Messages from Friends

Journals of this kind require the humanpower and clientele support, in ways other than funds. And in a country like India, it has to be groups in 10 to 15 locations supporting the central idea of the journals, but going their own ways in understanding currrent local realities. How do you get such 'friends' of the RJH ? That dialectical mode needs to be reinvented, where Gandhiji and the Naxalites left it. It would be flattering to re-launch the journal with such an ambitious co-objective, in which endeavour count on the support of this retired person living in Delhi.

New Delhi — R Srinivasan

I am so pleased to learn that RJH is going to be published once again. ...I dream of a society which results out of integrated and sutainable development where medicine is redundant because health will have become inevitable.

Kozhikode — Mundol Abdullah

We are glad to learn that RJH will make its appearance soon. It is a welcome step as there are very few journals at present focusing on inter-disciplinary approach to social sciences and health.

Wardha — S N M Kopparty

I am happy to learn that you are restarting RJH. I hope you will be able to publish it for a considerable time despite the odds at play in our society.

Nellore — M S P Rao

(On this page we will publish letters to us as well as circulars meant for a larger readership. We invite you to write. Keeping in mind the space limitation, please keep communications brief.—Ed.)

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Atomised Approach

The new approach to the control of tuberculosis is yet another techno-managerial fix.

THE recent resurgence of communicable diseases for long thought to have been brought under control, is an expected outcome of a combination of factors: falling living standards due to decreasing real wages, freezing of employment opportunities, dipping nutrition levels, breakdown of sanitary measures and debilitated public health services under the auspices of adjustment policies. However, a morbid population in the long run is economically unproductive and provides, eventually, a mass base for coalescing people's demands and protests. And that is not exactly part of the blueprint of the institutions which are prompting third world countries to adopt new economic policies. The World Bank for instance, has responded in a typical fashion; it has constructed social safety net programmes and fashioned 'new' approaches to disease-control, which seek to resolve in a techno-managerial fashion, problems which are rooted in the larger socio-economic situation. The revised strategy for tuberculosis control, termed directly observed treatment (DOT) proposed in consultation with the World Health Organisation is one such international prescription.

This new strategy, which derives its urgency from the AIDS/HIV epidemic, is being popularised and enforced in various quarters since 1992. It has a strengthened leadership from a central unit, standardised short course regimens under direct supervision for all patients (but especially those confirmed as sputum positive cases), regular supply of all essential anti-tuberculosis drugs and diagnostic material and a monitoring system for programme supervision and evaluation following WHO guidelines. The ultimate objective of the revised strategy is to cure 85 per cent of newly confirmed sputum positive cases and detect 70 per cent of existing cases by 2000 AD.

Mehsana district in Gujarat, one municipal ward in Bombay and one chest clinic area in Delhi are three venues in which pilot projects are being run with funds from a previously underutilised SIDA grant. The larger project for the World Bank will be established in the states of Gujarat, Kerala, Himachal Pradesh, Bihar, West Bengal; in metropolitan cities like Bangalore, Bombay, Calcutta, Delhi, Hyderabad, Madras as well as Bhopal, Jaipur, Lucknow and Pune, which are cities of intermediate size. This will be financed by a loan from the World Bank to the tune of US $ 20 million.

It is a matter of concern that the India's tuberculosis control programme whose excellent design grew out of sociological, epidemiological and technological insights, is being overturned without adequate justification. The programme, which is integrated with the general health services, was

expected, from the start, to sink or sail with it. If it is has failed to live up to expected levels of efficiency, it is because of the socio-political and operational problems that beleaguer the public health services; namely, irrational and inadequate funding, misplaced programme priorities and the undermining influence of an unregulated private sector. The last factor is crucial and explains why an identical control programme works in an underdeveloped district but fails in a developed district.

The imposition of DOT is set at a time when health care is no longer viewed as a right but as a priviledge that a certain section will be entitled to. Cutbacks in public spending along with privatisation and cost recovery schemes are resulting in curbs on the expansion of infrastructural facilities and making health care only more inaccessible and beyond the reach of a large section of the population. In the absence of universal coverage, even the most well laid out strategy runs the risk of failing.

DOT is partly concerned with the standardisation and rationalisation of treatment regimens. This is an honourable enough objective. However, the new regimen being proposed is expensive and its inclusion is indefensible unless the added costs can be absorbed entirely by the state and not passed on to patients through the imposition of user charges.

Equally, the emphasis on supervision of treatment poses a number of operational, social and ethical problems. While a concern about the patients' adherence to treatment regimes is natural from a clinical and public health point of view, the objective goes a step further and is founded on the premise that patients cannot be trusted to take their medicines unless they are monitored by an external agency. At one end of the spectrum are the hapless patients who now become targets in much the same fashion as 'eligible couples' do under the family planning programme. However, there is a qualitative difference here as the state does not restrict itself to the role of a persuader but becomes an enforcing agency. The visible presence of a health worker during the consumption of every dose during the intensive phase of treatment militates against the principle of confidentiality between patients and the medical profession. Considering the fact that tuberculosis is known to create or aggravate the social disadvantages that certain sections of the population (such as women, disabled persons, non-wage earners) face in families and in communities, the repercussions of this loss of privacy for patients are tremendous. And at the other end of the spectrum are the supervising agents, the community level health workers (health post workers, multipurpose health workers, etc.) who are already laden with the task of meeting unrealistic family planning and health programme targets under adverse working conditions. Under the circumstances, the necessity of supervising treatment will not only be additionally burdensome but will engender an atomised understanding of health that will only alienate them from the community.

—Aditi Iyer

Beyond Economics

The debate on structural adjustment programmes has so far sidelined a most significant factor: India's political system which by its very nature ensures that the vast masses remain disenfranchised.

IN India the structural adjustment and economic stabilisation programmes were set in motion in 1991. It may be argued, therefore, that it is too soon to assess the Indian experience. However, for a large part of the develooing world the 1980s was a decade of adjustment. And there are enough pointers available from the experience of other countries. What stands out is that the performance of structural adjustment programmes (SAP) in terms of their own objectives — rectifying fiscal and balance of payments imbalances and raising the rate of growth — cruelly affects the social consequences of these programmes.

Among the countries following SAP the experience has been mixed; Indonesia has combined SAP with rising investment and growth; on the other hand, in Argentina and Zambia there has been a decline in per capita incomes and investment. Despite the variations, the balance of experience in Latin America and Sub-Saharan Africa, two major areas implementing SAP, has been negative. Each region taken as a whole exhibited declining per capita incomes and investment and accelerated inflation in the 1980s. Among countries implementing SAP in Sub-Saharan Africa, three-fourths had declinig per capita income and half, declining investment and accelerating inflation. In Latin America and the Carribbean, more tha 4/5ths of countries had negative performance in terms of per capita investment and incomes.

How SAP affects the condition of the mass of the people is determined by three principal factors: (a)through incomes, which are affected by changes in employment, wages and income from self-employment; (b) through prices of basic goods, especially food; and through the availability of essential services normally provided by the state notably health and education. In Latin America the GDP per capita fell in 18 countries and rose or remained the same in five. In Africa the GNP fell in 26 countries and rose or remained unchanged in 12. The overall experience has been that SAP tended to depress real wages as control over money wages is combined with devaluation and price decontrol. Evidence for Latin America shows that average real wages declined in the majority of the countries. In Africa real wages declined in 16 out of 18 countries.

Stabilisation and adjustment policies lead to reduced employment and fall in real wages in the short run; but the hope is that new, more productive employment opportunities will come up over time. However, evidence shows that employment growth slowed down in most countries in Latin America and Africa in the 1980s. For Latin America as a whole it has been