against the one who is chosen; this process assures cooperation, support and participation; there cannot be any real work by an individual alone.

What do these procedures aim at?

These procedures impart information to the people (doctors never impart information about health and thrive upon the ignorance in which they keep the patients; people get a chance to assemble, exchange and make an effort to solve their own difficulties; the objective is to become self-reliant, "to stand on our own feet"; this helps to strengthen and spread the organisation GDS; the intention is to put an end to the deceptive practices of doctors and of the local miscreants who act hand in hand with the doctors; this brings a health knowledge to the village level; this develops a health consciousness; this gives the women an opportunity of having some role and stand in society; this offers a chance to everybody of speaking out.

Let us draw one clear operational conclusion from these data: the perception of health as a collective issue that confronts the whole community is generated here through a social process of cooperation, by the group, of a volunteer. It is not the perceptions of health as a community problem which comes first and leads to a renewed social practice. It is a renewed social practice which helps developing a new approach towards health, as it could have been with any other issue. There cannot be any real consciousness of collective responsibility unless it takes the form of an appropriate pattern of social relation or a cooperative social formation.

How Villagers Perceive Health Animator

Another determining factor, mainly at the initial stage, is the perception of the beneficiaries and their expectations. Four types of reaction characterise these attitudes, in the perception of HAs, which symbolise four cognitive structures through which villagers spontaneously approach this health experiment.

1 "The village has got a big 'doctorin'!" This derogatory remark related to the women health animators. It points out firstly, that the health worker is considered as a 'doctor'! And secondly, that the prestige and honour implied in this image serve conversely, to ridicule people—, especially the women, or the illiterate workers—volunteering for the scheme being projected so suddenly to such a high position! People did not react mainly in terms of the concrete advantages of the scheme, but with regard to the social image of the doctor and to the concept of health as a doctor's commodity both of them turned into arguments meant to throw discredit upon ignorant people pretending to be more clever than they were to involve themselves in these tasks!

2 This work was looked at as sort of employment for the volunteers. As the possibility of an initial honorarium of Rs 50 was known, the task was considered as resorted to by the volunteers under the motivation of this material incentive. The women would then be able to bring their contribution to the maintainance of their husband and children, as they are the *dhana* of the house, its source of wealth, its *lakshmi*.

3 The third understanding is that this task was just a chance offered to the women's eagerness for being 'set free', abandoning the household duties under the pretext of attending training course in health or undertaking health tasks. Only women upon whom husbands and family could not keep a firm control were so allured. Their volunteering showed their lack of social restraint and fear. "Men and women sit together!" "Women just like to follow their whims!" It was almost out of lust that they had volunteered!

4 The fourth image was that through this scheme, a dispensary would be set up, medicines and pills would be made available. In this respect, as people were saying that "an educated man is needed to give medicines", women had doubts about their ability to prescribe medicines, as they were conscious of their ignorance and absence of education.

These data show that two main and anti-thetic socio-cultural cognitive structures gave readymade referential yardsticks to understand and evaluate the event. The first reference relates to the women's roles and image: a woman should never go outside of the home where she is confined to subordinate and non-prestigious tasks. The second reference relates to the prestigious function and role of a doctor as a supplier of medicines and health services. As the health animators were considered as doctors, these two referential factors clashed and as a consequence, the women were derided, for assuming a role of high rank and superior knowledge!

The basic and spontaneous point of view was not a technical or practical approach, but a social reading; and this reading was no conceptual insight nor analytical apprehension. It was a judgement. The cognitive structures worked, as a judicial recognition, not as an act of cognition. If this is likely to be the case in any transfer, its sucess depends upon the will and the ability to develop a conceptual understanding and to refrain from any hasty and spontaneous interpretation by referring to the in-built structures of recognition which can lead nowhere but to a judgement which is only a reduction to the same. This seals the impossibility of any progress.

This is obvious in our case. If the judicial recognition turns into a judgement against illiterate women and ignorant men taking up the role of a 'doctor', as this is simply a contradiction, still a women may be considered as positively motivated to take up this task for the reason that she wants to bring home some income, for the benefit of her husband and her children, as the source of wealth of the house (*dhana*). This is also a very clear cognitive structure regarding the role of a woman. The understanding of her desire to become a health animator is therefore either, negatively, a will to escape her duties at home and the control of her husband, or positively a justifiable intention of bringing home (to her owner, for the benefit of her house) some wealth, as she is a *lakshmi*.

One operational conclusion can be drawn from this. If a health scheme aims at engineering a process of social change, *viz*, a transformation in the patterns of relationship and values, it should and it could boldly create a situation which will directly challenge the cognitive structures mentioned. For that purpose a health scheme should not start with doctors and medical services run by doctors: health should not firstly be looked at as a technical task. Secondly, the leading role in the implementation of the health activities should be given to those women whose health is the most affected by the present health system. These activities should mainly and

basically consist in imparting elementary health education to women and more technical knowledge should come as a secondary dimension. A health animation activity undertaken by women of the lower social sections, taking the initiative of visiting and educating village population is likely to prove one of the most effective levers of social change in the rural areas, as this practice breaks off strongly built-in cognitive structures which have a definitive repressive role and are very significantly responsible for the perpetuation of a particularly degraded health status among women: the partiarchal patterns of relationship and values, and the undue prestigious status of the (male) doctors as the only ones capable of dealing with health and medicines.

Socio-cultural Pressures Against Health Animation

Between 1981 and 1984, out of an initial group of 30 HAs (14 men, 16 women), 17 dropped out (6 men, 11 women), while 18 new comers volunteered (1 man, 17 women). Those who remained involved had collectively analysed the reasons why so many dropped out—26 answers could be specifically given for the defection of 17 HAs. These answers are classified into 9 categories as follows:

1:3 male and 3 female HAs abandoned as they did not obtain the expected financial profit. The honorarium was considered too meagre; even this was discontinued and substituted by small help given on the basis of the days spent on house visits and meetings held, etc. Motivations were put to the test.

2:5 female HAs left under the social repression obtaining against women's assertiveness.

3:2 men and 1 women left for reasons of economic pressure and poverty.

4:3 men left out of diffidence about their own ability and social inhibition.

5:1 man and 1 woman were frustrated in their expectation of a higher status sought through this activity.

6:3 left on account of personal reprehensible behaviour.

7:2 women left because they could not cope up with the task.

8:1 woman could not bear the clash between the knowledge received and her traditional beliefs.

9:1 woman left out of lack of proper motivation.

These reasons are indicative of the difficulties and of the nature of the psycho-social determination of those who maintain their involvement with a renewed conciousness. It is obvious that almost all HAs joined the scheme with the thought that they would get a sort of paid employment thus improving their low social status. As a matter of fact, if all of them could secure through this programme somehow better social position, a qualified social recognition and some social respect—and self-respect—, paradoxically would remain more involved in the scheme than those who were usually deprived of such social respect, often denied the right to talk in the open and assert themselves, while those who already enjoyed some social prestige left an activity which appeared to them as not enhancing their dominant social position, or even countering it.

One should be fully aware of the basic difficulties which any attempt of popular health movement among underdeveloped rural population has to overcome before becoming a strength. If we are convined that there is no alternative to such a movement for bringing about significant structural changes in the health care system, we ought to be still more aware of the socio-cultural challenges this implies in the first instance. Two testimonies may convey the magnitude of the challenge. The first one is the testimony of a woman HA whose potentialities as organiser are totally repressed by her husband.

> I was conducting a balwadi under the sponsorship of VCDA since one year. On this account, I was, therefore, going from house to house to fetch the children. I found many people sick during the monsoon. Althogh they were suffering from simple ailments they were going to the doctors and taking injections. Doctors were coming from outside and knew how to take advantage of this situation; they collected and lot of money from the population for this. I thought: let us do something about these minor ailments, through health education. Then I volunteered to become a health animator
>
> Private doctors do not give information on about diseases, they just give medicines. They come to our villages only to raise money from the population. I started telling people thus and trying to convince them. Six women came together and, through the Association, we requested Dr. Phadke to come and impart health education. The doctor used to come twice a month in the beginning and gave us information about the children's and women's health. We were getting Rs 50 as honorarium.
>
> In the beginning, women called me names. But, later on, opposition become less. People trusted the information that we were giving them and followed our prescriptions. Similarly, they could observe by themselves how the government doctors functioned.
>
> When I had to go and attend a meeting (training camp) and spend one night outside, my husband would object. "Who will look after our daughter who has reached the age of marriage? The younger children are going to school: who would look after them?"
>
> I have now after three year accepted the job of becaning health worker of the government so that the health education that I received during these years is not wasted. They organise only one meeting per month. When VCDA stopped giving the Rs 50 honorarium for the health work, my husband became completely opposed to my participation in these activities. This is the reason I accepted government work. And I continued this health activity with the same motivations that I got from VCDA training
>
> With the government we do not have the freedom to function as we think right; we have to do the work only in a very particular way. Although I have accepted the work of the government I like to attend the meetings and the camps for women of the VCDA. My experience with the government is very different. People get absolutely no health education from them. Only one thing matters: to distribute pills, and to keep monthly records. This is what the health officers consider good and important health work.
>
> Still, one should be able to study as we were doing which questions the women should think over and take up. For instance, women started a movement for clean drinking water, as a result of that education.

The second testimony is the account of the difficulties faced at the start by the group of HAs from Panshet whose level of deprivation makes difficulties more acute. 1) The first crucial question was a doubt about one's own ability to follow the teaching of the doctor. "We shall not be able to learn and study." We were not educated: "We did not know anything about health, dispensary, medicines..." There was no conviction of one's ability to repeat correctly the lessons of the doctor. None of the HAs had ever previously attended any meeting or expressed himself in a group. "For three months I just kept silent in the meetings!"

"We did not realise that we were human beings, as much as any one else. We did not know anything about government officers... We were only busy with our house, fields

and cattle. Where is the government? How to go and meet them? We did not have any idea about it. We had no idea that we had also rights. HAs were requested to commit themselves to assume a social role when they had hardly a clear consciousness of their own identity of social beings.

No wonder this generates a strong feeling of self-diffidence. "I am afraid that people will not come and attend our meetings, nor listen to us." Still, "I am convinced that going out to attend meetings, I shall learn something. How long should we continue to submit and surrender to the leaders?"

Going alone from house to house to give information about health was seen as a great difficulty by some. Some felt it was easier to impart health education in a meeting, with a group, when people are assembled together, because there can be exchanges and discussions, and those who understand can help others to learn.

There was the reluctance to listen to women: "They cannot even behave themselves in the society and look after themselves! How should they come and teach us! Men teased the female HAs, especially after having had their drink, "We shall, all of us, now, become doctors!" "Why make everyone a doctor also like you!"

The pressure of the authority of elders especially upon women makes these latter still more shy and inhibited to undertake something new and unusual. Men complain against women that they attend meetings and report there about the drunkards of the village and all their stupid and bad behaviour, and first of all about their insults against the HAs. The pressure of the more influential male leaders was and remains a serious difficulty for the women who volunteer or would like to volunteer.

The countter propaganda objected that outsiders had come and trained HAs who immediately listen to them and follow them, falling a prey to them. "We should only look after our fields, eat peacefully our pancakes of millet. Women should just go to the fields or to the forest for their tasks, earn a few rupees for the house; this is better than attending meeting and roaming about, everywhere, doing nothing, whiling the time in useless activities which do not yield any income. What will you get (money) from this work? What will these people give you?" Aren't they already 'social workers' in our village? (leaders who are supposed to care for the welfare of the community). Local leaders do often call women names because they follow people from outside instead of going to work to bring home a few rupees, listening only to them and keeping a submissive attitude towards them.

Another type of counter-propaganda says: "What did you obtain and what did you give us after three years?" The understanding behind the objection is that the organisation should immediately bring in some material improvements to show its credentials, to the population, free of charge and without any effort on their part. The reason motivating the objection is also that the organisation "of the poor of the mountain" is approaching directly the administration and demanding the implementation of the government schemes for the benefits of the needy, independently of the local leaders who have a vested interest in the poor depending upon them.

HAs insist upon the reactions of the local leaders who see in the HAs and in the organisation a direct challenge to their authority. "They are not Dhanagars (in one area, many HAs were from this caste), they are foreigners: they come to collect girls and send them abroad where there is a want of girls. One should not vote for them. If they can get four votes, we can still have ten of them... Listen to the head-men of the village. This is not proper. Our women should not talk with men from outside!" "The HAs get plenty of money: this is the reason why they roam about". "They get medicines free of charge and take money from us!" As expected, the same leaders make capital of caste feelings to object to the fact that HAs of different castes assemble together, and do not listen to the caste elders.

A few drunkards come to disturb the meetings, teasing, shouting, raising their voices with the result that people cannot express freely their difficulties, despite their genuine desire to do so. In the beginning we did not know how to handle these trouble makers".

Dynamics of Self-Assertion

The interviews of the new-comers—all women who happen to join the existing groups of HAs reveal the following processes:

1)Personal acquaintanees and a prolonged time of "wait and see" attitude preceded any decision. The example and the concrete testimony of some one else are necessary as a preliminary step.

2) A clear invitation to join was made, not to elicit a purely individual move but a commitment to participate in a collective effort.

3) The initial step were met with laughter, counter-propaganda, lack of appreciation on the part of the population.

4) The decision to join was personal and motivated by a will to achieve something and dedicate oneself to a task whose relevance was understood.

5) This understanding increaseed the strength of the personal motivation and developed progressively a wider and realistic social consciousness.

6) The motivation takes momentum, against objections, out of one's own effective commitment to tasks which are experienced as beneficial. Action generates self-assertion.

7) The group proves to be the best support for the personal efforts and commitment: A small group of like-minded people is the essential structural factor.

8) The elements of general personality development (self assertion, ability to express oneself and talk in front of a group, capability to understand a knowledge considered as difficult, etc,...) work as an encouragement.

9) When money is seen as the main motivating factor, no effective health animation can be sustained. Monetary compensation may not go against a real interest in health and health education, but once such an interest is maintained by monetary incentive only, we cannot expect it to develop into a social concern and commitment for health animation and community organisation on health issues.

Antagonistic Perceptions and Conflicting Practices

HAs wished to co-operate with the government health services rather than compete with them. A voluntary scheme is no substitute to public health sevices. The several attempts made by VCDA to operate jointly with the government services met with only a little success. As our concern here is with the local socio-cultural processes, we shall consider only the psycho-sociological dynamics obtaining between HAs and PHC personnel rather than the possible forms of co-operation. Let us give due attention to the perceptions of HAs concerning the behaviour and the attitudes of the government personnel, as articulated in health seminars by HAs.

1. Government doctors are to be seen at the taluka centre and in the villages only in the specific plaees where commodities and facilities are available. Government doctors will always be seen in the company of a limited, restricted and specific category of people: with the sarpanch, the patil, the teachers, and sometimes the talathi and the kotwal. Their social place is with the leaders, the rich, the notables, "with those who talk". They will behave with them with civility. They will be attentive and considerate with the established notables and leaders. They will be seen in their home places. They will accomodate them immediately when these latter come to meet tham and they will attend to them without delay, and show them small courtseys. The government accordingly behave also as local leaders.

2. The attitudes which motivate their way of talking and their behaviour lead them to make a show of their superiority and importance. Their arrogance is resented by the people; they do not let others talk and express themselves. They speak fast and loudly over the voice of others as to frighten the people. Their manners show that others are not worth attention, being all ignorant people. "They consider the poor as stupid and childish". With the poor, they are, insulting and offending their feelings; they do not give answer if poor people ask questions.

3. A few features characterise their language and ways of addressing the common people. They often use words (some special or English words) that people cannot understand, with the purpose of not being understood. This language shows their superiority and "if we ask, we are left with the following answer: "You are ignorant! What can you understand! Don't you have confidence in me?... I told you once, I shall not repeat... and so on they simply do not care for whether we understand or not: nor why we cannot understand.

A second feature consists in not giving information about any disease: they would just hand over medicines. They never impart nor show any readiness to impart knowledge about health and disease. Mainly concerned with cases of family planning, they do not give due attention to the sick. Expectations regarding money are another main feature of their behaviour. The question may often be raised, from the start. If there is no money, the patient may be sent back or adviced to come later, or another day... Money and injections are two main aspects of the doctors' behaviour.

The doctors would also easily entrench themselves behind the laws and rules of the government. They do not appear as responsible towards the population; they are not answerable to the people.

These frustrations and clashes with regard to the medical practices of the government personnel lead to conclusions already often drawn but naturally stressed by HAs in their analysis.

1) The doctor's services are alien to the needs themselves. "Our main expectations is that the government doctors reach us, the poor, who need them. They don't. They never come to the houses of the rural poor". "We don't know what the word nurse mean. If it a thing to be eaten, or an animal?" "We asked the PHC officer to send us a nurse: he just promises but nobody has ever come". Once, at Sakhari, thanks to the firm insistance of HAs, doctors came and HAs helped them to vaccinate the children. HAs motivated and assembled the people. Then the doctors promised to come to another village, Dudhavan, under the pressure of the HAs. But they never did. The false promises of doctors to the HAs are a permanent matter of tension, diffidence and disgust about the government health care system, and its personnel. Another area of tension is the insistance of the government personnel that HAs should bring to them women for being sterilised. The government CHV are supposed to do it, why should the HAs not give priority to this too? HAs answer:

Chart

We HAs	The Government Health Personnel
— We go and visit the poor at home	— They enter only in the house of important people
— We arrange for few cheap and good medicines being supplied to people	— They give importance to medicines
— We give priority to the people	— They give importance to money
—We educate people	— They just distribute medicines
— We look at the patient and give the appropriate medicine	— They don't give all the medicines required to cure the patient
— We think of the whole environment and situation	— They don't bother for the whole environment
— We select HAs taking into account the ideas of the people	— They make private choices
— We organise people for collecting action on health problem	— They don't try to assemble the people
— We promote health consciousness	- They don't bother about health awareness
— Health is a public issue and a political question	— Health is a private problem to be solved by doctors

"You don't give any protection to our childre. Four live and four die. First come and attend to our children, save them and we shall bring you plenty of cases. Otherwise, why should we undergo operations?"

2) The health system is not directed towards the people. Those HAs who were absorbed in the government scheme: "During the training meeting organised by the government every month, doctors and their CHV pretend that doctors are ready to go anywhere. If HAs protest that they have never seen them, that doctors make promises which they never keep... Government doctors and their CHVs look down upon us, repress us as women who talk too much and had better shut up in front of them! When we asked the doctors: "Why do you take money from people, regularly, although you are paid by the government?", doctors reply angrily: "Why don't you take money yourself also from the people?" Doctors insisted and added, addressing a *dai* "before doing any delivery, you must first ask for money from the people". Doctors advise their CHV: "You had better stay at home. Do not visit houses." We, HAs, tell the people: "Go and see the CHV of the government." People reply: "They do nothing. They do not inform us. They do not come and attend us. They tell us nothing, they just give a pill". We tell people: "It is your right to go and meet them and avail from them their services. It is a government service." People reply: "We prefer to come and see you. No improvement is gained from them. They are of no use". Doctors tell us: "You want conflict... You organise demonstrations... We shall also organise such demonstrations... You cannot even sign your name and you immediately strongly reply and object to what we say!"

3) The selection of CHV serves vested interests. In Panshet area, when the CHV scheme started, HAs insisted that women should also be taken, and not only men, and even illiterate women. Some were appointed but no further co-operation could materialise in other places, despite the readiness of the HAs to help goverment officers in the selection and implementation of the scheme.

Conclusion

Strategies of "Health For All" will prove effective when we succeed in translating them into alternative social practices of "Health by the People". The chart on p 50 is an attempt made by HAs of VCDA, on the basis of their experience, to define antithetically, these alternative health practices required as a foundation of a people's health movement among rural marginalised population.

In view of the magnitude of countervailing forces, there is little likelihood of such alternative health practices gaining *on their own* a significantly large and lasting momentum unless (1) they are locally part and parcel of an appropriate wider peasant movement putting out similar roots, (2) externally backed by and related to, other branches and forces of the national health movement and (3) internally born by a permanent self-learning exercise addressing the anthropological, socio-cultural and ideological dimensions of the primary health issues. For lack of space, we did not deal here with these pedagogical, anthropological and ideological components as essential to any effort towards health by the people.

References

Alma Ata 1978: Primary Health Care. Report of the International Conference on Primary Health Care, Alma Ata USSR, WHO-11978.

Bose A and Desai P B, *Studies in Social Dynamics of Primary Health Care,* Hindustan Publishing Corporation, New Delhi, 1983.

Djurfeldt, Goran and Lindberg, *Pills Against Poverty,* London, Curzon, 1975.

Health for All: An Alternative Strategy, Report of a Study Group set up jointly by ICSSR and ICMR, Indian Institute of Education, Pune, 1981.

Jobert B: La Participation populaire au development sanitaire: le cas des volontaires de la sante en Inde, *Revue Tiers Monde,* t XXIII, 91; Juillet-Septembre 1982, Paris.

Poitevin G and con der Weid D, *Roots of a Peasant Movement,* Shubhada-Saraswat Publications Private Ltd, Pune, 1981.

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Immunisation as Populism

A Report

asha vohuman

A mass polio immunisation campaign was launched in Maharashtra in May 1983 with much fanfare. The 'war on polio' was meticulously planned and 6,000 volunteers mobilised, the All India Institute of Physical Medicine and Rehabilitation acting as medical advisers. By the end of July two-thirds of the slum colonies were supposed to have been covered. The article takes a closer look at the campaign and discovers shocking lapses. The campaign it is pointed out, was merely a gimmick created to aid and abet the then health minister's political ambitions.

THE use of health in populist politics is as old as the Emperor Ashoka. But it is difficult to find as blatant an example as the mass Polio Immunisation Campaign launched in May, 1983, by the then health minister of Maharashtra whose "War on Polio" campaign warrants close study for its sheer ambitiousness, and its unabashed use of a health intervention to achieve a tawdry political end.

Before one describes the programme or rather, "campaign", it is vital to understand the motivating factors behind it. The appointment of this particular health minister had been violently opposed even from within her own ruling party ranks. Within weeks of her appointment, there were several moves to oust her for "incompetence" and being for "an embarassment to the cabinet". The Chief Minister apparently warned her that she had to do something to effectively silence her opponents or he would have no choice but to replace her. Evidently, a considerable part of the furore over her appointment was caused by communal factors, since the health minister was a South Indian by birth (though domiciled in Maharashtra for over 30 years) and her Bombay constitutency was also predominantly South India. Yet another source of political pressure on the minister was the falling popularity of her party especially among the poor, who had, in the previous elections, voted largely for Opposition candidates.

Thus it was that the beleaguered health minister had to find a quick means of securing her own position in the Cabinet as well as improve the party image among the City's poor and a means which was within the confines of her portfolio. She hit upon the idea of the "War Against Polio" as the proverbial stone which would kill both birds. We shall see why this was a brilliant choice.

Consider first of all how beautifully polio immunisation in a image compaign fits the bill:
When asked "Why polio?" the health minister reportedly said. "other vaccines like triple, the child gets fever. The parents are upset and don't bring the child back for second dose. Also, these reactions would be used by our opponents to spread fear and make the compaign fail. With polio doses, we were confident that this would not happen."

"I had to have a programme which would take my party workers into the slums, doing a good community service, to improve the image of the party among the poor."

"Another thing—anyone could give polio (sic) because it need not be injected. So with polio, I need not depend on medical people to help me. I could use our party people and volunteers".

Several observers of the programme commented on how candid the health minister was, privately, about her political ends. She did not bring in unnecessary rhetoric about which rationale was reserved for public consumption: such as one of the printed "public appeals" which said; "Of all these diseases, polio is the most dreadful... (it) not only causes death but also produces permanent disabilities of varying degrees, which not only makes the life of the children and parents miserable but also burdens... Society. This problem is more acutely felt in the case of female children due to the problem of difficulty in marriages..."

"...There is no specific treatment for this disease, that is why it is extremely important to protect every child by immunisation as early as possible".

Having chosen her medico-political weapon in March 1983, the health minister planned the war with a meticulousness which would do credit to a Field Marshal. It was decided to launch the campaign on May 1, Maharashtra Day, (ironically, Labour day as well) with maximum fanfare. The planners then worked backwards, systematically plotting and preparing each step.

With 30 years' experience as a family physician the minister knew that if the cafeteria approach would work immunisation would have to be taken to the dorrstep of every eligible family. Existing health manpower in the city was not touched overtly because their routine duties should not suffer, but actually because they were unlikely to cooperate and even if they did, it would not ensure that the credit went to the minister's party and party workers.

Thus a broad spectrum of organisations and institutions were approached—colleges and schools (whose students were promised extra marks in return for their participation), "social organisations" (which were by and large communal and caste groups interested in "public service"), clubs like the Lions, Rotary, and Giants, political parties, and associations of the medical fraternity like the IMA. The Directorate of Health Services and the Bombay Municipal Corporation was asked to provide support services in the form of vehicles vaccines and equipment but were otherwise kept on the periphery. The All India Institute of Physical Medicine and Rehabilitation (AIIPMR) acted as medical advisors to the programme. Even the Bombay Restaurant and Hotel Owners' Association was approached to provide cold-storage facilities and ice to immunisation teams to maintain the cold chain at the field level. Within a month, not a single source of help and support was left untapped. By May 1, some 6000 volunteers were standing by.

Meanwhile, the problem of identifying the target areas and members was taken up. In consultation with the AIIPMR, it was decided that the campaign should aim to cover only 0-5 years old living in slums with 3 doses of vaccine. To

determine exactly where and how many, the polio-endemic identified in a survey conducted by the AIIPMR in 1981 were superimposed on ward-wise maps of the city. Teams of student volunteers accompanied by party workers then fanned out into these areas to survey the number of unimmunised under-5's and within weeks delivered the target figure: 1,00,000 children. This enabled the organisers to promptly obtain adequate supplies of the vaccine from the Haffkine Institute.

The campaign plan was now further elaborated and entrustead to a team of 'campaign managers' each with a specific set of responsibilities: e g, manager-volunteers (enlistment, deployment, supervision); manager-vaccines (cold chain maintenance, supply, distribution); manager-publicity (printing, media, etc), manager-transport (commandeering, co-ordination, deployment), etc, etc. Each campaign manager was a trusted party lieutenant of the minister's, personally loyal to her. In addition, a "Ward Chief" (again a trusted party worker) was appointed to co-ordinate and supervise all activities at the ward level.

Publicity came next. By early April, thousands of poster, banners and hand bills were flooding the target areas. Party workers addressed hundreds of local public meetings to spread awareness of the campaign and to enlist more volunteers. But the minister's coup-de-etat was undoubtedly her "padayatra" through the slums accompanied by polio-affected children. In each locality, the crippled child was made to address the people, appealing to them to immunise their children and prevent them suffering a similar fate.

Simultaneously, immunisation cards were printed in thousands to be filled in by the vaccinators and handed over to the parents as a record, to ensure completion of the doses and prevent double immunisation of the same child.

The problem of supplying thousands of flasks to the immunisation teams was solved by asking the volunteers to bring their own flasks. Hotels and restaurants near each target area were alerted a day before to kep supplies of ice ready for the teams. The vials were themselves deployed to there focal points the day before and kept in their deep freesers.

An intelligence system was also set up to achieve an efficient, up-to-the-minute flow of information regarding immunisations performed (area-wise, dose-wise), vaccine supply, member of volunteers and their deployment; and the transport position. The campaign would start on the first Sunday of every month (to enable the maximum member of volunteers to participate) with mop-up operations for each dose on the following Sunday.

This is only the bare bones of the campaign's organisation, since a detailed description would take up a book. But it is clear that little was left to chance of accident—far too much was at stake, politically, for any risks to be taken. One observer records that the team-spirit and hardwork put in by the minister, managers and wardchiefs was most impressive; but also very aggressive, as if daring anyone to criticise or better their efforts.

The "War Against Polio" began on May 1, 1983, with the then Governor of Maharashtra symbolically immunising the first child from a central city slum at 8 am. By 7 pm some 70,000 immunisations had been performed, or 70 per cent of the target figure. The second round was conducted on June 5, with 85,000 doses being administered—60,000 second doses and 25,000 first doses. By end of July, a total of 1,35,000 0-5 years old had received first doses, 50,000 had received two doses, and 85,000 children had received all three doses. Two-thirds of all slum colonies in the city were supposed to have been covered under the campaign. This, of course, is the Gospel according to the health minister's cohorts, and is quite open to interpretation, as we shall see.

Having understood the motivations for the campaign, and the plan of action, we can now take a closer look at what actually happened.

As pointed out earlier, virtually none of the considerable health resources directly under the health minister's command were utilised in the campaign. The role of the state Directors of Health Services, for instance, was limited to ensuring supplies of vaccines and vehicles for transport (though the latter were apparently withdrawn by the Directorate after the first round), printing the publicity material and forms, and "arranging" meetings (though not attending them). One Assistant Director of Health Services is reported to have said: "This is another political tamasha. We are here always; we have to serve the people and face them throughout. These people come and go, so they have to make a tamasha while they are in power". He was also bitter that the Directorate had been ignored entirely because the campaign organisers wanted none of the credit to accrue to anyone else.

Notwithstanding this, a sizeable number of public health service doctors and officers actively participated in the campaign in their personal capacities. They were frankly seeking political favours by associating themselves with the campaign. One municipal health officer apparently absented himself from his normal duties for the duration of the campaign, knowing his superiors could not touch him without risking political retribution.

As for the much-proclaimed involvement of "voluntary organisations", they were conspicuous by their absense. Not a single secular or progressive grassroots agency working in the slums was approached to assist the campaign, despite their initimate knowledge of the local people and their extensive networks. The health minister was dismissive about this, telling an observer "They have done nothing all these years. If they had, we would not have to do this now". An aide was evidently more blunt: "We approached mainly the South India social organisations; we ourselves being South Indian; we felt that they would give a better response. The North Indian organisations we approached did not take much interest. But on the whole, very few of these organisations have done very much... That is why we are relying mostly on our own party workers." In response to why they did not involve grassroots agencies working in slums, the same aide reportedly said, "Why should we ask them? We wanted to show what (our) party could give the people—and have succeeded. Why should someone else take the credit? Can they run the country?" The defence rests.

The poor involvement of medical organisations, particularly IMA members, was interesting. This was apparently because several leading paediatricians advised the health minister not to launch the campaign in May, since epidemiologically this is a peak period for poliomyelitis. Mass immunisation at this time could, in their opinion, actually

increase the incidence of the disease. Other members sheered at the whole campaign as a political tamasha with which they had no wish to associate. The organisers, however, ascribed a different motive to the attitude of the private practitioners: that they couldn't care less about the slum dwellers.

Let us now turn from the medical fraternity to the legion of volunteers (mostly college students) mobilised into vaccination teams. These were the "front-line" of the campaign and therefore vital to this success. It is shocking in the extreme therefore that a campaign in which so much detailed planning and preparation went into every aspect, no one bothered about training the volunteers for their tasks.

On the morning of each of the campaign days, hundreds of student volunteers would be milling around the health minister's residence, without a clue as to why or what they were there for. The majority did not know, until they were actually taken to the sites, that they were to perform immunisations, much less which vaccine was involved. To ask if they were aware of polio, and the concept and importance of the cold chain, was an exercise in futility. One journalist got the following response from scores of students when he asked them if they knew what they were going to do that day: "They said they would explain everything when we reached the place. They haven't told us anything. The college also said these people would tell us what to do".

One eye-witness reported that the entire gamut of information to the volunteers—from maintenance of the cold chain ("Keep the vial in the flask. After you open it keep it in the saucer with ice"), how to measure and administer each dose, what questions to ask the parents, and some contra-indications—was packed into a five-minute lecture at the entrance to the slum, before the teams were give their vials and told to fan out. The claim made by the organisers that each team was accompanied by a doctor, nurse, medical student or student nurse was more fantasy then reality.

Qualified observers who accompanied the teams were horrified at the repeated breaks in the cold chain, and the administration of the vaccine to children with several contra-indications. For example, unopened vials of the vaccine were carried in handbags (not in flasks) for hours together in 38° C temperature (May being the hottest month of the year); opened vials were exposed to sunlight for nearly an hour, with all the ice around it melted away, and then the same vial used to "immunise" more children; infants with coughs, colds, diarrohoeas were immunised; infants were breast-fed within seconds of swallowing the vaccine. This bizarre scenario was compounded by the fact that the same volunteers were rarely present at the next round of the programme. The high turnover of volunteers ensured that each round was as bad as the previous one. No one thought it worthwhile to train these volunteers in even basic procedures to ensure cold-chain maintenance and effective immunisation. But then, this was not really the objective of the exercise.

The real objective of the campaign was well achieved, in the words of one aide: "Our party workers are acompanying every vaccination team to tell the people that this service is coming from the (name of the party). I am confident that in the next election, these sections will vote for our...candidate—these slums will be behind our party from now on". One consultant observing the programme confirmed this: "In two slums I visited, I asked whether polio vaccine had been provided by the government. The answer was "No, not by government—by party".

Let us now examine the role played by the medical advisory institution which was assisting the campaign as their technical watchdogs. Far from watching, they followed a "see-hear-speak no evil" policy which destroyed any chance of this politically-motivated campaign achieving some social good. Either the Director of the Institute or a senior associate was present on all the campaign days. But while they admitted their fears about the programme in private, they were far too intimidated by the presence of political power to do so publicity, not even directly to the health minister and her aides. They simply joined the ranks of yes-men surrounding any politician—rendering the Hippocratic oath into a hypocritical one.

What about the people themselves? If reports of the campaign are to be believed, they were far too wise to reject any gratuitous offering, even though few knew what it was. The vast majority of mothers when asked, had no idea that their children had received a vaccine against polio, thinking it was against tuberculosis, measles, smallpox, or tetanus-but none refused. This was simply because in most slums, no one had actually seen a polio-affected child (except in the padayatra) and those who had could not see the connection between the physical disability of a 7 year-old and the pink drops given to the 7-month-old. This is not surprising in view of the fact that the AIIPHR survey itself had found the incidence of poliomyelities to be highest in the lower middle class group and not among slum dwellers. The publicity campaign which the organisers had designed to "create an awareness" was clearly aimed at an awareness of things other than the causes, symptoms, effects and prevention of polio.

As for actual coverage, there was considerable evidence that the elaborate system worked out by the organisers for "initial attack" and "mop-up" phases broke down rapidly under the sheer weight of the tamasha being enacted upon it: entire pockets of "target" slums had not been touched—the teams had covered the peripheries and left; more often, people complained that one round had been completed with the promise to return next month, and the teams were never seen again; in other areas, two rounds had been done before the disappearing act; in some of the poorest areas, cynical parents told a visiting observer "May be them came-may be they didn't. How do we know? Why should we care?".

Consequently, experts who closely monitored the campaign feel that not more than 25 per cent of target children actually received three doses of vaccine, and that under the prevailing conditions, only about half of these were effectively protected against polio.

However high our eyebrows rise, the fact that the health minister retained her place in the cabinet—for the duration of that particular ministry, at any rate—is now history. Heady with the "success" of the "War Against Polio", she quickly abandoned the campaign to her lieutenants to complete as best they could, and moved on to new pastures: *viz*, a "War Against Leprosy". But for the battle-weary poor, one question remains: Will the wars against them ever cease?

Asha Vohuman
C/o Radical Journal of Health

Programming Reproduction?
Maternal Health Services

manisha gupte

In the absence of a basic questioning of women's status and role in society, birth control, abortions and even maternal health care end up merely replacing an old set of traditions with new ones. Do maternal and child health services as they exist today have the potential to emancipate or to further bind a woman to her traditional role albeit in subtler ways? The article contends that the entire primary health programme reflects social attitudes towards women, viewing them primarily as mothers or as potential mothers.

IT is no more a disputed fact that working class women participate in production with men and that like the latter are alienated from the means of production. What makes their position still worse is that women participate more actively in reproduction than men do and yet unfortunately the former are alienated from the means of reproduction as well. Juliet Mitchell argues that as in capitalist production the social product is confiscated by capital, so is the child snatched away from a woman (Mitchell, 1966). Not strictly speaking, perhaps so. In patriarchial society, the child, a result of physiological and emotional interaction is seen as property, and male property at that. Concepts of illegitimacy and patriarchial lineage are examples. A child, created so actively by a woman, grows up in a capitalist and sexist milieu, and alienation occurs through the conditioning and values that she or he absorbs since infancy. Physical alienation does not usually occur because both women and children are conditioned socially not to question or to rebel inside the family. When women do so, physical alienation too does occur in the form of custody in divorce, since custody is more often than not in favour of the male.

The changing role of the family further determines the newer roles that a woman performs within and outside the family. The institution of marriage too on the exterior becomes rather destabilised, say for example through a divorce or through voluntary rejection of marriage by a sexually involved couple. However, the psychological and sociological functions and grip of the family remains the same—it creates the 'masculine' and the 'feminine', resulting in a 'man's world' and a 'woman's world'. It also conditions the newly born infant to accept and appreciate the 'security and stability' that the bourgeois family has to offer.

The prescribed role model of the husband-wife-child determines and influences the roles that men and women perform within and outside the family. As a vivid example, one may quote the doctor-nurse-patient relationship being analogous to the earlier mentioned hierarchal familial triangle. Looking deeper, these role models by virtue of their predecided status determine the extent of food, health facilities, education and employment opportunities that men and women will receive in relation to each other. Therefore, even though women do enter the production force with vigour and compulsion, they inevitably land up doing jobs that are qualitatively and thus economically inferior to those performed by men.

The wage system continues to be structured according to the assumption that a woman's wage is only supplementary. Women are thus seen as economic attachments to men, not as free labourers who participate equally (Rowbotham, 1973). Women are thus financially compelled to stay with their men even in the face of unmasked oppression. Separation and consequently living single or with the children and without a man, often means a drastic drop in the standard of living for women, if not abject impoverishment.

With enforced backwardness, it is also easy to push women out of the labour force more easily than it is to push men out, be it due to automation, unemployment or the omnipresent and omnipotent reproductive duties. Women thus become a reserve army which will work at half pay and who will be reabsorbed by the family if there is unemployment (Rowbotham, 1973). Underpaid outdoor work, invisible domestic labour and conjugal duties therefore leave a woman vulnerable to be doubly exploited. Unfortunately, though the condition of working class women is ideal for the creation of a powerful political force, their realisation of exploitation dissipates instead of being sharpened. The shunting from reproduction to production and back to reproduction acts as a safety valve to smoothen conflict.

The changing role of the family also determines the reproductive potential of the woman. The family in turn is governed by historical inevitability, market compulsions and often by the prevailing political will where reproduction is concerned. In peasant households with considerable landholdings it might be desirable to have as many extra pairs of hands as possible; similar may be the case in not so advanced capitalism, where the quantity of workers needs to be maintained at a high level so that their exploitation through underpayment is possible. With the decline of labour-intensive industry and with the emergence of capital-intensive industrialisation however, the main economic task of the family would no longer be to produce a large number of children, since then quality rather than quantity would be important in the labour market (Morton Peggy, quoted in Mitchell, 1966). The family adapts itself accordingly, and in turn monitors the reproductive ability of the woman to suit the requirements of the contemporary wage market.

The woman in question therefore, is only seemingly liberated to become a wage earner. In truth, however she holds no real power in either structure; in fact forces that are alien, incomprehensible and beyond her control monitor her, both inside and outside the family. In the existing context, birth control, abortions or even good maternal health care, in the absence of the basic questioning of a woman's role in society, end up merely replacing an old set of traditions with new ones. Not only does the woman perform the necessary functions that the traditional orthodox set up demands from her, but she also faces the 'consequence' of being the modern, sexually liberated bohemian woman.

It is in the light of this framework that we have to view

the ideology of maternal and child health (MCH) services; whether they do liberate a woman even marginally, say from the risk of maternal and child mortality, whether a healthy pregnancy and childbirth coupled with birth spacing gives her more choice and more control over her body or whether the existing MCH programme in form and in content, ends up merely making her a more healthy and well programmed baby making machine. In short, whether MCH as it exists today has the potential to emancipate or to further bind a woman to her traditional role, albeit in subtler ways, calls for examination.

MCH: Sexist Bias in Planning

In a patriarchial world, it is no great surprise that male hegemony would exist in all aspects of health care—at the policy level, at the implementation stage and throughout the delivery of this care. Women as a group therefore have to receive health care that is designed in their own favour. Effective health care, provided free of cost and which is accessible to all, especially to women during pregnancy, delivery and the post partum period should be considered a fundamental right. We must fight to see that no woman or child is at the risk of dying, especially during those crucial months. But we must also emphasise that mere MCH will not do. Motherhood is only one of the roles that a woman may voluntarily wish to perform during her lifetime. She may accept it or reject it and in spite of opting out of motherhood or marriage she is a full human being. Health services must be available to women irrespective of their childbearing role.

The entire primary health programme reflects social attitudes towards women, viewing them primarily as mothers or as potential mothers; in fact health services for women have been termed as MCH services (ICSSR/ICMR, 1981). The same report notes that there is positive evidence to conclude that the health status of Indian women has declined over the past thirty five years in spite of improved MCH programmes, mainly due to the fact that women are more 'at risk' nutritionally and yet that they utilise health services less than men do. They are of interest to the health services only when they conceive or when they have reached the upper limit of child bearing permitted by the government's family planning (FP) programme.

The infant mortality rates too are highly unflattering (114 per 1000 live births in 1980 as compared to 129 in 1971) and there has been no appreciable improvement in the nutritional level of children, in spite of programmes directed towards them, neither has primary education become universal.

To shift resources towards women as a group, it is necessary for policy makers to be firstly convinced that women contribute greatly towards world production—within the family, in the agricultural sector, in traditional as well as modern sector industries and also in commerce. An estimate of 18-30 per cent of the world's families are solely supported by women, while in many others the woman's financial contribution is a substantial component (Wayne, 1985). Statistics unfortunately miss family and informal sector activities, resulting in this contribution to the overlooked. Within the health care system, factors that contribute towards women's ill health are not considered—their socio-economic status, total workload, the daily and seasonal pattern of activity, access to health care and so on. Neither are problems which affect women more severely, such as malnourishment, anaemia and occupational hazards, or those which affect women specifically, such as abortion or spouse abuse considered (ibid).

MCH activities, in an informal manner, began in India around the turn of the nineteenth century: mostly voluntary efforts ranging from enrolling women students in medical colleges to training of midwives and Lady Health Visitors. The first transition of the official control over voluntary direction in MCH came in 1938. In 1953, following the introduction of training courses for Auxiliary Nurse Midwives (ANMs) and public health nurses, most voluntary health schools closed down (Sethna, 1978).

The Indian government's official MCH package includes the antenatal, perinatal and postnatal care, the Integrated Child Development Scheme (ICDS), the National Programme for Control of Blindness, the Programme for Control of Diarrhoeal diseases and Family Planning.

There exists undoubtedly a role, however limited, that MCH can play in a woman's and child's life, provided it is universally available and is of high quality. However, in the absence of a woman's control over her own reproduction, a culturally and socially conditioned inability within her to be able to vocalise her gynaecological problems to a health worker, especially male, and the latter's reluctance to bridge the communication gap by demystifying pregnancy, make the MCH a watered down programme, reduced to a mechanical distribution of iron-folic acid tablets, a mindless target oriented approach towards immunisations and endless weighing of children to identify the 'at risk' individuals in an already malnourished population.

The lack of control over one's own body is experienced by many women in the clinic approach to pregnancy and childbirth. Most often, questions that bother a woman deeply remain unasked. The concept that pregnant women should swallow tablets or receive injections for their own benefit without any active partcipation from their own end reveals the ambiguity and myth of 'people's participation' so loftily considered the basis of the Family Welfare programme in India. In fact, passivity is a fundamental feature of the relationship between the providers and users of maternity services (Graham and Oakley, 1981).

Growth charting, accepted so enthusiastically by our health care system is yet another instance of mystification. When less than ten percent of under five children in deprived sections are nutritionally normal, expensive growth monitoring is unnecessary. If 50 per cent of underfives in India (amounting to 55 million children) were to be covered through growth monitoring charts, this activity of weighing and charting alone would require 110,000 workers annually and would incur an expenditure of US $ 27.5 millions for salaries, $ 20.0 million for Salter scales (one per 100 underfives) and additional expenditure for repairs, replacements, maintenance, transport and new growth charts (Gopalan and Chatterjee, 1985).

Such luxurious and unnecessary activity in fact detracts from motivational and educational work which is of primary importance in child health and nutrition programmes

(Srilatha, 1984). In a country with limited resources for child care, a social *group* that faces a high risk of nutritional problems needs to be identified and standard intervention is necessary to *all* their members (Nabarro, 1984).

MCH and Population Control

The scope of the already small package of MCH services is further reduced by making it a screen to achieve family planning targets. There is constant talk of 'integration of MCH and FP' and under this euphemistic slogan, a curriculum for undergraduate students of medicine and interns has been prepared by an expert committee. The training programme has already been adopted by three teaching colleges. In one year, three courses were conducted, which nine teams of twentyseven professors attended (GOI, 1985, p 125).

In the minds of policy makers, MCH figures not as an independent programme but as a means to reduce fertility. The Annual Report (1984-85) of the Ministry of Health and Family Welfare (MHFW) states that 'to reach a couple protection rate (CPR) of 60.0 per cent of eligible couples by 2000 AD, it is essential that the younger group of eligible couples be motivated to accept spacing and the small family norm ... *Moreover, use of spacing methods ... has a significant impact not only on curbing the population growth, but also on the health of the mother and child*' (p 116).

The Ministry's own assessment states that the crude birth rate (CBR) at the end of 1984 should have been 32.6 per 1000 population, whereas actually it was slightly higher—33.6. Whereas 29.4 per cent of couples were 'protected' by the end of 1984 (sterilisations accounted for 23.7 per cent of these), a CPR of 60.0 per cent is desired by the turn of the century. To give the FP programme a boost, especially in backward areas, partial assistance from DANIDA, ODA(UK), UNFPA, USAID and the World Bank has been received to cover 63 districts in 14 states as 'Area Projects' for intensive development of health and family welfare. 'The objectives are reduction of fertility and reduction of maternal and child mortality' (GOI, 1985, p 150).

The government has introduced the concept of Net Reproduction Rate Unity (NRR-1) in its FW programme ... "after considerable experience in this regard (need to control population growth), the country has set before itself the long term demographic goal of achieving NRR unity by 2000 AD, with a birth rate of 21.0, death rate of 9.0 (life expectancy at birth being 64.0 years) and infant mortality rate less than 60.0. In order to achieve this goal, the National FW programme has been and will be strengthened. It is a voluntary programme ..." (GOI, 1985, p 164).

In the context of these new goals set by the Indian government, the stranglehold of FP over MCH can be fully understood. In fact, the first UN Advisory Mission, as early as 1966 had gone as far as to insist that ANMs should be 'relieved from other responsibilities such as MCH and nutrition' so as to concentrate efforts on FP. This mission stated that "This recommendation is reinforced by the fear that the (FP) programme may be otherwise used in some states to expand the much needed and neglected maternal and child welfare services" (UN Advisory Mission, 1966).

The first double-edged tool within the FP programme came in the form of the Medical Termination of Pregnancies (MTP) Act in the early seventies. Regarded by feminists as a much-desired means to control one's fertility, the legalisation of abortions is in itself welcome. However, the government's interest in this legalisation becomes clear when one notes that by the end of March 1984, in all 4,553 institutions were rendering MTP services as compared to 4,170 at the end of March 1983. In Bombay city alone, 50,000 MTPs are registered annually (Karkal, 1984).

The official acceptance of NRR-1 by the government is especially sinister because in lay person's terms it spells that only one daughter should replace her mother. Thus female foeticide through sex determination (amniocentesis, chorionic villi biopsy) or through sex pre-selection (Ericsson, Japanese method) is inbuilt within the government's population control (PC) policy.

The government's emphasis on 'child survival' rings another ominous bell. Welcome in itself, the slogan is reduced to 'spacing methods'. The earlier mentioned Report of the MHFW states that "since child survival is amongst the foremost factors which induce the couple to adopt the two child norm, MCH programme has been given due importance." The strategy becomes clearer when along with the slogan of 'child survival', the government has markedly increased its budget for FP in the Seventh Five Year Plan period and the emphasis will now be on spacing methods for women. It is estimated that by 1990, spacing methods will account for 20.0 per cent of 'protected' couples against the present level of 5.5 per cent. A Contraceptive Marketing Organisation has been registered to promote spacing methods (GOI, 1985; p. 107).

The government now admits that one-third of all IUCDs ever inserted are removed and one fifth are expelled. The officially accepted dropout rate for IUCDs therefore is 53.3 per cent (GOI, 1986). Naturally, the proponents of population control would be desperate to design a centralised and foolproof system that leaves little or no control in the women's hands to withdraw the contraceptive and it is in this context that the importance of injectable contraceptives (ICs) or implants should be understood. Though ICs as yet do not form a part of the FP programme, a Programme-introductory Study on ICs (Net-En) at PHCs attached to 15 medical colleges is underway. Based on the results of this pilot project it is hoped to introduce this spacing method soon. In fact, according to official plans it was to be introduced in 1984-85. The ICMR is also conducting its studies with Norplant—an implant for women. An appropriate version of this contraceptive was to be available by the end of 1985 to start the programme introduction studies at the PHCs (GOI, 1985; p.107).

It has been decided to intitiate a two million corps of women trained to motivate for FP. These corps will be nonpaid and interestingly, acceptors of FP methods themselves. Another significant move by the government in the near future is to disband all male community health volunteers. Through the IUCD programme, it has been learnt that male motivators cannot do the job where spacing methods are concerned. Male health workers have experienced embarrassing consequences while having to explain Copper-T insertions to a woman or to her husband. To close all loopholes therefore women motivators exclusively would approach women-targets henceforth.

Motivation: Distortion of Human Relationships

The state's emphasis on women targets and women motivators is a cause of feminist concern for the distortion of human relations which the coercive, target-oriented campaign brings along. When motivators are women, be they the health staff or primary school teachers, they are constantly threatened with dire consequence such as job transfers, sexual harassment, humiliation and delayed salaries it they fail to fulfil their targets. The dangerous limits are reached when these women are the major or only source of livelihood for their families, when they are single, living in an alien village and are unable to complete targets. Recently, in March 1986, Manda Padwal, a female health functionary (an ANM) in Talasari PHC of Thane district committed suicide after reprimand and order from the doctor in charge to sterilise twenty tribals (Barse, 1986).

These women, with the proverbial sword hanging over their heads, are forced to see every other woman in the village as a potential target. All their conservation, whether at the doorstep or at the village well, invariably ends with motivation for FP. Little surprising therefore that the village women resent these motivators and consider them as scheming nags. The entire fabric of woman-to-woman relationships is eroded in this situation, with each party outsmarting the other whenever possible and harbouring deep rooted resentment mutually.

This distortion of basic human relations and support systems has dangerous political consequences. Sexist bias, international conspiracy and the government's population control policy are responsible for the inhuman family planning campaign. Targets are planned outside the micro-environment in which the masses live. Dangerous contraceptives are dumped by ruthless, profit-hungry multinationals. Yet, all of these are invisible to the rural working class. The only visible oppressor they see is a poor ANM like Manda Padwal; most often the latter being from their own class and a victim of the present system as well. Therefore, the anger directed towards another helpless victim helps the ruling class through a divide and rule strategy. Not only does it break working class solidarity, but it also diverts the issues, allowing the real enemy to escape without confrontation. It makes the rulers seem like paternal and benevolent Caliphs out of the Arabian Nights.

As regards the delivery of health services, the 'integration' of FP with primary health care has in fact had an adverse effect on the utilisation of health care at PHCs. A substantial majority of the rural population utilises the private practitioner in times of illness and the major reason for non-utilisation of government services is the absurd emphasis of the latter on family planning. Women still prefer to be delivered at home by traditional dais or relatives, one reason being that any perinatal or postpartum contact with a woman is immediately seized for target completion in a PHC. Immunisation camps suffer because covertly many such camps are used to gather young mothers for Copper—T insertions.

The overshadow of the population control programme over all other essential public health services is resented by people and results in poor utilisation of all these basic services. It is angering that public health services, especially maternal and child services are used as a bait to lure people towards reducing population growth, without any consideration for the existing socio-economic conditions, the helplessness and the inability of the oppressed sections to rebel. In fact coercion thrives on these very conditions, and it is only a conscious, organised working class that can focus on contradictions, unearth the intricate conspiracies and then demand that the health services be geared in their own favour.

The conspiracy of the ruling class and the inhuman strategies employed by them, often in sugar-coated pills such as maternal and child health or as emancipation through birth control, works to control the lives of already exploited populations. Patriarchy, which has the art of adapting itself to new situations, in fact of moulding new situations to suit its end, prevails in policy making research, medicine and science. Our own demands, be they of safe deliveries, of our children's survival and their well being, or birth control, of abortions and the like are snatched away from us and given back to us blunted and decolourised.

Under the guise of giving us the choice, we are made spectators of our own oppression, be it through dangerous contraception, female foeticide, sex selection, surrogate motherhood or the perpetual tight rope walk where our productive and reproductive duties are concerned. It is therefore, necessary to constantly expose this design and to build a strong women's movement that attacks both class and patriarchial control over the various institutions that govern our lives. We have to relate the personal to the political and should constantly question our role as women within and outside the family.

References

Barse, Sheela: *The Afternoon Despatch and Courier*, April 21, 1986.

Gopalan C and Meera Chatterjee: *Use of growth charts for promoting child nutrition: A Review of Global Experience*, Nutrition Foundation of India, 1985.

Government of India: Ministry of Health and Family Welfare, Annual Report, 1984-85, 1985.

Government of India: Evaluation Report on Family Planning Programme, Planning Commission, p. 173, 1986.

Graham Hilary and Ann Oakley: "Competing ideologies of reproduction: Medical and maternal perspectives on pregnancy" in *Women, Health and Reporduction*, (Ed. Helen Roberts), pp. 50-74, Routledge and Kegan Paul, London, 1981.

Indian Council of Social Science Research (ICSSR) and Indian Council of Medical Research (ICMR): *Health For All: An Alternative Strategy*, pp. 131-140, Ind' ute of Education, 1981.

Karkal, Malini, Personal com. ...on, 1984.

Mitchells Juliet: *Women's Estate*, 1966 (Penguin Books, 1971).

Morton, Peggy: Quoted in above.

Nabarro, David: (1984) Quoted in Gopalan and Chatterjee, 1985.

Rowbotham, Sheila: *Woman's Consciousness, Man's World*, Penguin Books, 1973.

Sethna, N.J.: *Maternal and Child Health Services in India*, All India Institute of Hygiene and Public Health, Calcutta, 1978.

United Nation's Advisory Mission. (1966), Quoted in Banerji Debabar, *Health and Family Planning Services in India*, Lok Paksh, New Delhi, 1985.

V. Srilatha: Nutrition Foundation of India (Mimeograph), 1984.

Wayne, Stinson: *Salubritas*, Vol. 8, No. 2, April-June 1985, (Published by the American PH Association and World Federation of PH Associations).

Manisha Gupte

The Holistic Alternative to Scientific Medicine: History and Analysis

howard s berliner and j warren salmon

The resurgence of the holistic health movement in the US in the 1970s can in part be attributed to increasing consumer dissatisfaction with the present system of medical care delivery. This article traces the rise and decline of modern medicine and the concept of public health by analysing the assumption of hegemony by scientific medicine and its practitioners. Then it describes the challenges that holistic medicine's theories and therapies currently pose to scientific medicine's organisational form and practical content. Holistic medicine is assessed in terms of its organisational and conceptual basis, and the relationship between holistic medicine and the needs of advanced capitalist society is discussed. The article is reprinted in a slightly edited form from the International Journal of Health Services, *10: 1, 1980.*

IN an era of concern over the costs of medical care and disarray in the health-care delivery system, the rise of a countertendency centering on a quest for health deserves attention. A resurgence in the healing arts, manifested through a diverse collection of "holistic health practices," is underway in the United States and Western Europe (1). Movements and theories such as humanistic medicine, transpersonal psychology, parapsychology, folk medicine, herbalism, nutritional therapies, homeopathy, yoga, massage, mediation, and the martial arts have spread widely over the last five years (see for example, reference 2-6). (See also reference 7 and 8).

To grasp the complexity of the emergence of this movement as a social phenomenon today, it is necessary to explore the historical and theoretical dimensions of both the holistic tradition itself as well as the tradition to which it is now in opposition. We begin by describing how the rise of scientific medicine in the late 19th century led to the demise of a prior holistic understanding of health and medicine. Next, we relate the re-emergence of holistic health thought to the broader economic crisis that currently confronts technologically based forms of medicine, as well as to the inability of Western medicine to adequately address the health problems of advanced societies (see refs 9, 10, 11).

Medical Theories and the Rise of Capitalism

In early to mid-19th century Europe, two different theories arose to explain the nature of origin of disease. The first, known as contagionism, postulated that some disease were contagious, spreading via commerce and population migration. the strategic consequence was the quarantine, and the system of quarantine enforcement was intended to shut down commerce and trade to keep disease away from non-infected areas. The second theory, known as anticontagionism, postulated that disease instead resulted from local sources and arouse out of "miasmas" —clouds of rotting matter and filth activated by certain meteorological conditions. The practical outcome of this story was to leave ports and commerce alone, and to eliminate filth and swamps in the disease-laden areas. What makes these previous medical theories of more than marginal interest is their direct association with distinct political perspectives. As Ackerknecht point out (12):

> Contagionism was not a mere theoretical or even medical problem. Contagionism had found its material expression in the quarantines and their bureaucracy, and the whole discussion was thus never a discussion on contagion alone, but always on contagion and quarantines. Quarantines meant, to the rapidly growing class of merchants and industrialists, a source of losses, a limitation to expansion, a weapon of bureaucratic control that it was no longer willing to tolerate, and this class was quite naturally with its press and deputies, its material, moral, and political resources behind those who showed that the scientific foundations of quarantine were naught, and who anyhow were usually sons of this class. Contagionism would, through its associations with the old bureaucratic powers, be suspect to all liberals, trying to reduce state interference to a minimum. Anticontagionists were thus not simply scientists, they were reformers, fighting for the freedom of the individual and commerce against the shackles of despotism and reaction.

The high point of anticontagionism occured just before the political revolutions of 1848. It lost its strength in the wake of the subsequent reaction, while contagionism remained dominant untill its reformation into germ theory in the 1870s.

The leaders of the contagionist movement, primarily high-ranking royal military or naval physicians, were politically unified. The anticontagionists were split between liberals and radicals. Opposing quarantine and state bureaucracy, the liberals favoured sanitary reform by cleaning up filth, purifying drining water, and controlling refuse disposal as solutions to disease eradication. This position attributed disease to a primarily biological condition: the miasma. The radicals instead saw disease (and the miasma) as arising from broader social conditions: the poverty, filth, malnutrition, and oppression bred by nascent capitalism. The liberal position, typified in Britain by Edwin Chadwick's report of 1842, recommended environmental and sanitary reforms that left untouched the production system and its social relations (13-15). On the other hand, the radical position, as typified by Friedrich Engels's *The Condition of the Working Class in England in 1844* (16), fully implicated the developing capitalist system and its class relations for disease, as well as for the class-related incidence and distribution of morbidity (17).

In France and Germany, radical anticontagionists formulated "social medicine", the core of which maintained that resistance to disease was not purely biological but depended on class and social position (18, 19). This orientation implied that the human body could resist or become more susceptible to disease, and that prevention of disease was possible through adjustments or change in the social structure. Thus, in reporting on a typhus epidemic in 1948, Rudolf Virchow, a social medicine physican (and founder of pathology in his later years), called for measures such as free public education, separation of church and state, higher wages, progressive taxation, cultural autonomy for national minorities, agricultural collectives, and full employment (20). With the defeat of the

revolutions of 1848 in Europe, social medicine was virtually obliterated. As the anticontagionists lost power and prestige, contagionism was revived as the leading medical theory.

Nevertheless, anticontagionism had lefts its mark, and the movement of sanitary reform went forward from England to other European countries and America. Between the late 1840s and the 1880s, centralised water supplies, sewage systems, ventilated housing, and improvements in factory construction were all introduced (21). Health standards began to improve. Better transportation between town and country enabled larger quantities of fresh food to reach people. Improved standards of living resulted from successful efforts to gain higher wages and from the general deflation in Europe due to lower production costs (22). Death rates began to plummet. Not ony did sanitary reform improve health status, but it had secondary benefits for capital as well. Centralised water supplies, for instance, removed locational dependence upon rivers, fostering industrialisation. Moreover, water supplies allowed for the design of effective fire-fighting techniques that could reduce the unplanned destruction of capital and lower fire insurance costs. The sanitary movement also assisted in the creation of new industries such as refuse disposal; by the end of the 19th century, trash had become private property—and was collected only when one paid (23). That sanitary reform was controlled by the bourgeoisie meant that it emphasised benefits to capital more than to other social groups. Although far removed from revolutionary class struggles, it was nonetheless progressive.

While the sanitary revolution, as it is called, was proceeding, medical theory was being greatly influenced by technical developments which allowed the visualisation of bacteria. The germ theory of disease emerged in France and Germany during the 1870s and 1880s and became the means for constructing new conceptions of disease and health—conceptions that are still maintained with slight alterations today under the rubric of "scientific medicine."(22)

Germ theory and the theory of specific etiology (single cause of disease) served as the basis for a total transformation of medicine. When germ theory produced its first practical success (vaccines for cholera, rabies, diphtheria, anthrax), popular acclaim mounted. As these discoveries were being made, death rates throughout Europe were falling dramatically, to an extent that was publicly noticeable. Yet, ironically, this decline in death rates was erroneously attributed to germ theory advances, rather than to the sanitary reforms and higher living standards that had actually caused the decline. Studies of death rates for virtually all infectious diseases show them declining precipitously after the introduction of sanitary measures, and well before specific therapeutic interventions occurred (25). Nevertheless, scientific medicine took the credit. The end result was the reification of germ theory, which came to be employed as a total expansion, rather than as a theory that could explain *some* things—but not everything—about disease. Environmental and social factors were no longer considered very relevant to the understanding or causation of disease.

Implications of the Imposition of Germ Theory

Gem theory and the concept of specific etiology were tremendously progressive steps for the development of medicine. Although scientists at the time exaggerated the importance of specific etiology and neglected much previous knowledge about infectious diseases, the importance of these advances cannot be doubted. Germ theory was deeply influenced by the social context in which it developed. The growing strength of the labour movement in Europe, as well as in America, had helped to focus attention on health hazards in the workplace, but germ theory's placement of blame for most sickness and disease on microorganisms served to exculpate industry for responsibility. Scientific medicine, as opposed to the social medicine of the 1840s tended to focus on the biological problems of the individual in order to understand and treat most diseases. The diagnosis of illness was made on an individual basis and treatment or therapy was also individually prescribed.

There are serious problems with this approach, which still dominates contemporary medicine. The physician deals with an individual patient (already a socially determined process) (27). The patient is not an abstract being, but of a certain age, sex, race, and clsss, and has internalised a specific historical experience from childhood to adulthood (28, 29). The taking of a purely medical history individuates the patient; however the disease or injury from which the patient is suffering is received as part of a collective experience in a particular historical, cultural, and social setting. These latter circumstances are as much a part of the cause, and *should be* part of the treatment, as are purely medical facts. (The medical facts themselves are social-historical facts.) Thus the essence of scientific medicine's treatment of disease discourages a proper understanding of disease by excluding from consideration the most relevant internalisation of the external world by the patient. As Wartofsky (30) puts it: "Human ontology cannot be reduced to an asocial or ahistorical biology without doing violence to the very specificity of human biological structure and function itself."

By abstracting disease from its social framework and reducing it to the biological sphere, social conditions could be and were ignored. Scientific medicine became consistent with, and indeed legitimated, capitalist development by integrating a model of healing with the social structure; in so doing, scientific medicine has obscured the relationship between disease and the form of social development. Today heart disease, cancer, and auto accidents are posited as "diseases of civilisation."(31). They are conceived of as necessary consequence of economic growth and industrialism, when it is uncertain that this is so (32).

The greatest decline in the death rate has come from the reduction in infant mortality, attributable mostly to public health measures and not to medical advances. Life expectancy has increased in the United States only when the reduction of infant mortality is included in the statistics—in other words, a man of 60 in 1900 had virtually the same remaining life expectancy as a man of 60 today (33). Despite the fact the expenditures for medical care now constitute almost 10 per cent of the Gross National Product in the United States and are growing at a rate almost twice that of the rest of the economy, it is not at all clear that *health* is improving. Medicine is largely ineffective against the leading causes of death for those under 45 (accident, suicide, and homicide) as well as those over 45 (heart disease, cancer, and stroke) not so much because the biological origin (if any) of these problems is misunderstood as that their social aspects have

been relatively unexplored and unincorprated into medical practice.

Success in finding specific causative agents for infectious diseases led to a particular understanding of causation: the view that a specific biological agent was responsible for a specific disease. This assumption remains at the heart of modern epidemiology, even for the study of chronic diseases.

Epidemiological research, especially after World War II in the United States and Europe, has attempted to link social and economic factors to morbidity and mortality distribution. Social epidemiology, as this type of reserach is called, received emphasis during the War on Poverty programmes of the early 1960s and, at the same time, gave some scientific justification for their inauguration and continuance (34, 35). Studies indicated differences in occurrence, severity, and length of specific illnesses based upon a person's income, race, age, and especially class. While these findings become widely accepted within the discipline of epidemiology, they never had a substantial impact on medical education. (In fact, most health workers, including physicans, are not taught epidemiology.). Yet, just *associating* a relationship between social characterstics, disease incidence, and health status does not fully explain the totality of that relationship. To the extent that social epidemiology was content to remain on a descriptive level, it became merely a form of demography (36). While social epidemiology allows for the use of "multifactorial" explanations for disease occurrence, it still tends to rely upon a notion of specific etiology and sees social and economic factors as contributive rather than causative.

The search for a specific cause tends to preclude a thorough and exact analysis of the particular societal context. This problem can be illustrated by the relation between smoking and lung cancer. While smoking is clearly *related* to lung cancer and people who smoke are far more susceptible, there is no *known* agent transmitted from the cigarette into the lungs which can be said to specifically cause the disease. It cannot be maintained by remaining within acceptable grounds of epidemiological thought that cigarette smoking *causes* cancer, although a high correlation between smoking and lung cancer incidence exists. In other words, where causality is multiple and/or approximate, no firm conclusions can be drawn that are generally acceptable within the scientific community.

If this is true of cigarette smoking, where the effects are relatively apparent, image the difficulty in trying to establish the causative nature of industrial pollutants, occupational chemicals, or excessive noise-all of which clearly fall outside the notion of cause that is accepted by classical epidemiology. Consider the difficulty in firmly establishing the causative nature of specific social, economic or political factors, given these limitations! The methodological emphasis on determining a direct causative link limits the study of many of the more pressing problems of illness in advanced Western society by its reductionist orientation. Moreover, research scientists, as opposed to epidemiologists, often try *not* to think in terms of multiple causation. The following quote (cited in reference 37, p 29) from Lewis Thomas, M.D., president of the Memorial Sloan-Kettering Cancer Center in New York, is indicative:

> It has become something of a popular notion to say that the diseases we are left with, now that we have got rid of the major infections, are in some sense so complicated and so multifactorial, as the term goes, that they have something to do with the stress and pace of modern living—that we can't do anything about them until society itself is remade... I simply can't take that point of view very seriously—not as long as we are as ignorant about the mechanisms of those diseases as we are. We really don't know anything at a dog's level about the mechanism of heart disease, or cancer, or stroke, or rheumatoid arthritis. We can make up stories about them and it could be, I suppose, that they do have multiple causes, and are due to things we can't control in the environment. If that's true—if that should turn out to be true—that would be quite a piece of news. Because it has never happened before. Every disease that we do not know about, and for which we have really settled the issue, so that we can either turn it off, switch if off or prevent it once and for all—every such disease turns out to be a disease in which there is one central mechanism. ... In the case of pneumonia, it's the pneumonococcus, and in the case of tuberculosis, it's the tubercule bacillus, and in pellegra, it's a single vitamin deficiency, and I have a hanch, of course, I can't prove it, that it will turn out to be that way for cancer.

For all the billions that have gone into cancer research, no single etiological agent has been found. But the WHO claims that 80-90 per cent of all cancer is environmental or occupational in origin, hence preventable in some way (38). Although there are constant pronouncemnts on the cause of heart disease (e.g. highfat diet, excessive sodium intake), none appears to be specifically responsible. The most fruitful approach to the control of heart disease may be the alteration of the social environment (i.e. stress reduction) (39). Suicide and homicide are obviously not amenable to biological answers, despite the protestations of the sociobiologists (40).

Therefore, the present understanding of medicine and disease spread is most valuable for infectious diseases—ones that have largely been brought under control in the advanced capitalist world. For diseases that are not infectious, there does not seem to be specific etiology, or a single cure; it is these diseases that constitute most of the morbidity and mortality in the United States.

Popular Disaffection with Scientific Medicine

It is through the study of chronic diseases, the so-called diseases of civilisation, that one confronts the ineffectiveness of scientific medicine. It was not until the discovery of sulpha drugs and antibiotics in the 1930s and 1940s that modern medicine could intervene in the disease process in a specific way with a relatively guaranteed result (excluding surgery, of course). However, this seeming success with infectious disease both increased the expectation of medicine's capabilities and, at the same time, wreaked havoc with the demographic profile of the Western world by increasing longevity. Thus, millions of cases of chronic degenerative disease resulted in people who would not previously have lived past childhood.

Since the 1960s, a growing disaffection regarding medicine has been noticeable. There are several compounding facets to this: (a) doubts regarding the value of a medicine which prolongs life to old age, but often in hospital or nursing home settings and in a manner which tends to deprive people of their human dignity; (b) ethical questions arising from the inequitable access to and allocation of extremely scarce medical resources, e g, artifical organs, dialysis machines, and certain surgical procedures; (c) an awareness that modern medicine has been unable to cure and reduce the number of cases of certain diseases, despite the large sums of money

spent on research; (d) the realisation that much disease results directly from the degradation of the physical environment, the workplace, and the individual, coupled with a sense that medicine does not adequately address prevention on either the social or the individual level; and (e) the explosion in the costs of the provision of medical care to individuals, the government, and employers. This section will expand on these points and relate them to an explanation of the rise of holistic medicine in the 1970s.

While there has been relatively little change in life expectancy rates for those already over 50 in the United State since the turn of the century, there has been a significant increase in the number of people, and the percentage of the population, living to an older age. In 1900 there were only 3.1 million people 65 years and older, but by 1975 there were 22.4 million, with a population projection of 3.18 million aged by the year 2000—perhaps a conservative estimate (33). This will create a pool of largely unemployed elderly, dependent on a social security system warcked with financial dliemmas and a private pension system unable to maintain parity with inflation. Needless to say, the economic plight of the elderly adversely affects their health stauts. Given that the elderly consume more health resources than other segments of the population, this demographic change implies greatly expanded medical care costs. Currently, 68 per cent of the care for the aged is financed by public monies through legislatively guaranteed benefit packages (41). Medicare has continually had the most inflationary outlays due to current hospital behaviour and failings in the largely proprietary nursing home industry. It is not difficult to grasp why the issue of passive and active euthanasis is now under discussion and why a concern over dignity in dying (and even a life after death) is being promoted in this decade (42, 43).

A somewhat related problem stems from the ethics of allocating scarce medical resources in a demoractic society. As sophisticated medical technology becomes evermore expensive, the question of how to decide who should have access to that technology and on what basis allocative decisions should be made pose a series of critical bioethical issues. A whole set of dilemmas have arisen to further complicate this problem. For example, in the United States today all people with kidney disease can get their treatment reimbursed through the end-stage and renal dialysis programme of Medicare, yet poor women have been denied access to legal abortions through Medicaid.

A third facet of the growing dissatisfaction with medicine comes from the ineffectiveness of medical research in adequately answering the most pressing disease problems today. Results of a curative nature from cancer and heart disease research have been negligible, let alone significant in alleviating these problems. While there have been advances on an individual clinical level (44), the morbidity-mortality data demonstrate how limited these have been. In the face of a population apparently not getting healthier, palliative therapies abound for a wide gamut of current disease conditions. For example, the huge consumption of psychoactive drugs in the United States has been given wide attention. One can only speculate on the numbers of people who use some form of medication or drug (e.g. alcohol) to get them through the day (45).

Another facet of the overall problem results from the mounting evidence that much disease, especially heart disease and cancer, results from the degradation of the physical and social environment. Air and water pollution, radiation exposure, and additives to food substances have all been implicated in the disease process and clearly must be addressed if social prevention strategies are desired. Further, occupational stress and health hazards in the workplace reveal additional social origins of disease (38, 46-49). Millions of workers have been exposed to chemicals whose long-term effects on health were previously considered inconsequential (or in some case known to be hazardous but used anyway). Greatly increased cancer death rates among certain categories of workers will emerge over the next two decades. Moreover, the degradation of the individual citizen through lack of exercise, inadequate or inappropriate diet, heightened anxiety and chronic social stress, and other aspects of alienation from labour and life adversely affect health status indicators and drive up the utilisation of health services. What is of special importance about all these factors is that, by definition, they are preventable. Yet, medicine, medical research, and the medical care system continue to ignore the possibility of prevention by not addressing the social occupational, and environmental origins of our current disease structure.

Each of the above points has an underlying economic aspect. The cost explosion in medical care today has established cost containment as the overriding priority in most decisions. With the US economy facing severe problems of inflation and intermittent recession, both corporations (who purchase the bulk of health insurance for their employees) and the Federal Government (which funds services for the poor and aged) are calling into question the amount of money being spent on medical care services (50). The cost of medical care and other associated health services (such as environmental and workplace clean-up requirements) has increased at an exponential rate over the last three decades, making the health sector a leading growth industry. From the corporate perspective, these health benefit costs might have their own justification if the present array of services returned an even larger increase in the labour force productivity via improved heath. But the past two decades have brought significant change in health status, despite this escalation of expenditure. Complicating this problems is the fact that the major portion of health expenditures flows out of the corporate sector and State into the hands of professionals and hospitals. Thus health care expenditure appear unequivocally as a major factor limiting capital accumulation, and a corporate strategy to reduce inflation in health costs is currently becoming evident (51). Replacement of costly, high-technology medicine with cheaper, non-technological therapies is a major redirection advocated by proliferating medical-care evaluation studies (52, 53). Corporations have developed an interest in holistic health as *Forbes magazine* notes, "because it emphasises more money-saving prevention and patient responsibility."(54).

In addition, to the extent that the provision of successful medical care has become a source of legitimacy in advanced capitalism, increasing popular dissatisfaction with current medical practice will become a chief focus of the State (It has become clear for instance, that right-wing political groups have latched on to the public disaffections with medicine through the promotion of anti-abortion crusades, laetrile

legalisation campaigns, etc.).

All of these problems have led to a heightened concern with health in recent years. The holistic health movement has arisen in part out of this concern and in part has helped to generate it.

Holistic Health Movement

There are problems in defining the holistic health movement beyond grouping together all practitioners who place themselves against or outside the mainstream of modern medicine. Further, it is difficult to distill commonalities from the potpurri of alternative therapies, since such a diversity has been linked as a movement by its organisational advocates (1,57-59).

The positive health orientation of holistic therapy has two separate components. The first is the perception of health as a value in and of itself; the second is the notion of health as a praxis—the active participation of the individual in the ongoing maintenance of his/her own helth. Holistic therapies also assume a unity between mind, body, and spirit, the major implication of which is that illness is regarded as more than just physical disease and is assumed to have causes and dimensions beyond the purely biological. The separation of mind and body has long been a philosophical issue in Western thought, and the elimination on downplaying of the mind as a component of the disease process has been considered as of the cardinal success of scientific medicine. The critique of the mind-body duality and the reintroduction of elements of spirtuality in holistic medicine form a strong counter to the crude materialism of scientific medicine in its narrow emphasis on what it takes to be the physical and biological source of disease.

The holistic health movement has philosophically set itself in direct opposition to some of the basic tenets of scientific medicine. The potential power of the "mind" over the "body" is being tested in the treatment of various diseases as practices such as meditation, biofeedback, autogenic training, and hypnosis become quite popular. The exploration of psychic phenomenon (e.g. clairvoyance, telepathy, precognition, psychokinesis, and extrasensory perception) may encourage a new understanding of pathophysiology and ongoing health maintenance. Other practices (such as yoga and the various forms of martial arts) are promoted as aids in forming an integrated view of the individual's health and a greater consciousness of health.

Although it is challenging the taboos of scientific medicine, holistic medicine has not yet established itself as scientific. Holistic therapies primarily have relied upon ancedotal evidence, with "proof" of efficacy to be found in individual testimony. Since scientific theory prides itself on repeatability and universality medicine orientations easily fall prey to charges of quackery and hucksterism. Several factors, however, complicate the picture. For one thing, a number of scientifically established medical procedures and therapies have been found in many cases to be no more effective than treatment by a placebo. This applies not only to certain drugs, but also to various surgical and medical treatments. Indeed, several recent Government reports have criticised the scientific medical establishment for choosing many of its practices more by intuition than by science or study. Most notable is the recent survey by the Office of Technology Assessment, an agency of the US Congress on the safety and efficacy of 17 common medical practices (52). The implication of this orientation is apparent: if scientific medicine were to subject itself to the same rigorous testing that it demands for holistic medicine, many of its forms of intervention would not fare too well either! One may conclude that science, as we presently know it, is insufficiently developed to properly understand the interactions of body, mind, and spirit over the course of the disease process. At the same time, this line of reasoning should not suggest immediate acceptance of holistic medicine and its various therapies without some proof of efficacy.

By concentrating on individuals and tailoring therapies to individual needs and desire, holistic medicine achieves a great degree of client satisfaction. Interpersonal sensitivity and responsiveness to patient's needs ans values which are generally operationalised in the holistic practitioner-patient interface. Since the patient is held responsible for his/her own health (and in many cases, the results of therapy), people are loathe to blame failure of the invervention or the therapy itself. Rather, it is usually assumed that the patient has not tried hard enough, "it's not the time yet," or that the search must continue for the real root-cause of the illness. Often, the power of suggestion and belief plays a dominant role in therapy. For the most part, then practitioners of holistic medicine tend to generate loyal followings for their particular theory and therapy among their clientele. In an era of growing disenchantment with modern medicine, one finds in holistic therapy a popular modality upon which to center one's hope for alleviation, if not elimination, of a plaguing health problem. It is less invasive and dangerous than scientific medicine; it tends to use natural or symbolically ritual medicines or drugs; and because it employs more intimate forms of treatment such as touching, holistic medicine is usually enjoyable and pleasant.

As public support wavers for the scientific establishment, various forms of holistic health care are generating attention and hope from both those suffering from maladies and those wishing to grow in new dimensions of their lives. Nevertheless one finds in the holistic health movement many of the same organisational and social patterns that predominate in the present health care system: solo, fee-for-service entrepreneurial practice; knowledge or skill sold to "consumers" in commodity forms elitist and sexist behaviour on the part of the practitioners; a concentration of availability of services to middle-class, white people able to play; and a clear separation between practitioners and those who are served. Most practices also tend to be focussed on the individual, as in scientific medicine, and lack virtually any focuss on the larger social grouping.

In the midst of the growing narcissism in the United States today, holistic health practices are being explored as part of strivings toward self-growth and self-actualisation (60). In addition, some corportions are beginning to seek increased employmee productivity by offering training in practices such as mediation for stress reduction (61-63). While taking a positive step by including the mind as a causative as well as a healing agent, most holistic practices continue to exclude the external social world from their attempts at healing, failing to provide strategies for changing economic and social relations. Some practices are serving to further commodify

alienation "personal" problems are temporarily relieved as a particular practice tends to adjust the individual to the society from which the pathology has arisen. Thus, this adjustment of the individual may become a prominent tendency (64).

Most holistic practices contain heavy doses of mysticism and charismatic elitism. Their Eastern (and precapitalist) origin often results in an authoritarian elitism that has taken interesting—and—disturbing—forms as these age-old practices have been transplanted into America. The most glowing deficiencies of holistic practices, as they currently exist, arise out of their intense individualism and limited notion of totality. Most assume that they are totalistic by stressing the unity of the body, mind, and spirit. However, this ignores the larger social world outside the body from which much of disease originates. Meditation, for instance, can relieve the effects of stress on an individual, but it does not *remove* the stress source. When one stops meditating, the social stress is still there. A readily apparent weakness of many of the holistic medicine practices is that they ignore politics, declining to connect disease to existing social relations. When these connections are made, the problem is often defined in terms so general—"the West," "modern society"—as to suggest that the only sensible course is exclusive concentration on healing the individual in a chaotic and brutal world. The philosophical thrust of holistic medicine assumes emotional and spiritual dimensions of the individual transcending the physical body. Yet even this expansion still centers on the internal dynamics of the individual to the exclusions of external reality. This, of course, differs from the social medicine of the 19th century, which defined the totality to include the physical and social environment as well as the human organism.

Conclusions

Various holistic medicine therapies are rapidly becoming popular alternatives to scientific medicine. In just a few years, holistic medicine has been able to achieve significant public support in the Western world, as well as the nascent support of both corporations and the Federal Government. It is imperative that health policy analysts and health practitioners understand the nature and content of holistic medicine and the social dynamics out of which it arises.

That holistic medicine poses challenges to the hegemony of scientific medicine cannot be denied. One example is the pressure for the National Cancer Institute in the United States to hold controlled clinical trials to test the alleged efficacy of laetrile in cancer treatment. Some 17 state legislatures have legalised the prescription and sale of laetrile within their borders, a decision made in spite of the almost unanimous opposition of the medical profession. Chiropractic therapy now receives reimbursement from several Medicaid plans and from Medicare. Court cases regarding the rights of people to choose a holistic therapy (i.e, nutritional therapy or laetrile) against the wishes of their physicians, who advocate either chemotherapy or some invasive treatment, have been heard with mixed results to date (see, for example, refernce 65). It seems apparent, though that many more such issues will be fought out in the legal arena. Meanwhile, a groundswell of investigation into alternatives to scientific medicine has been occurring as patients seek out therapies suggested by the multiplicity of articles in the popular press. Bookstores have been devoting higher and higher percentages of shelf space to sections on health, psychology, and the occult; many of the ideas gleaned from this recent explosion in publishing are used by people as supplements—it not direct alternatives—to what scientific medicine-oriented physicians suggest.

Its nontechnological nature and extreme emphasis on individual responsibility for health are aspects of holistic medicine that imply cheaper modalities of care than the present medical care system offers. Those social groups advocating cost containment in helth care have an obvious interest, then, in the explosion, growth, and spread of holistic health care. As noted earlier, medical care inflation has been running at a rate almost twice that of the rest of the economy, and the likelihood of its being slowed down dramatically is quite limited in the absence of major cutbacks in care, which seem politically infeasible at this time. Given this reality, there is a definite political and economic necessity for new approaches to healt and health care problems. Holistic medicine just may fill that need.

Similarly, a changing ideological focus is being promoted in health today. A medical care system emphasising the individual's role in maintaining his/her own health and promoting a significnt lessening of absenteeism among employees would be of considerable value to the corporate sector. It the infusion of holistic medicine modalities into the workplace could keep people on the job and improve their individual productivity by making them either objectivity healthier or at least believing they are healthier, it would serve to address one of the most pressing problems in America today (as defined by corporations): low productivity due to worker alienation. Thus holistic medicine could be of great utility to our present malfunctioning system of economic production.

Finally, if holistic medicine should succeed in giving people a sense of caring for themselves and being the decision-making subject in their lives rather than just an object; if it should succeed in promoting dramatic changes in current, unhealthy lifestyles; it if does provide a more meaningful justification for living in a relatively unpleasant world; then it most certainly will be utilised by greater numbers of people in our society. Yet, by achieving such results, holistic medicine may then become a part of corporate and state strategies for cost constainment in health care. Also holistic medicine could easily be formulated into a social mechanism for allaying criticism of present inadequacies in health care delivery and the social production of disease (66).

We have attempted to demonstrate that the resurgence of the holistic health movement in this decade is no social accident, but clearly arose in response to degenerative social and psychological conditions of the day. Holistic therapies are addressing some of the crises that have been created by the ongoing demise of scientific medicine. It should be noted that scientific medicine is far from dead at the moment, however, and may, with some propitious discoveries, regain its hegemony. At the same time,we have tried to indicate that holistic medicine, to the extent that it focuses solely on the individual and ignores political and social dimensions, is not the entire answer for health either. Nevertheless, holistic medicine is an up-and-coming social movement gaining wide

popular support, and as such, demands attention from all health workers and policy analysts (67-69). This attention should, hopefully, be directed toward uniting people in the transformation of their social conditions necessary for improved health (70).

References

1 Berkeley Holistic Health Center. The Holistic Health Handbook. And/Or Press, Berkeley, 1978.
2 Miller, S. et al *Dimensions of Humanistic Medicine*. Institute for the Study of Humanistic Medicine, San Franscisco, 1975.
3 Tart, T. *Transpersonal Psychologies*. Harper Colophan, New York, 1977.
4 Cousins, N. The mysterious Placebo: How mind helps medicine work. *Saturday Review*, pp 9-16, October 1, 1977.
5 *The Journal of Holistic Health*. 1977-1979.
6 Carlson, R. *The End of Medicine*. John Wiley and Sons, New York, 1975.
7 Leonard, G. The holistic health revolution. *Journal of Holistic Health*, p 81; 1977.
8 Carlson, R. *Frontiers of Science and Medicine*. Henry Regnery Company, Chicago, 1975.
9 Berliner, H A, Larger perspective on the Flexner Report. *International Journal of Health Services* 5 (4): 573-592, 1975.
10 Sigerist, H, *Landmarks in the History of Hygiene*. Oxford University Press, Longdon, 1956.
11 Rosen, G, *A History of Public Health*. MD Publications, New York, 1958.
12 Ackerknecht, E, Anticontagionism between 1821 and 1967. *Bull Hist Med 22 (5): 562-593, 1948.*
13 *Chadwick, E, Report on an Inquiry into the Sanitary Conditions of the Laboring Population of Great Britain*: Edinburgh University Press, Edinburgh, 1965.
14 Chadwick, E, *The Health of Nations*. Longmans, Green, and Company, London, 1887.
15 Finer, S, *The Life and Times of Sir Edwin Chadwick*. Methuen and Company, London, 1952.
16 Engels, F, *The Condition of the Working Class in England in 1844*. Progress Publishers, Moscow, 1973.
17 Marcus, S, *Engels, Manchester and the Working Class*. Vintage, New York, 1975.
18 Rosen, G. What is social medicine? A genetic analysis of the concept. In *From Medical Police to Social Medicine*, pp 60-119. Science History Publications, New York, 1974.
19 Galdston, I. *The Meaning of Social Medicine*. Harvard Univesty Press, Cambridge, 1952.
20 Ackerknecht, E. *Rudolf Virchow: Doctor, Statesman, Anthropologist*. University of Wisconsin Press, Madison, 1953.
21 Ringen, K. Edwin Chadwick: The market ideology and sanitary reform. *Int J Health Service* 9 (1): 107-120, 1979.
22 Ringen, K. The Development of Health Policy: Norway, England and Germany. Unpublished dissertation, Johns Hopkins University School of Public Health, Baltimore, 1977.
23 Stern, B. *Society and Medical Progress*. McGrath Publishing Company, Washington, DC, 1970.
24 Ackerknecht, H. *A Short History of Medicine*. The Ronald Press, New york, 1968.
25 Powles, J. On the limitations of modern medicine. *Sci Med Man* 1 (1): 1-30, 1973.
26 Renaud, M. On the structural constraints to state intervention in health. *International J Health Service* 5 (4): 559-572, 1975.
27 Waitzkin, H, and Stoeckle, J. The communications of information about illness. *Adv Psychosom Med* 8: 180-215, 1972.
28 Reich, W. *The Mass Psychology of Fascism*. Farrar Strauss and Giroux, New York, 1970.
29 Reich, W. *Character Analysis*, 3rd edition, Simon and Schuster, New York.
30 Wartofsky, M. Organs, organisms and disease: Human ontology and medical practice. In *Evaluation and Explanation in the Biomedical Sciences*, edited by H T Engelhardt, Jr, and S Spicker, pp 67-83. D Reidel Publishing Companym, Boston, 1975.
31 Knowles, J H. Introduction to *Doing Better and Feeling Worse: Health in the United States*. Norton, New York, 1977.
32 Eyer, J, and Sterling, P. Stress-related mortality and social organisation. *Review of Radical Political Economics* 9 (1, 2): 1-44, 1977.
33 US Department of Health, Education and Welfare. *Health: US 1979-77*. US Government Printing Office, Washington, DC, 1978.
34 Hurely, R. The health care crisis of the poor. In *The Social Organisation of Health*, edited by H P Dreitzel. MacMillan, New York, 1971.
35 Susser, M W. and Watson, W. *Sociology in Medicine*. Oxford University Press, New York, 1962.
36 Tiesman D. The Institute of Psychiatry sackings: Ideology, science and the organised scientific worker. *Radical Science Journal 5*, 1977.
37 Sontag, S. Disease as political metaphor. *New York Review of Books*, p 29, February 23, 1978.
38 Epstein, S. *The Politics of Cancer*. Charles Scribners Sons, New York, 1978.
39 Eyer, J. Hypertension as a disease of modern society. *Int J Health Service* 5 (4): 539-558, 1975.
40 Caplan, A L. *The Sociobiology Debate*. Harper and Row, New York, 1978.
41 Cambridge Research Institute. *Trends Affecting the US Health Care System*. Aspen System Germantown, Md, 1976.
42 Kubler-Ross, E. *On Death and Dying*. MacMillan, New York, 1973.
43 Veatch, R M. *Death, Dying and the Biological Revolution: Our Last Hope*. Yale University Press, New Haven, 1976.
44 Israel, L. *Conquering Cancer*. Random House, New York, 1978.
45 Waldron, I. Increased prescribing of Valium, Librium, and other drugs: An example of the influence of economic and social factors on the practice of medicine. *Int H Health Service* 7 (1): 37-62, 1977.
46 National Cancer Institute. Estimating the Fraction of Cancer in the United States Related to Occupational Factors. Washington, DC, September 15, 1978.
47 Brodeur, P. *Expendable Americans*. Viking, New York, 1974.
48 Stellman, J, and Daum, S. *Work is Dangerous to Your Health*. Vintage, New York, 1975.
49 BerMan, DM. *Death on the Job*. Monthly Review Press, New York, 1978.
50 Salmon, J W. Corporate Attempts to Restructure the American Health Care System. Unpublished dissertation, Cornel University, Ithaca, 1978.
51 Salmon, J W. Monopoly capital and the reorganisation of the health sector. *Review of Radical Political Economics* 9 (1, 2): 1-44, 1977.
52 US Congress Office of Technology Assessment. *Assessing the Safety and Efficacy of Medical Technologies*. US Gvernment Printing Office, Washington, DC, 1978.
53 Cochrane, A L. *Effectiveness and Efficiency: Random Relections on Health Service* Nuffield Provincial Hospitals Trust, London, 1972.
54 Physician Heal Thyself...or Else. *Forbes*, p 95, October 1, 1977.
55 Culbert, M L. *Vitamin B-17: Forbidden Weapon Against Cancer*. Arlington House, New York, 1974.
56 Harton, H, editor. *The Truth About Laetrile*. Public Affairs Press, New York, 1977.
57 LaPatra, J. *Healing*. LcGraw-Himm, New York, 1978.
58 Walker, M. *Total Health: The Holistic Alternative To Traditional Medicine*. Everest House, New York, 1978.
59 Kaslof, L J, editor. *Wholistic Dimensions in Healing: A Resource Guide*. Doubleday and Company, New York, 1978.
60 Lasch, C. *The Culture of Narcissism*. Norton, New York, 1978.
61 Relaxation breaks instead of coffee breaks lower employees' blood pressure. *Wall Street Journal*, p 1, December 1, 1977.
62 Drew, D R. Transcendental meditation and productivity. *Academy of Management Journal* 17: 362-368, 1974.
63 Flanagan, W. Reducing stress through transcendental meditation. *Business Week*, pp 101-102, October 26, 1974.
64 Crawford, R. You are dangerous to your health: The ideology and politics of victim blaming *Int J Health Service* 7 (4): 663-680, 1977.
65 Follow-up on the Chad Green case. *New York Times*, P 33, January 21, 1979.
66 Berliner, H S, and Salmon, J W. The new realities of health policy and influence of holistic medicine. *c/o Journal of Alternative Human Services* 5 (2): 13-16, 1979.
67 Ullman, D. Holistic health as a model for personal and social change. *c/o Journal of Alternative Human Services* 5 (2): 9-12, 1979.
68 Burlage, R. New health care alliance could build new system. *Democratic Left*, pp 9-12, June 1979.
69 Salmon, J W, and Berliner, H S. Health policy implications from the holistic health movement. *Journal of Health Politics, Policy and Law* (forthcoming).
70 Salmon, J W, and Berliner, H S. Can Holism Turn Left? Paper presented at the 107th Annual Meeting of the American Public Health Association, New York City, November 7, 1979.

UPDATE

News and Notes

Privatisation of Medicare: Help from GIC

THE General Insurance Corporation (GIC) has announced the introduction of a medical insurance scheme, named Mediclaim, with effect from November 3. The introduction of medical insurance should ordinarily have been welcomed as an important step towards extending the benefits of modern health care to the mass of the people. However, the scheme announced by GIC through a high-powered advertisement campaign should instead be expected to, and is indeed intended to, give a strong fillip to the privatisation of health care in the country—and this notwithstanding the fact that the GIC itself is a wholly government-owned corporation. In fact, we have here another instance of how the government and public sector organisations closely collaborate with private business for the advancement of the latter's interests.

The manner in which the GIC has chosen to advertise its Mediclaim scheme tells its own tale. The advertisements read very much as if what is being advertised is a sort of lottery: "Claim medical expenses upto Rs 17,600 a year by paying just Rs 250", the GIC proclaims. Also noteworthy is the prominence given in the advertisements to the fact that the premium paid on Mediclaim policies will be deductible from taxable income under section 80D of the Income Tax Act, making it clear that the GIC is aiming the scheme mainly, if not wholly, at income tax payers who constitute some three per cent of the country's population.

In any case, the terms of the Mediclaim scheme are such that there is no possibility of anyone except the very well-off benefiting from it. The GIC is offering five classes of policies. The annual premium on the least-priced two are Rs 250 and Rs 350 and entitle the insured person to claim 80 per cent of the cost of medical treatment in hospitals subject to a maximum of Rs 17,600 and Rs 25,500, respectively. Under these policies the GIC will pay nothing if the medical expenses are not incurred in a hospital but on treatment at home. Then there are three other more expensive classes of policies, costing Rs 600, Rs 840 and Rs 1,300 per annum, which entitle the insured person to reimbursement of hospitalisation expenses upto Rs 37,750, Rs 52,750 and Rs 82,500, respectively; in addition, under these policies medical expenses incurred on treatment at home too will be reimbursed upto Rs 5,250, Rs 7,400 and Rs 11,500, respectively.

At first sight, the premium rates may not appear excessive. The catch lies, however, in the fact that to be meaningful medical insurance must cover the whole family. Taking a family of five members, the two cheapest policies, which cover medical expenses only in case of hospitalisation, will cost Rs 1,125 and Rs 1,575 per annum, respectively (after allowing for the 10 per cent discount which the GIC is offering where one or more dependents are also covered). At the other end, the premium on the more expensive policies, which alone cover the cost of domiciliary hospitalisation, vary between Rs 2,700 and Rs 5,850 per annum—quite large sums even for those in the upper income brackets. No wonder that the GIC has realised that it desperately needs the crutch of tax deductibility of premium payments to be able to sell Mediclaim. Incidentally, by its very nature, private medical insurance of the type being offered by GIC tends to be expensive. As a result, it can be meant only for a small select section of the population. Even in a country like the UK, according to one estimate, whereas nearly a quarter of professionals have private health insurance cover, for semi-skilled and unskilled workers the coverage is less than two per cent.

If, on the one hand, Mediclaim is meant to cater to upper-income income-tax payers, on the other hand, it is intended to cover the cost of medical treatment in the exclusive private hospitals set up as corporate business enterprises, the rapid proliferation of which has been one of the major developments in the area of health care in the country in the last few years. This is evident from the fact that the hospital room charges that Mediclaim allows for are Rs 550 and Rs 350 per day for the two most expensive policies and Rs 250 per day for the remaining three types of policies. Of course, there is in this country a class of people who can without batting an eyelid pay for treatment at the new private hospitals at these or even higher rates. But it is naturally a small class. So if the private sector hospitals are to continue to attract the required large investments and their number is to continue to grow and their profits are to keep rising, the demand for their services needs to be enlarged beyond that provided by the above-mentioned class of the very rich. This is precisely what GIC's Mediclaim scheme aims to do with the direct help of the government in the form of tax exemption for premiums paid under the scheme, which amounts, roughly speaking, to between one-third and one-half of the private hospitals' charges being paid out of the public exchequer in the form of tax revenue forgone. It should by now be clear how

the government and the public sector GIC are aiding the privatisation of medical care in India.

The GIC's Mediclaim scheme is only one of a series of recent moves by the government to help privatisation of medical care. In December last year the Income Tax Act was amended so that reimbursement by employers of medical expenses such as operation fees, hospitalisation charges, cost of medicines and tests, etc, incurred by employees and their families is no longer treated as a perquisite. In other words, the amounts so reimbursed are not now added to the taxable income of the employees. The term 'employees', it has been specifically provided, is to include "managers/directors" (with their families). The Income Tax Act 1961 already permitted government employees to receive such tax-free reimbursement of medical expenses. This benefit has now been extended to those working in the private sector and in public sector undertakings.

The change in the tax treatment of expenditure on medical expenses has to be seen together with some other decisions of the government to appreciate its full import. Under the scheme to encourage non-resident Indians (NRI) to invest in India, hospitals have been included among the areas qualifying for NRI investment upto 74 per cent. Later the definition of hospitals was enlarged to include 'diagnostic centres' as well in order, as the government press note on the subject put it, "to facilitate the inflow of NRI expertise and investment in the area of medical diagnosis through specialised and sophisticated equipment not readily available in India". Apollo Hospitals in Madras was the first to come up in response to the government scheme, as a public limited company with non-resident investment. Others have since followed in its wake.

In addition to these specific measures to facilitate their growth, the government is only too ready to give the private corporate hospitals legitimacy and respectability. For instance, while inaugurating its Diabetes Foundation, the Vice-President of India acclaimed Apollo Hospitals as "the first fully-equipped, corporate, multi-speciality hospital in India" and added, "I have had the privilege of being associated with the development of this unique all-round medicare facility". What followed was even more explicit underwriting of private medical care at the cost of the facilities provided in government hospitals. The Vice-President said that to depend on the government alone for health services would be to reconcile oneself to mediocrity and paucity of such services. In other words, because government health services are of indifferent quality and inadequate, the government needs to support private establishments such as Apollo Hospitals.

This is a piece of deliberate misrepresentation, for the high-cost private sector hospitals with their high-powered doctors, their sophisticated diagnostic machines and therapeutic aids provide an altogether different type of medical care from that provided by the government health services and to an altogether different class of people. Far from making up for the undoubted deficiencies of the public health services, privatisation of medical care with the active support of the government is bound to further distort the priorities of the government's health policies and thereby further choke the flow of resources and qualified medical personnel to the government health services, rendering them even more unequal to the task of providing health care for the mass of the people.

K R

Legislation of Abortion in Yugoslavia

Yugoslavia is a country where abortion is legal and very simple. It is sufficient that the woman chooses the hospital and the gyneacologist, pays about 50 guilders for the whole treatment including the anesthesia, and she is back home the next day. All this is due to the very good laws and to a struggle that the women of Yugoslavia won fighting against the conservative behaviour and practice. The struggle for various women's rights including the right to decide about her own childbirth, dates in Yugoslavia from the second world war. In 1952 the interruption of pregnancy was legalised but only for medical reasons. The social reasons were accepted too. From 1960-1978 the abortion had to be approved by a commission, instead of the woman herself. Various commissions had different opinions, which made it impossible for women to use their legal rights. Although the commission approved of 97 per cent of the petitions, in order to lessen the tension for women and to liberate them from the haste, and all the waiting in the medical clinics, women still made further efforts to liberalise the law even more.

A new law was passed in 1978 and according to it the decision about childbirth is a personal matter. A part of the law is about contraception: the rights of people to learn about contraception and the planning of the family is acknowledged. Sterilisation is allowed for persons older than 35 or if there are other medical reasons. The main feature of the law about abortion is that every woman has the right to ask for it, that they are safe financially, and institutions are available, which is very important. And that abortion can be refused for medical reasons. The law makes it possible for a woman to have the abortion after a medical examination on her request, till the 10th week of pregnancy. From the 10th to 20th week and later it is possible only if the commission finds it not dangerous for the women's health. Persons under age can also ask for it, but with the agreement of parents or the person responsible.

After bringing up the free law the number of abortions has increased a great deal, which is alarming considering that Yugoslavia has about 22.5 million inhabitants and the number of abortions done annually is about 300,000. There are some parts of Yugoslavia where the number of abortions is larger than the number of births. In Servia there is one birth to 1.4 abortions, in Croatia one birth to 0.75 abortions. And it is still increasing.

In Yugoslavia contraception is not very popular, there are not enough services for it and young people are not well-informed about it. Although the number of services is increasing, only 40 per cent of the women use contraception. A lot of women still use abortion as the only method of contraception together with the traditional methods—39,000 abortions have been done on married women out of 40,000 that were done in Croatia. The figures tell us that the planning of the family is not valued. Sterilisation is very unpopular, men do not ask for it at all.

[Abridged from *Women's Network on Reproductive Rights Newsletter*]

Fifth International Women and Health Meet

WOMEN health activists, researchers, and practitioners form all over the world will gather in San José, Costa Rica next spring for the Fifth International Women and Health Meeting. The Centre Feminista de Informacion y Accion (CEFEMINA) is co-ordinating the planning for the conference, which is scheduled to take place from May 23 to 28, 1987. This marks the first time the meeting will be held in a Third World country; the previous four meetings have been held in European cities.

The conference will focus on five main themes: population policies and reproductive rights; community health; environmental health hazards; drugs; and the health care system. The organisers welcome any suggestions for specific workshops to be organised under these categories as well as general input into the planning of the conference. Meetings will be held in Spanish, French or English, with simultaneous translation available for plenary sessions. Childcare facilities for participants' children will be provided.

The conference organisers also urge women who want to attend to begin fund raising immediately to cover travel costs and expenses. Those who can are encouraged to help raise funds for women who cannot cover their own costs.

Eleven national and international women's organisations, including Isis International and the Latin American and Caribbean Health Network which we co-ordinate, are sponsoring the conference. The others are Peru Mujer, Centro Ecuatoriano para la Promoción y Acción de la Mujer, Women's Global Network on Reproductive Rights, International Baby Food Action Network, Health Action International, SOSHIREN Tokyo, Isis WICCE, Dispensaire des Femmes, and the Boston Women's Health Book Collective.

For further information please write to:
CEFEMINA, Apdo 5355, San Jose 1000, Costa Rica.

Ills of Public Hospitals

Recent events have drawn fresh attention to the atrocious state of public hospitals all over the country. The glycerol tragedy which is unfolding every day in the courts in Bombay can well serve as a case study of the degree of inefficiency in these hospitals. Even more disconcerting is the fact that the doctors and the officials appear to be exhibiting a degree of nonchalance which can only be termed inhuman and callous. Officials have admitted that no action was taken other than issuing a routine alert, and that after a delay, even though several similar deaths had occurred in a single ward; doctors have confessed that they did not deem it important to read circulars marked urgent; and units have been found to have continued to use the same batch of suspect glycerol for 48 hours after an order was issued to impound the batch.

It was around this time that the doctors at KEM hospital in Bombay went on unique strike with the sole objective of highlighting the utter lack of adequate and necessary facilities in the hospital. And what they had to tell the patients was indeed a revelation—sub-standard equipment, operating theatres with fungus growth on the walls, machines sitting idle for want of simple repairs, shortages of drugs, and so on.

However, all this attention on the inefficiencies of public hospitals has given rise to a feeling that the only choice then is to make use of private practice facilities, even if one has to foot the fabulous bills later on. In fact, state governments, like Uttar Pradesh have already set in motion, plans to hand over rural health care to private sector.

There cannot be a more mistaken notion than this. The roots of the malady in public hospitals probably lie in the proliferation of private practice and private hospitals. And it is these hospitals which have received enormous support and patronage from the government even as the government-run institutions have lacked both finance and other support. There is need to look more closely and critically at the relationship between the private and public institutions. Today the state is openly admitting its inability to provide welfare services such as health and seeking to move its responsibility to the private and voluntary agencies. Can the government abdicate its responsibility to provide 'welfare'—even if it is rudimentary? Have we as health activists been altogether more concerned about evolving alternatives than with pressurising the government to be accountable?

—p p

Female Patients versus Male Doctors' Universe

jytte willadsen

How does medicine view women's health problems? In recent years the women's movement has posed many questions to medicine which has in turn set the medical establishment thinking. This article is an 'insider's view by a Danish woman psychiatrist and discusses how bias influences both the diagnosis and the treatment of women's problems.

SCIENCE is unscientific in the way it analyses and treats women. Virginia Woolf says, "Science it would seem is not sexless, she is a man, a father and infected too".

It is very important and essential to confront the medical world with feminist viewpoints. You may then be able to explain many otherwise unintelligible problems and treatments. If we raise the consciousness about this confrontation we can go ahead in a much wiser way and otherwise we will obtain impossible results in the treatment of women patients. In the industralised part of the world women live about seven years longer than men do. Why is it so? On the other hand, depressions are much more widespread in our societies among women, and women are depressed between three and six times as often as men. What's the explanation of this? Women go to see their doctors twice as often as men. Is this good or bad? Women are drugged twice as often as men, and many healthy women are constantly under the control of an artificial intake of sex-hormones, while healthy men as a rule don't take hormones. Why is it that men most often abuse alcohol and drugs? Why is it that nearly exclusively, men are imprisoned?

Women's Biology

Women have a wonderful biology. Our life is cyclic and cyclicity is an underestimated richness. From puberty the woman is constantly changing. She is influenced by a hormonal balance which all the time changes quietly, little, just like the moon and in the same pace as the moon. Every 28th day women menstruate and after this, in the middle of the period, we are in ovulation. After this and before the next menstruation we have the premenstrual phase, where many women feel extra energy, extra power and vitality. During menstruation many women feel their womanhood confirmed and sealed. Some times the female cyclicity takes other forms. When you are pregnant you are in a long cycle of nine months, where you feel new changes, new hormone balances controlling your organism and from moment to moment you and your child are in quiet change and movement towards birth. The birth itself is a series of oscillations and the labour begins quietly and slowly. As the labour continues the oscillations become more and more intense, until the child is born. Afterwards a new cyclicity arises and you find a new hormone balance with new experiences. When you nurse the child, your breast slowly fills up and afterwards your love to the baby slowly and peacefully empties the breast again. This sort of cyclicity continues until you again return to the ordinary cyclicity and the ordinary menstrual cycle. May be after more pregnancies with ordinary cyclicity in between, you at last reach the 'large' cycle, the climacteric, where you experience the menopause and your organism again reaches a new hormone balance in quiet pace. For some years you then will go on this balance until old age and death.

The female doctor and psychoanalyst Therese Benedek wrote a paper, 'Climacterium a Developmental Phase'(1950). She found that psychodynamically the female sexual cycle involves a greater integrative capacity within the personality. Thus when the approaching menopause diminishes the fulctuations of the sexual drive, the ego is flexible enough to use the energies released from previous tasks for new integrations. In other words, the female cyclicity is an advantage because it creates flexibility to manage new life situations and use the energies in a new and satistying way, as may happen in the climacteric.

Margaret Mead talked about the postmenopausal zest and as you know she herself enjoyed her zest and many of her world famous works were made in her postmenopausal phase.

Karen Blixen, Danish female author, wrote in *The Caryatids, an Unfinished Tale* (1957), "He watched the figure of his wife, sunk in musing in the carriage seat. He recognised the thoughtful mood which had come over her, the wave-motion of her being, following the rhythm of the moon like the tidal waves of the sea. It was as if a weight was being gathered grain by grain, within the depth of her, balancing down her vitality into a new calm and a deeper understanding. Sometimes she would disappear from him altogether for a day or two, but only to come back, radiant, as from a flight into a distant world from which she brought with her fresh flowers to adorn her home." When we talk about the female cyclicity, the phases in our lives, in this way, it is difficult for many of us to recognise ourselves. Also in my daily life, femininity is quite different from the way I have tried to describe it here.

Menstruation

You see the problems clearly in advertisements. An ad from a Danish paper "Girls! Be balanced every day! Menstrual days and the climacteric don't need to be problems! Take the new Melbrosia pill every day." The advertiser trusts in our imbalance and especially in that we feel it.

In an ad for doctors, the drug company offers hormone therapy for premenstrual syndrome (PMS) and the pill is said to remove irritability, crimes, accidents, breast tenderness, emotional turns, headache and so on. This is an audacious claim by the drug company, because premenstrual syndrome lacks scientific proof. In connection with this ad we had a debate in the Danish media. Female doctors emphasised that crime and accidents primarily are male problems and that it was farfetched to believe that women should need treat-

ment with hormones to prevent crime. After a long debate the company at last admitted that the ad was not objective and it was then withdrawn. In a mass-circulating newspaper a cartoonist showed his new understanding—his cartoon showed a battered woman calling the drug company, "Can't you produce some similar hormones for my husband—but they have to work every day." *Menstrual troubles: Symptoms, course of disease, treatment*, is the title of an informative book for all women. It was published after the debate, and the author is one of our prominent gynaecologists. From an illustration in the book you see the endometrium changing through the period. At the top of the picture is an illustration showing how the woman feels. She looks free and well until the last days before menstruation. Then she is shown to be sitting down and she looks like a person who is unable to do reasonable things. It is interesting to look at this picture and at the same time be conscious of the fact that this is never scientifically shown to be a normal situation for women. Some healthy women can feel negative sensations in the days before menstruation, but other women can feel the opposite or nothing and this is totally forgotten in medicine.

In medicine a woman is regarded as a handicapped man. It is considered a negative factor that she may be premenstrual or menstrual or in ovulation and that she may be pregnant or in puerperium and for a certain period she may be nursing and later she will experience the worst, the menopause. A women is thus always in a 'special condition'. She is never okay, but what about the original model, the man?

Some female doctors have studied 'the man' and we plan to publish a book with the title, *Testosteron troubles: Symptoms, course of disease, treatment*. As yet nobody has taken care of the poor man with this strained condition. We will stress, that the level of the man's testosteron concentration in blood is nearly always the same, and as everybody knows, men are always in the same spirit. But many men suffer from testosteron poisoning, and they are in the same aggressive condition all the time. We hope very much that we can help them, but until now we have no sure and certified method of doing it.

Giving Birth

In Denmark nearly all women give birth in hospitals and both the labour and the condition of the child are monitored in several ways. It is difficult to imagine how women giving birth will be able to experience the many sensations and great moments in their lives, when they are treated as patients in the hospital milieu. We know that women nowadays are at a larger and larger risk of having to undergo Caesarian sections so that their experience of giving birth will be an experience of being under narcosis. And what about the children? Is it good for them to come into the world and live without the normal experience of birth? Of course it is advantageous that we have the possibility of a Caesarian section when it is really necessary, but is it with advantage that we perform the operation more and more?

Climacteric

In ads for the climacteric the drug companies tell us that we can do something for this otherwise hopeless situation. Hormone therapy solves the problems. The atmosphere in illustrations is depressing and resigned and often against the background of rainy weather or autumn.

In Denmark two well-established male gynaecologists have written an 'informative' book about the climacteric. It is issued in the same series as the book about PMS mentioned above. The title is, *The Climacteric: Symptoms, Courses, Treatment*. The book has illustrations presenting the woman before and after the menopause. You see a profound change between these illustrations. The postmenopausal woman is fat and her appearance is totally without charm. We must wonder why male doctors want us postmenopausal women with zest to identify ourselves with such pictures of women.

The diagnosis of the menopausal syndrome was first introduced to English-speaking doctors late in the last century, and it became an instant success. Joel Wilbush (1981) in an article, "What's in a name? Some linguistic aspects of the climacteric " views the diagnosis of menopause as a 'wastebasket' and the introduction of this diagnosis in the last century gave little offence. It was an excellent label which satisfied doctors and patients alike.

It is important to stress the lack of proof of the connection between mental illness and menopause. In Sweden Tore Hällström (1973) undertook a thorough epidemiologic study of 800 women and found no correlation between the menopause and mental disorder. In Denmark, a study including all patients in the psychiatric institutions has shown no peak in the number of patients in the middle years per number of inhabitants in the same age group. Weissman and Klerman (1977) in a comprehensive review of the literature concluded that there was no evidence that women are at greater risk of depression during menopausal period.

Many men and women feel that menopause is the worst experience in the life of a woman. And some even claim, that it will leave her as a castrata for the rest of her life. In the treatment of menopause the most important task of the doctor is to give the women careful and factual information. It is necessary to distinguish facts and myths. I would like to stress once again that no mental disease has ever been proven to be caused by the menopause. Therefore hormonal treatment cannot be expected to, and has never been proven to alleviate such diseases. When the woman is well informed it is up to her to choose whether and for how long she wishes to have hormone therapy. The informed choice of the woman is much preferable to an authoritarian decision by the doctor.

Depression, Thy Name is Woman

Now let us take a look at depression. Depression is a 'woman's disease' and it is up to six times as common among women as men. Today most psychiatrists and psychologists agree that we see quite smooth transitions from the normal sorrow to very deep and serious depressions. The psychiatric diagnostic apparatus is here, as in many other places quite uncertain and unstable. In all the professional textbooks you find the description of the depressive person as passive with lack of initiative, lack of self-confidence, introjection of aggression with subsequent feeling of guilt and with a lack of sexual desire and performance, men are impotent and

women frigid. Here it's essential and interesting to remember Freud's description of the normal woman and after him, many other identical descriptions. Freud tells us that the normal woman is passive with lack of initiative, lack of self-confidence, as a rule she introjects her aggression and she cannot show her anger, is inclined to feeling guilt and sexually she is masochistic. As you can see the two descriptions are rather alike. Indeed they are nearly in accordance word by word. Yet the normal woman is labelled as masochistic, which I think many feel is worse than the depressive woman's frigidity.

Freud's and other description of the woman is, I'm sorry, current also today. Women's sex role is a norm which in many ways demands passivity. When passivity is pronounced, depression will follow. It is more than hypothesis that the female sex role in many cases is the same as mild depression. And when the woman experiences psychological traumas, strain and so on, she overplays her female role as a defence and then she develops a more severe depression (Willadsen, 1983).

The bringing up of girls is an upbringing to passivity, to potential depression. In many situations it can be easy to be passive and it is important to understand the tempting aspect of convenience of the female sex role. You can identify female passivity and helplessness in many ways.

Have a look at the language. Sheila Rowbothan says in *Woman's Consciousness, Man's World*: "As soon as we learn words we find ourselves outside them. We need a language which constructs the reality of women's strength, women's power. When you are angry and want to express your strength and power, you have not your own words for it".

The normal result of the normal upbringing of a girl, is a mild, attractive and kind woman and whatever happens she will stay by her man. Often she cannot manage to accept this normal sex role, and cannot find her psychic balance, and then, nowadays, very frequently she ends up a depressed woman. The depression is for her a flight from an intolerable life situation and in the depression she can relate to her surroundings although in a negative way.

Hysteria

In other cases the women ends in another exaggeration of the female role, the so-called hysterical personality. In the leading Danish textbook of psychiatry our first psychoanalyst (Vanggaard 1985) as late as last year writes about the classical hysterical personality, "A known example is the colourful, lively, attractive and seductive woman, but it turns out that she is not serious. In intimate sexual relationships she is frigid. Even outside the narrow erotic sphere the inviting, charming and seemingly emotional attitude of these persons can impress people—often resulting in disappointment at a larger moment." The editors of the textbook, five other male Danish psychiatrists, all in high positions, have not commented on this outpouring. You see the alarming distance from women's reality. It's the same in many well-known international textbooks.

In the USA's diagnostic statistical manual, the commonly used diagnostic system in the States, DSM III, the term hysterical personality is abandoned and it is now called 'histrionic personality disorder'. In the description in the manual you see that the histrionic personality is described in the light of the usual oppressive concept of women. There you read that histrionic personality disorder is diagnosed far more frequently in females than in males. Such individuals are typically attractive and seductive, superficially charming and appealing. They are demanding, egocentric, and manipulative. They may be sexually unresponsive and in both sexes overt behaviour often is a caricature of femininity. All these pejorative descriptions are known in all sorts of psychiatric literature. The hysterical or histrionic woman is accused directly of looking lovely and being attractive and, at the same time, of being unreliable in their sexual accessibility for men. They bypass the traditional norms and are accused of using the femininity in order to manipulate the surroundings. The textbooks forget the simple fact that behaviour that is rewarded will be promoted. The behaviour of the hysterical women is, of course, determined by their living conditions. The essential issue is the deleterious lack of real female life realisation. Hysterical symptoms act as a substitute and they can be regarded as a caricature of the demands to women's behaviour in general and her sexual life in particular. Hysterical symptoms are distorted communication with the surroundings and an attempt at protest against the conditions. The hysterical person lives under the motto, "Don't think, don't know, don't feel". You have to act as another alien person and to satisfy the needs of other instead of your own, and at that be so kind as not to see through it.

In the Danish textbook the psychoanalyst also writes about the spouses of the hysterical patients. He finds it surprising what many spouses are willing to acccept the hysterical personality. There is really no basis for surprise. Lawrence Durrell formulates so shrewdly: "We get the partner who corresponds to our own inner ugliness, i e, when we look for a partner, our negative aspects will be decisive, while the positive aspects will be without any consequences, because they will be accepted by everybody. The hysterical woman will often marry a special type of man, superficially he is clever and permissive in relation to her, but if you analyse the relation, you will often understand that he plays his own game. For his own good he keeps to the hysterical because he experiences himself as strong and important and as safe as possible in his male role. At the same time he 'fixes' her symptoms because he can't do without.

The label frigidity is often linked to the hysterical. Sexologists have tried to replace frigidity with general sexual dysfunction of the female. They have tried to be progressive, but in vain. Frigidity is essentially the women's skewed protest against participation in the traditional sex life, when everything is dictated by the wishes and needs of the man. She experiences all of it as an attack against her integrity. Many womens suffer from lack of sexual life realisation. The woman's common inclination to passivity explains that she often finds herself to be, what we call, frigid or suffers from sexual dysfunction.

I have read Sheila Kitzinger's *Women's Experience of*

Sex (1983) with great profit, and in many ways I agree with her. She writes in the postscript that she has learned much from writing the book. Before writing the book she took it more or less for granted, that sex therapists must be right when they talk about female sexual dysfunction and when they often use therapies to help women adapt without questioning the social values and codes which impose on us particular kinds of sexual behaviour and assumptions about sex.

It's a fact that nearly all diseases occur with a skewed sex-distribution. In every textbook you find the unequal sex-distribution mentioned. But without any analysis and without recommendations for prevention and cure of the diseases in this light. Drugs are used widely and it is alarming that many, many healthy women are medicated in several ways. In gynaecology, hormones, as I mentioned before, are often used in the treatment based on myths about women's biology and sexual life. The same happens in some cases of gynaecological operations. In general practice the treatment very often is a drug treatment and it is the general practitioners who prescribe most of the psychotropic durgs. Most of them are sedatives but they also issue many prescriptions for antidepressives and neuroleptics.

The pharmaceutical industry is aware of the sex of the doctor and the sex of the patient,. In the ads you often find the attractive woman, with a nice hairdo, make-up and posture and the elderly grandfather-like doctor—he usually has grey hair and a bald spot on top of his head just to inspire confidence. If his patient is a hysteric who cannot manage her frigidity or a depressive who suffers from passivity and lack of self-confidence, where can she go for better treatment, than to the psychotherapist?

Many patients feel that the psychotherapist puts them back in their box and not to a worthy life outside the fixed conventional role. The male society makes its demands. A woman has to be the good wife and mother and at the same time she is expected to be attractive and be able to manage competition from pornography.

Can men (as psychiatrists or doctors) treat women? It is a difficult question, because it depends on the scope of the treatment. In the treatment of the weakest patients it necessary to work with very limited purpose. It's a sort of camp hospital treatment at times where you cannot free the patient from war. If the possibilities are better and the woman has resources and can depend on a supportive social network, then she can go ahead and develop her personality. I'm sure she needs help from others who understand her suppression. Some few male doctors do, and honestly many female doctors do not. We are educated in the male medical world and we have internalised so much.

Voluntary helpers and self-help groups sometimes can be good solutions for women with psychic problems, but often they have very few resources. It can be difficult to offer the necessary steady help. The society should on one side support the pioneering initiatives and on the other side, learn from them and transform the established treatment apparatus accordingly. More importantly than appropriate treatment, we need to raise the woman from childhood to a realistic concept of her own biology and psychology. Then she will appreciate her cyclicity and not be apt to biologise her problems, and more or less unconsciously overplay the normal sensations in the female biological cycles. We need to be conscious of our problems and try actively to solve them. We will define our femininity ourselves rather than to accept the traditional definition put forth by men.

When we meet psychic problems, it's necessary in the earliest phases to be active, to take responsibility for ourselves, to use our anger and aggression and not to introject all of it. In every way we have to counteract the objectification of women in our society. I think our sex life is most important. We must be aware of our sexual position.

Clara Thompson (1942) wrote, "The characteristics and inferiority feelings which Freud considered to be specifically female and biologically determined can be explained as developments arising in and growing out of western woman's historic situation of underprivileg, restriction of development, insincere attitude toward the sexual nature, and social and economic dependency. The basic nature of woman is still unknown." The basic nature of woman is still unknown, we must acknowledge. We owe our children, our species to discover it. We need to think, to know, to feel, if we dare, and if we manage it will give our species a much-needed survival value.

[Paper read in a slightly modified form at the 2nd International Feminist Bookfair, Oslo, June 21-27, 1986]

References

Benedek, Therese, Climacterium: A Developmental Phase, *The Psychoanalytic Quarterly*, 1950; 19: 1-27.

Blixen, Karen, The Caryatids, An Unfinished Tale, in *Isak Dinesen*, (edited by Karen Blixen) (*Last Tales*), Putnam, London, 1957.

Hallström, Tore, *Mental Disorder and Sexuality in the Climacteric: A Study in Psychiatric Epidemiology*, (DISS), Göteborg, 1973.

Kitzinger, Sheila, *Woman's Experience of Sex*, Dorling Kindersley, London, 1983.

Thompson, Clara, Cultural Pressures in the Psychology of Women, *Psychiatry*, 5, 1942: 331-9.

Vanggaard, Thorkil, Neuroser, I Welner J, Reisby N, Lunn V, Rafaelsen OJ, Schulsinger F (eds): *Psykiatri: En tekstbog*, FADL, Kobenhavn, 1985.

Weissman, Myrna M and Klerman, G L, Sex Differences and the Epidemiology of Depression, *Arch Gen Psychiatry*, 1977; 34: 98-111.

Wilbush, Joel, What's in a Name? Some Linguistic Aspects of the Climacteric, *Maturitas*, 1981; 3: 1-9.

Willadsen, Jyttee, *Depression, dit navan er kvinde: Mandsvaelde or helbred*, Lindhardt and Ringhof, Kobenhavn, 1983.

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Organising Doctors: A Difference in Approach

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ANANT PHADKE (*SHR*, II (3) p 151-2) in his critique of my article (*SHR*, II p 57-66) has chosen to employ rude words e g, "shame-faced defence of the interests of the doctors". Rude words may have their appropriate uses but, as I am inclined to believe, are never known to be good substitute for argument. To confess, my article has not been intended to be any sort of defence of anyone and I have not happened to feel any sort of shame in informing certain aspects of a certain section of the medical profession which is yet misunderstood. Reading Phadke's own article (*SHR*, II (3) p 198-50) on the same topic I find I can identify the difference between our basic approaches to the problem but before that let me clarify a few minor points raised by him.

Phadke takes me to task for my original title "Medical Profession in Health Care" which the working editors thoughtfully changed to "Doctors in Health Care" in order to, I presume, save me from ignominy. Phadke claims that the "medical profession being only doctors" is a popular but mistaken notion and it should include nurses, social health workers, etc. On the other hand, I had no intention to suddenly change a popular category of almost universal usage and if I did, I am sure, would have invited another, irrelevant debate. I do not feel much enthusiasm to emulate the purists' example of using the word 'doctor' for only medical doctors which is also a popular but thoroughly mistaken category. Phadke insists that general practitioners should be said to be involved in "petty commodity relations" and not "precapitalist mode of production" because the former is a "part of a capitalist social formation". Frankly, I do not understand the significance of the difference between the two. The production relation of the GP is neither capitalist nor post-capitalist and further, it is also a part of pre-capitalist social formation.

In his own article, Phadke deals with the subject from the traditional and over-worked idealistic approach to which I alluded in my article: "The profession has hardly been looked into as what it is, but often analysed on the basis of what it should be" That is why, Phadke wants to organise the doctors towards the end of fulfilling the tasks set by his own lofty ideal. He starts by uncritically superimposing the formulation of a particular western school of analysts on the Indian situation. This school categorises the highly skilled wage earners of advanced capitalist society as "new middle class" and Phadke adopts this formulation to place the Indian wage-earning doctors to that class and therefore attributes them similar contradictory role towards social revolution.

This he does without even a cursory glance to the Indian reality. By no stretch of imagination could the Indian society be labelled as an advanced capitalist society. The section of Indian wage-earning doctors is yet to be consolidated in a well-defined social layer. In my article, I have briefly narrated the social events which tend to show that this section of doctors is in the process of consolidating towards a distinct social layer, quite different from the other sections, under the influence of objective forces—particularly economic and political—despite individual tendencies to the contrary. Again, I find that Phadke's assignment of these doctor's role in the function of Capital (according to the same formula of new middle class of developed capitalism) is at variance with reality. I have not found these doctors, as a class, performing "the function of capital, of supervising, extracting work from the paramedics" in order to earn a part of the surplus value (from unidentified source). In fact, the current trend shows different picture. In Bihar, UP and West Bengal, this newly organising band of doctors has joined hand with the already unionised hospital workers in common struggle on common demands—particularly trade union—and democratic rights. Phadke 's estimate that these doctors earn a "comparatively high salary" also appears, devoid of clarification, to be another borrowed assumption. With whom has this comparison been made? With employees of the lower hierarchy, or with employees of the same hierarchy or with their work value/utitlity value/market price?

From this dubious promise, Phadke asks the left "to determine its strategy of organising this layer of doctors". He castigates the leadership of the doctors' organisations for organising them on a trade union platform; discounts trade unionism itself as unworthy because this will only consolidate their already earned privilege; laments that there is no "well-thought out strategy in organising doctors; and calls for appealing towards a small section of enlightened doctors "on the basis of comprehensive revolutionary medical programme which asks doctors to throw away their privileges as elite doctors in return for the promise of decent, meaningful working life."

Well, there may not be nobler ideal and more humanitarian appeal to the heart and conscience. But such idealistic approaches have never helped. Trade unionism does not owe its origin and development to anyone's desires and wishes. Trade unionism develops from objective compulsions. Economism is one of the primary driving force behind trade unionism. Forgetting that we live in a country where even the mature organised working class itself is bogged down in economism, Phadke is so angry with doctors' trade unionism that he admonishes me for giving importance to the West Bengal doctors' movement in 1974 which did not raise any slogan in the peoples' interest. I do not understand why narration of fact or event should be taken as shame-faced defence? Rather I believe it is of no use theorising without a look at facts and events. True to his disinclination to face facts, Phadke has missed an entire paragraph in my article where I narrated the subsequent events revealing how the doctor's organisation later came to understand the linkage between economic aspirations and egalitarian health care service and raised, an entirely new set of demands voicing people's interests.

Contrary to Phadke's assumption, I have not tried to determine doctor's role in social revolution—certainly not at this stage. I wanted to draw an eventful picture of a sec-

tion of the medical profession in the perspective of hard reality. Because I found that the observers almost always dealt with the medical profession from individual presumptions and pre-determined positions without bothering to sift empirical findings. Even the bitter critics of doctors have fallen prey, perhaps unwittingly, to the concept of noble profession and, for no coherent reason at all, expect the doctors to remain unaffected by the nuances of the commercial society and to conduct themselves as holy men. Hence, the exploitative practice of the doctors which is an utter contradiction to the ideal of noble profession, shocks them. Why should the noble doctors behave as other wage-earners do? Why should they indulge in trade unionism and economism as the common workers do? Why should they demand 8-hours duty as everyone does? Why shouldn't they, as noble ones, "throw away their privileges as elite doctors in return for promise of decent, scientific, meaningful working life", as the other commoners do not do? When these doctors do not oblige, Phadke goes searching for a "small critical mass of doctors" who may persuaded to raise a sufficiently strong clamour for "a revolutionary change" in the medical system.

I have little hope he will find one and even if he is fortunate to find them, his ideal may remain unrealised. One thing is certain. We cannot run a medical system without doctors—certainly not by a small critical mass of revolutionary doctors. Before jumping ahead to determine the role of doctors in social revolution, let us try to understand and determine their role in health care. What role do we envisage for the doctors in today's health care? What are they performing? What are the nature and cause of short-comings in role performance? What changes should we demand and strive for in the medical system and what will be the role of the doctors in such dynamic situation? In order to find answers to these questions we have to purge ourselves of the myth of noble profession, step out of our idealistic world of believe and turn a fresh look towards doctors as just a social layer with the relevant particularities. We have to collect real life data and analyse them. We have to know how the doctors practise medicine in the state hospitals, how they, as a class or interest group, interact with the recipients, non-doctor workers and the employer. In this context, discussion on professionalism, role expectation, role performance, as well as agitative movements become relevant.

When we do this, we may be able to understand and determine the service-doctors' role on the basis of their own conduct and not through any wishful thinking. Then only will we be in a position to determine their relationship with a people's health movement for a just health care service. The relationship—I quote Thompson again – "must always be embodied in real people and in a real context".

Without going into details, I may draw attention to the experience of USSR and China. There, in the post-revolutionary period, the state had to deal with the entire medical profession in reshaping health care service. Revolutionary exhortations were found to be inadequate. The instrument of incentive and disincentive was ultimately resorted to and it brought results. The problem has yet to be resolved. Professionalism, job satisfaction, economism, role expectation, role performance, private practice, technocratic scienticism etc, are still living problems.

References

Phadke, A: 'One sided defence of professional interests', *SHR*, II (3), 151-2, 1985.

Das, S K: 'Doctors in Health Care: Their role and class location', *SHR*, II, (2), 57-66, 1985.

Phadke, A: 'Organising Doctors: Towards What End?, *SHR*, II (3), 148-50, 1985.

Light on 'Blind Spots'

u n jajoo

ANANT PHADKE in his review (RJH, June I: 1) of our book *When the Search Began* contends that: "It is not clear from their account as to why the response to this scheme was better than to the earlier one. No economic or political activity has been reported. Perhaps the support of the medical college including the doctor's monthly visit made this difference."

This and other such statements need some clarifications. The insurance scheme demanded Rs 3/person/year as contribution from 75 per cent of the village population and offered hospital services at 75 per cent subsidised cost (See Introduction). Though highly subsidised, hospital charges were beyond the reach of poor villagers. The Jwar Insurance Scheme provide free hospitalisation for all unexpected illnesses and thus provided a sense of security. It was essentially this modification which attracted people and not any economic or political activity.

Regarding Phadke's comments on cost analysis, a close look at the cost analysis will reveal the following:

Hospital indoor admission rate per year = One per 10 population
Government expenditure for 10 people 28×10 = Rs 280/year

Contribution from the people = Meets the cost of peripheral health infrastructure plus spares Rs 18.50

Therefore the amount which can be spared for hospitalised treatment per patient = Rs 280 plus Rs 18.50 Rs 298.50

With a proper referral established between the hospital and the specialised care hospital, I feel that with the amount available, and health insurance coverage for indoor admissions can be provided. It is futile to compare this cost-analysis with existing government PHC set-up where distribution of funds provides only 12 paise/person/year towards drug cost. What is important I believe is that the alternative strategy appears feasible.

Elsewhere Phadke comments that the increase in percentage coverage for health insurance from 46.5 in the first year to 71.5 per cent in the third year does not tally with the earlier claim. The data quoted earlier is from village Nagapur—the village where by trial and error health insurance scheme evolved over the years. The data on increase in coverage (on page 14) is pooled information from the new villages where health insurance scheme was introduced and then implemented once it was found feasible. The strategy of our entry

in village life was totally different.

As for the 'blind spots' the search continues. We began with what was possible in the given social structure, involving people to the maximum, without corrupting them with blind charity. The 'blind spots' can only be eliminated when really democratic health services evolve. What matters today is whether there are attempts towards the democratisation process.

We did try towards decentralisation, e g, village contribution is now collected by villages and is kept in the village as a village fund. Its utilisation is now decided by gram sabha, thereby controlling the village health workers performance. The attempts towards appropriate health education was the natural corallary but the extent to which attempts towards 'conscientisation' can breed 'health actions' is a question we have yet to answer.

It must be understood that for the goal of democratisation to be achieved the consumer should be participating. For people's participation to emerge, a felt need has to exist. The needs cannot be created. If need-based participation ensues, it has to be guided towards democratisation, the value which under-privileged section rarely visualises. It is here that the role of activist lies. The vision of democratisation is perceived by those individuals who can see beyond the immediate gains, i e, people who join the struggle through conscious committment.

As far as health work is concerned it is a moot question whether the consumers are motivated enough to actively participate. In case they are not, health work remains "for the people" and not "by the people." The experience narrated in the book describes our march towards "for the people." Though conscious of the goal "health by the people", we stumbled against the reality, that health is not a priority need of the people and hence we did not see community participation emerging.

One should not compare the strategy of work at organised sector like the Chattisgarh Mines Shramik Sangh and among unorganised rural agrarian population. Running a hospital by contributions from the beneficiaries is not new. What matters is how far the democratisation has been inculcated in health actions. It will be a nice idea if someone from Rajhara hospital shares his/her experiences of the democratisation process in health action, its feasibility and failures.

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ECT and Drug Therapy: Is There an Alternative?

AR

IT is true that medicalised attitude towards psychiatric problems is a misdirected one and we have to look at psychic disorders in a holistic way (SHR II: 4). But can we totally reject the use of drugs or even electro-convulsive therapy in psychiatric illnesses? The articles tend to suggest this by denouncing psychiatry *in toto*, without giving an adequate basis for such a total rejection.

To begin with, we must distinguish schizophernia (madness) from neuroses ("queer behaviour"). It has been well-established that there is some genetic factor involved in schizophrenia. Moreover, some schizophrenics become violent either to others or to themselves; many cannot take care of their bodily functions. It is almost impossible to keep such a person in one's house without treating him/her with powerful drugs or electuroconvulsive therapy (ECT). Like any other medical therapy, ECT may have its own risks and disadvantages. If the medical establishment is hiding these, or glorifying ETC, we must oppose it. We need a better mode of treatment then ECT. The scientific basis of how and why of ECT was not at all clear when it was started and is still not clear today. But this empirically established form of treatment is on the whole quite helpful in tiding over crises, and in reducing hospitalisation and in the absence of a better alternative, cannot be rejected. Are there any alternatives better methods of treatment available? Where is the proof? Similarly, powerful psychotropic drugs also reduce hospitalisation. These methods of treatment many-a-time convert the schizophrenic into a passive, dull individual. A few who do not require long-term treatment may become almost normal but many others loose vitality in their life. But again—is there a better alternative?

Schizophrenia is not simply "deviant" behaviour. It is quite troublesome and often may be dangerous to others. If it is considered as a revolt against the society, how should society react to it? In a social political revolt, there are certain definite demands. But the schizophrenic does not have any such demands.

What is precisely wrong in conventional psychiatry is the medicalised conception of schizophrenia. ECT and drugs are not looked upon as temporary resorts in extreme conditions, but as the solution. Though there are genetic factors involved, stressful life situations, continued tensions and humiliations are often responsible for converting a genetic potential into the reality of madness. Instead of being sympathetic to the patients for the sorry state to which the society has brought them, the victims then are blamed, castigated and the role played by social-cultural conditions in creating this illness is forgotten. Unlike neuroses, a change in the family or work-environment may not bring the schizophrenic back to complete normalcy. In this regard, one is tempted to compare schizophrenia with byssinosis (a bronchitis-like condition found in cotton-mill-workers which is caused by continuous exposure to cotton-dust; once developed, it cannot be cured). Like byssinosis and many cancers, schizophrenia can be prevented. But once the damage is done, it can rarely be reversed. The real solution to schizophrenia is to create a society which would not create such stressful situations which foster schizophrenia. Even then, there may be a few people going mad, but to be sure, the incidence can be brought down considerably. But in the present circumstances, all that the medical people can do is to be sympathetic to the patient, to use drugs, and so on when essential and identify the family and society as an important cause of this malady.

In neuroses, the family and the society at large are completely responsible for a person's neurosis; there being no genetic factors involved. Early detection of "strange behaviour" and identifying the cause in the immediate interpersonal, social surrounding may help a lot. If the situation around such a person continues in the same fashion, the person may end up with serve neurosis and then the person may never revert back to complete normalcy; years of illness-creating-environment create a change which cannot be easily reverted. Drugs can only be useful to tide over a crisis. But by no means are they the real solutions.

In the absence of a holistic view of mental health and illness, and also due to vested professional or business interests of psychiatrists, and the drug-companies, psychiatry has been overused, abused. This fits well into a society where there is a culture of scienticism, compartmentalism. This overuse, misuse of psychiatry has to be opposed. We need to create a countertendency in addition, which identifies concretely pathogenic interpersonal and social practices, their economic-political basis. Such a countertendency has also to evolve and practice an alternative, healthy culture to demonstrate an alternative. The seed for socialist, healthy culture has to be sown today! But I doubt whether ECT or drug therapy for those who are already ill can be totally rejected.

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my sin....analgin

those were the last dying gasps,
(or so it seemed then),
that were kept 'alive' with galloping agony,
that pushed my life into hopeless despair.

fever juxtaposed with spasmodic chills
and that soar throat that quenched my voice
into oblivion,
was signal enough
to let loose
tiny, horrendous microbes,
in tens of thousands, millions and billions,
to pounce on my flesh,
in an effort to strip me to my skeleton.

the healing messiahs,
gathered around me.
(in a state of helplessness)
pumped desparately blood into me,
to replenish the granulocytes,
that had vanished from my blood,
thanks to the pain-killer,
which i was prescribed.

i survived somehow.
they said i was lucky.
"it's a miracle,
50 percent don't see through."

"pain-killer ? driving me to the height of agony ?
plunging me into misery ? dragging me to death ?
why make such a monster ? "i cried
with a voice that had barely returned.
and the messiahs said,
there were 'profits' in making this monster

"profits"?" i was puzzled.
"profits" they said,
"for companies which manufacture it,"
"profits for the governments which allow it,"
"profits for the messiahs who prescribe it,"

"but what of me" i said,
"i was pushed into the doors of death."
"oh !" they said,
"you are just one that gets into such a mess,
after every hundred thousand."

i wished i was amongst
those 50 percent who did not see through,
for this callousness
was more agonising than the disease.

"but what was my crime,...what was my sin."
they laughed cynically... "you ingested analgin."

anil pilgaokar