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INTERNATIONAL HEALTH INITIATIVES IN THE CONTEXT OF PRIMARY HEALTH CARE AND ALMA - ATA DECLARATION

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MASTER OF PHILOSOPHY

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CERTIFICATE

Certified that the dissertation entitled "INTERNATIONAL HEALTH INITIATIVES IN THE CONTEXT OF PRIMARY HEALTH CARE AND ALMA-ATA DECLARATION", submitted by Mr. Sebastian K.S. is in partial fulfilment of requirements of six credits for the award of the degree of Master of Philosophy of this University, has not been previously submitted for any degree of this or any other University and this is his own work.

We recommend that this dissertation may be placed before the examiners for evaluation.

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DEDICATION

I would like to dedicate this work for all those in the history who fought relentlessly for social justice but were not "fortunate" enough to be popular by getting awards, titles, lucrative foreign assignments and positions in international bureaucracies. May the spirit of their struggle inspire all these who fight for the cause of health and development of the masses, in world over.

(K.S. SEBASTIAN)

CONTENTS

PREFACE

The exposure of the Third World intelligentsia to international influences after the decolonisation was essentially, exposure to western influences. The internationalisation of social sciences and its professionalisation is still primarily based on Western dominance. West achieved it not always through legitimate intellectual means, but quite often through naked and subtle use of political as well as money power. Agencies backed by money and might of the developed countries distorted the perspectives and priorities of social science research and social scientists are grappling with such problems that are considered important in the Western World and not with issues aggitating their own national communities.

A distinction is not often made between scientific method and western conceptual and theoretical structures; between the humanist and revolutionary thought of the west and its neocolonialist legacy. This precipitated a situation where in the social scientists resort to a mechanical imita-

tion rather than boldly innovating new approaches, concepts, theories and methodologies. Field work divorced from historical and theoretical perspectives has strengthened conservative and anti developmental tendencies. Scholars neglected the dynamic processes at the macro level and in the pre-occupation with micro situations, within a frame work of statistics, they under played the critical potentialities of social sciences. The pre-occupation with technical virtuosity at the expense of challenging social questions has resulted in the erosion of the human content from social research. Above all, questions were often raised from the stand point of the 'haves' rather than from that of the 'have nots'.

As a result the social science research in India could not effectively challenge the problems of social inequality, mass poverty and ill health. However, recently there have been a few attempts to liberate social sciences from such bondage and to relate research to the needs and problems of the country using as interdisciplinary and integrated approach. The present study attempts to be one among them.

CHAPTER 1

Introduction:

The ancient Indians had a distinct 'health culture' with a well developed 'health infrastructure' and well preserved 'health supporting systems'.[10] But it was the powerful European city states like Venice which passed laws that have an international ramification, first time, in recorded history. The 'quarantine laws' passed by Venice required all ships to anchor outside the city for a period of 40 days before unloading its cargo and passengers in to its port.[72] The other European states also followed the suit and thus they assured that their country is protected from contamination by outsiders. Later, in early 19th century the Europeans plundered the Afro-Asian nations to provide raw materials to sustain their Industrial Revolution. After politically subjugating the non-white nations, they made sure the constant flow of minerals, cotton, spices etc. along with the cheap labour to Europe and in return they provided the colonies with finished products.

The canals and the railways made in the colonies facilitated not only the transportation of raw materials but also the smooth passage of communicable diseases like Cholera and malaria.[107] To protect Europe from unwanted micro organisms of the East, the European governments resorted 'Sanitary Conventions'.[55] Through such 'international efforts' the Europeans wanted to preserve their 'health', but were not that much curious to initiate similar efforts for protecting the people of the East. They generously supplied venereal diseases, like Gonorrhoea and yaws to the Easterners during their commercial visits to colonies. A good example can be the complete decimation of the Maya people and their civilisation due to the rapid spread of venereal diseases brought in by the Spanish colonisers.[133] Recently when AIDS was reported, the Blacks were subjected for AIDS screening tests at the first immigration point in U.K., similar measures were not insisted on whites who were touring to the African destinations.[76]

The business and trade houses were influencing the international health initiatives from the very beginning itself. In 1851, at Paris, 12 European nations got together

to reach some understanding on public health matters and this is referred as the 'first international sanitary conference'. Though an 'international sanitary code' was prepared here, only three of the participants ratified it and two of them withdrew from it later, due to the powerful influences of business houses.[133] The nine sanitary conferences which followed could not accomplish anything substantial. Two world wars and various other developments which followed, culminated in the creation of UN in 1945, followed by its affiliatory agencies that include World Health Organisation, World Bank and UNICEF.

By this time, the colonies started getting independence one by one and the newly independent countries faced a multitude of problems. The newly created international agencies assisted them in their health efforts mainly through demonstration projects, with the support of staff and technologies formed by these agencies themselves. It was expected that the indigenous staff would take over and develop further those programmes initiated by WHO. But the developing countries were unable to continue such demonstration projects due to their inability to mobilise sufficient

resources and deficiency of trained personnel to run them. At this time various socio-economic forces were acted and reacted upon to direct the health systems of the Third World through ways which are beneficial to 'certain interests'.

The early efforts of international agencies failed to facilitate a rise in the living standards of the Third World people. Subsequently, models based on "Economic Growth with out distributive justice" were deconstructed and those based on equity and social justice were proposed by development thinkers of the Third World.[2,125] Over the years, the meaning of health and the means of attaining it were reinterpreted in terms of a variety of technical, social, economic, environmental, ecological, psychological and political factors and preference values. The new paradigm viewed health development as an integral part of social and economic development, both contributing to and benefiting from it. 'Health' can be best pursued as part of 'development' and these are closely associated as both are aimed at improving the quality of life.

Public health scientists pointed out new approaches for developing health based on the above paradigm. These includ-

ed: "the complementary efforts of national self reliance and international collaboration and the fundamental need to involve communities in finding solutions to their own health problems; the importance of evolving a national health development process and of creating permanent mechanisms to initiate and maintain their continuing development as a joint effort of all the social, economic, sectors concerned; the need to ensure that resources, whatever their origin are channeled in to socially relevant health actions; and that all these should be through a multisectoral mass action for social change".[133] Towards this end firstly, the social goals had to be defined, secondly those components of health technology that would best help towards achieving those goals would have to be identified, thirdly, the most appropriate technology that society as a whole can afford would need to be selected and finally political will and commitment would have to be mobilised to ensure both the formulation of pertinent health policies and their proper translation in to health initiatives.

This new articulation resulted in the conducting of International Conference on Primary Health Care at Alma Ata in 1978. The Alma Ata Declaration made in this conference

adopted Primary Health Care as the key approach to achieve the goal of health for all by the year 2000. The conference assigned new values to health, based on equity and social justice. The new dimension of 'health' which is a state of "well-being" and not just the availability of health services, calls for the removal of the obstacles to 'health' which go beyond medical interventions.[141]

Considering the nature of health initiatives and development programmes of the past, one may curious to know about those which came up after 1978, especially in terms of their impact in the Third World where a large section of the poor of the world live. Though there were isolated attempts to analyse international health initiatives, so far there was no systematic attempt to critically look at them with a subaltern perspective. The present study is expected to fill this gap. India has taken as a representative and reference point of the Third World, though the latter is not a homogeneous entity. Though the focus is on programmes started after 1978, the study could not be limited on them only, as they are not the products of a particular decision, made on a particular day, at a particular meeting. It needs

the analysis of various sociological and historical forces which shaped such initiatives and programmes.

B-Title of the Study:

"International Health initiatives in the context of Primary Health Care and Alma-Ata Declaration".

C- Objectives of the Study:

The study aims at understanding the socio-economic forces and ideologies that are inherent in, as well as those which shaped the international initiatives to solve the health problems of the Third World. This is to be made in the context of the Alma Ata Declaration and the Primary Health Care strategy outlined in the declaration. It also wants to examine how these initiatives influenced the health policy, development potential, health infrastructure and ecology of a recipient country like India. Keeping the above two general objectives in mind the present study formulated the following specific objectives:

1. To understand the history, composition, functioning and scope of international organisations such as United

Nations and its affiliataries that include World Health Organisation, World Bank and UNICEF.

2. To understand the global initiatives in health, since the Alma Ata Conference (1978) by;

(a) analysing the broad antecedents which culminated in conducting the international conference on primary health care at Alma Ata in 1978;

(b) elaborating the concept of Primary Health Care as enunciated in the Alma Ata Declaration;

(c) tracing the developments after the Alma Ata Declaration which had a bearing on the initiatives which emerged thereafter; and by

(d) exposing the intentions behind these initiatives through an examination of their influences on the health status and health supporting systems of the Third World people.

3. To understand the influences on the health systems of the Third World people with particular reference to India, due to its involvement in initiatives sponsored by international organisations; through

(a) appreciating India's colonial legacy

(b) analysing various development initiatives such as Community Development Programme, Green Revolution and Specific Health initiatives such as single disease control campaigns and Family Planning Programmes.

(c) Examining the developments after Alma Ata Declaration especially the formulation of the National Health Policy, Universal Child Immunisation programme National AIDS control programme and programmes in the field of environmental health.

4. To make the understanding of international health initiatives complete, the study aims at a brief analysis of other activities of sponsoring agencies, especially that of World Bank in directing the Third World countries for structural adjustment programmes. The study is to take a birds-eye view of the role of Trans national pharmaceutical companies in the Third World health system.

D. Conceptual Framework:

The conceptual framework of this study is composed of a

broader meaning of health and health systems, and faith in the use of Primary Health Care as a strategy and approach towards achieving health. The international organisations of a particular time are influenced by the social and economic forces of that period and the initiatives which emanate from their deliberations would reflect the dominant ideologies which are decided by the ruling regimes of the day. However, one can always find similar forces which struggle for the health and development needs of the masses and their influences in the policies and activities of national governments and international bodies.

The constitution of WHO defined health as a "State of complete physical, mental and social well being and not merely the absence of disease or infirmity".[129] It is a dynamic state of being where by an individual or a community is adjusting continually to its environment-social, economic, cultural, political, psychological and biological. Health could not be achieved in vacuum and needs sufficient resources to meet human needs and protection of life and work environment from health threatening activities, events and materials. Inadequate income, deficient living and work environment, over crowded poor quality housing, the sheer

powerlessness due to which an individual is unable to even influence events which decide his destiny etc. would keep people in a state which is devoid of health and vulnerable to illhealth.

Health and development are closely related as development is generally understood as the process of improving the quality of human life. Both promotion of health and development has aspects such as raising people's living standards, creating conditions conducive to 'self esteem and increasing freedom of choice. Thus there is a close relationship between health and income and the latter is a necessary condition, though not sufficient to achieve health. The other variables are distribution of incomes and capital assets within a society; the position of individual in the power structure, the quality of housing and living environment, the quality of infrastructure and services, level of knowledge and education in health enhancing action and behaviour. This indicates that the responsibility of health promotion is not the responsibility of health professionals only, but of planners, policy makers, government, and all others who influence the physical and social envi-

ronment. A citizens right and capacity to organise and act themselves has also become crucial for health.

The health system is essentially an abstraction from the larger social system and it encompasses the health culture, the health infrastructure and other health supporting subsystems of a society. The 'Health Culture' is constituted by the cultural meaning of health and health problems, means which a community adopts for dealing with health problems and health behaviour of individual and groups.[7] The health infrastructure' is composed of time tested institutions technologies, practices and practitioners developed through cultural innovations or cultural diffusions based on epidemiological behaviours of existing health problems and ecological, socio-cultural and economic conditions. It can further be argued that the health infrastructure of a society is normally a function of its political system as decisions concerning the resource allocation, man power policy, choice of technology, accessibility to health services by the community etc. are depending on the political system. The health supporting systems of the people include a broad range of things, activities and situations from the opportunities for income generation, participate in the decision

making functions of the community, ability to get educated and organise themselves and so on to the availability of clean air, water and fertile land.

Primary Health Care could be used as both a strategy and approach to achieve health and is defined as care which is "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."[141] The International Conference on Primary Health Care held at Alma Ata in 1978, which defined primary health care as above, emphasized eight important aspects of the latter, as listed below.

i. Democratisation of health services,

ii. Encouraging indigenous mechanisms of health care,

iii. Inter-sectoral action in health,

iv. Social control of medical technology,

v. Involvement of people in policy formulation, planning, programming and execution of health services,

vi. Recognition of basic right of every individual to health,

vii. Empowering people with a strong sense of self reliance and control over their own lives exercising responsibility over their own health.

viii. Emergence of a new international order coupled with a new international development strategy.

The concept of Primary Health Care has been analysed thoroughly during the course of this study (in Chapter III).

As mentioned before, the International health initiatives dates back to the 14th century when the city states of Europe undertook measures to protect their citizens, from epidemics caused by diseases brought by trading ships. With the development of means of communications and growth of international trade, the spread of communicable diseases in Africa and Asia became more rapid and extensive. Through the "Sanitary Conventions", the European governments intended to defend Europe against pestilential diseases from the East, particularly cholera, no such mechanisms were envisaged for the control of the spread of diseases from European countries (particularly venereal diseases) to other parts of the world. Lately WHO came in to existence and in 1978, Alma Ata witnessed the articulation of the goal of "Health for

all by the year 2000 AD", by 134 countries of the world.

By 'international health initiatives' the present study means those health initiatives which started after the Alma Ata Declaration, assuming the Alma Ata conference as a watershed in the history of international public health. These initiatives are sponsored by WHO, UNICEF and World Bank. They are child survival and Development Revolution (with its focus on growth monitoring, oral rehydration, breast feeding, immunisation, female literacy, family spacing and feeding programmes), Global Programme on Immunisation, Safe Motherhood Initiative and Global Programme on AIDS. Initiatives in the field of environmental health ranges from activities aimed at safe water supply and sanitation to "Healthy Cities" projects.

Within the above frame work the present study would examine the following themes:

i. There has been a definite tendency of the interests of the developed countries dominating the deliberations and activities of official international organisations and this in turn acted against the efforts

to break free the hunger, disease and poverty of the Third World countries.

ii. The international initiatives after the Alma Ata declaration not only discarded the principles outlined in the Primary Health Care paradigm but also served the interests of the commercial as well as imperialist aspirations of a few developed countries.

iii. India's involvement in initiatives sponsored by international organisations resulted in the inclusion of inappropriate structures, concepts and policies with governance of the health system of the country, at the cost of the Primary Health Care strategy outlined in the Alma Ata Declaration.

The present study is essentially a critical understanding of the political economy of international public health based on secondary sources. Thus use of complicated statical tools, scales and experimentations have no place here.

E. Sources of Data:

As mentioned earlier, the international health initiatives are not the product of any particular resolution or

conference at a static moment, rather it had a history and many socio-economic forces acted and reacted upon to gave it a structure, form and ideology. Therefore, to get a clear understanding of international initiatives, the present study uses a 'system approach' in which macro level historical and sociological analysis is used along with micro level empirical analysis in an integrated, interdisciplinary framework. Firstly an exhaustive list of secondary data sources which could act as a universe to this study is prepared on the following lines:

i. History, stated objectives, composition and functioning of various official international organisations (UN, UNICEF, WHO, World Bank) which sponsored various developmental and health programme.

ii. Literature on events, issues, debates and meeting which had a bearing on health related initiatives sponsored by the above agencies.

iii. Reports, research papers and monographs on the above initiatives.

iv. Analytical reports and studies on the impact of structural adjustment programmes not only to all the

Third World countries but also the expected impacts of which in India.

v. Journals and books which provide analyses regarding the role of Trans National Pharmaceutical companies in the Third World.

vi. The history of colonial medicine in India.

vii. Data regarding India's involvement in various health and development initiatives co-sponsored by international agencies. (This include Community Development Programme, Green Revolution, Family Planning, Single Disease Campaigns, Universal child Immunisation and National AIDS control programme). This include not only the government evaluation reports but also those done by public Health activists and NGOs.

Thus the study is mainly depending on secondary data, though the researcher abundantly made use of insights derived from personal interviews with a cross-section of prominent personalities in the field of public health and from his own experiences in associating with various NGOs involved in community health.

F. Scope and Limitation of the Study:

The present study while making a critical analysis of the Political economy of the international public health, attempts to include an all gamut of issues which affects the health system of the third world. Due to this, the specific mistakes or failures of various international health initiatives are not described in detail, rather attempted to raise larger theoretical questions in the context of the broader meaning of health and its implications on social justice. The study has not aimed at analysing the flow of health related aid from multilateral and bilateral agencies, though they are mentioned at places where it is necessary.

The findings of the present study would be useful not only to the policy makers, but also to other vigilant public bodies and activists of the Third World where the various international health initiatives are in operation. This being the first systematic attempt to study the international health initiatives in the context of the primary health care paradigm which was articulated at the Alma Ata conference, it avails opportunity to curious minds to investigate further in to various other initiatives.

G. Chapterisation:

The chapters are not strictly following the order of objectives given (in section C). This is to accommodate the scattered facts is a coherent manner and accordingly the 4th objective (viz. analysis on structural adjustment programmes and role of Trans National Pharmaceutical companies) found its place in Chapter IV and Chapter V. The titles of various chapters included are given below and they are self explanatory on the contents of respective chapters.

Chapter 1: Introduction.

Chapter 2: Scope of International Organisations in contributing towards Health and Development of the Third World.

Chapter 3: International health initiatives since the Alma Ata Declaration.

Chapter 4: Primary Health Care and international initiatives in India.

Chapter 5: Conclusions and Suggestions.

CHAPTER 2

The Scope of International Organisations in Contributing Health and Development in the Third World

Introduction :

Though prototypes of today's international organisations can be found in ancient and medieval history, it is only in the 20th century, permanent organisations of a nearly universal type have emerged and proliferated. By definition, they are co-operative arrangements, instituted among states and they are supposed to perform some mutually advantageous functions[40] implemented, through periodic meetings and staff functions. A casual look at the history of such international arrangements reveals the fact that they served the interests of those who dominated its policy making organs, funding systems, programme formulation and technical advisory functions. Whenever their hegemony faced a threat, either they broke off from the system or they want for alternate arrangements. With this historical understanding, the present chapter examines the role of United Nations, and its affiliataries (that are relevant to this study, viz. World Health Organisation, UNICEF and World

Bank) in promoting social and economic welfare and well being of the people.

This chapter aims at examining the assumption that there has been a definite tendency of dominating the interests of developed countries in the deliberations and activities of official international organisations and this in turn acted against the efforts of the Third World countries to break free the hunger disease and poverty. (The activities in terms of the programmes sponsored by them have been studied in detail, in the other chapters and therefore a complete picture will emerge only at the end). the present chapter is presented as a back ground to the chapters which follow and all the care has been taken to sketch the international organisations in the shortest possible way. Further, a detailed assessment of these bodies is beyond the scope of this work.

There are a large number of private international organisations like Rotary, Red Cross and bilateral agencies like CIDA, SIDA, DANIDA, USAID etc. These agencies undertake not only relief work, but also various developmental activities. Generally, the goal of development aid from

First to Third World countries is one of stabilising the economic and political relations between these countries. The Western countries through their bilateral aid opened up and guaranteed access to Third World raw materials and labour, essential to their economies and corporations; they intended to develop markets for export of burdensome surpluses that include agricultural products and non competent commodities. To ensure acceptance of such economic bonds the western countries sought to stabilise the political structure in the Third World which would be sympathetic to such First World economic needs. More over, often they engage in fixing political regimes which are supportive to their needs and destabilising others which may hinder their advances.

There are a number of international and national voluntary organisations which engage in developmental activities. The voluntary organisations or NGOs have originated in Europe after the passing of "Elizabethan Poor Laws" and Co-ordination of Charity Organisations. In most of the Eastern countries, though voluntarism as an ideal was inherent in the life and traditions of the people, it is the European

missionaries who initiated the NGOs. Presently the label 'NGO' is over used and abused by many and their structure and forms vary from those radical NGOs which oppose government policies that may perpetuate ill health and under development to those yuppie organisations, staffed by middle class professionals, administered through formal bureaucratic procedures, less politicised, technocratic, more concerned with programme implementation than policy and political critique. The criticism of most of these NGOs in the Third World are on grounds of inefficiency of programmes rather than their distributional biase. The discussion which follows is more on official international organisations not only because they sponsor the initiatives which is the focal theme of the present study but also because they are expected to be more responsible than private and bilateral organisations.

A: Major International Organisations

The United Nations

United Nations (UN) is a worldwide organisation of sovereign nations founded in 1945 and based in New York. The

roots of UN can be traced back to the League of Nations which was founded after First World War. The second world war ended with the defeat of axis powers - Germany, Italy and Japan and the Allied Powers - the U.S., Britain, Soviet Union and France and China became the winners. The major countries and Allied powers were contemplating a global organisation, during the war itself. The UN was officially founded at the conference on international organisations convened at San Francisco, in April, 1945.

The 50 nations (majority of which were western)[56] assembled, adopted the Charter of UN; which lists the following purposes;[57]

i. to maintain international peace and security,

ii. to encourage friendly relations among states based on the principle that all nations have equal rights and are entitled to self determination,

iii. to promote international co-operation in solving social, economic and cultural problems.

By the end of 1993, UN membership had risen up to 184 and

was predominantly composed of Third World, non White nations.

The UN Charter designated the following six principal organs - Security Council, General Assembly, Secretariate, Economic and Social Council, Trusteeship Council and International court of Justice. In addition the Charter allowed the General Assembly to make agreements linking other self governing organisations to the UN as specialised agencies.

The Security Council is composed of five permanent members - China, France, Soviet Union (presently Russia), Britain and US and ten non permanent members who are elected. The need for unanimity among permanent members created several procedural problems and the importance of Security Council began to decline in early 1950's as a result of the Veto problem.[57] By 1980, the US had used the Veto 18 times mostly in order to defeat hostile majorities on issues concerning Middle Eastern and African Affairs. For example in 1977, US joined Britain and France to veto a resolution that would have imposed full economic sanctions against the Racist South African Government.

All UN members are represented in the General Assembly, each of them has one vote. Most decisions in the General Assembly are made by simple majority vote. During the years of cold war, the US usually had its way in the General Assembly[57]. Of the original 51 members of the UN in 1945, at least 35 were closely associated with US and thus US could easily muster majority votes. During the rise of Afro-Asian-Arab block in 1960's and 70's this majority ceassed to be automatic and came to demand increasing pressure tactics of America.[100]

The Economic and Social Council (ECOSOC) was made up originally of 18 members. In 1966 the membership was enlarged to 27 and in 1980 it stood at 54. Members are elected by the General Assembly for 3 year term. One third of the membership comes up for renewal each year. Although the Charter contain no specific membership provisions, in practice the permanent members of the Security Council had permanent seats in ECOSOC as well. The rest of the membership has been tilted in favour of the more advanced industrialised nations.[110] ECOSOC takes decisions by simple majority vote. Its task is to study ways of promoting international economic and social co-operation. It recom-

mends to the assembly, those economic and social programmes it considers worthy of UN support. It receives reports from all specialised agencies work within the UN system.

A number of specialised agencies which are involved in problems relating to education, technical knowledge, research, health, food problems, industrial development, agriculture and labour are the hall mark of UN. The ECOSOC co-ordinates the activities of these agencies through special agreements negotiated with them. Eight specialised agencies were set up during the Pre UN era. These include the International Labour Organisation (ILO), International Bank for Reconstruction and Development (popularly known as World Bank) and International Monetary Fund (IMF). The two other specialised agencies- World Health Organisation (WHO) and United Nations Educational, Social and Cultural Organisation (UNESCO) have been established by the UN immediately after the world organisation came into existence.

Several special bodies have been established "to foster international economic and social co-operation".[4] The United Nations Children Fund was originally established in 1946 to alleviate the miseries of children and adolescents

suffered from war time damages. It was in 1965, the General Assembly established United Nations Development Programme (UNDP).

Members of United Nations contribute to the expenses of the budget. These contribution vary according to the respective country's ability to pay. In 1980 the range varied from 0.04% of Iceland and 30% of USA.

The International Bank for Reconstruction and Development(IBRD)

The International Bank for Reconstruction and Development commonly known as the World Bank has been established "to provide multilateral aid for economic development of its member states".[5] The Economic Conference held at Bretton Woods in July, 1944 formulated the Articles of agreement and the bank has been set up on 27th December, 1945. In November 1947, the bank has been associated with UN as a specialised agency through an agreement approved by the General Assembly.

At the initial phase the basic objective of the bank was to assist in the reconstruction of the war devastated

regions of the world and to offer financial help to economic development of under developed countries. The bank "aspires to promote the longranged balanced growth of international trade and maintenance of equilibrium in balances of payments by encouraging international investment for the development of productive resources of members, thereby assisting in raising productivity, the standard of living and conditions of labour in their territories".[5]

Membership of the Bank is open to all nations who were members of the International Monetary Fund before December 1945. Other members of IMF may be admitted by majority vote of Board of Governors. The bank comprises Board of Governors, Executive Directors and a President. The Board is composed of one Governor and "one alternate appointed by each member". The Board meets once a year to review the performance of the bank and formulate policies. The directors meet once a month at the head quarters of the Bank at Washington.

Five of the Directors are nominated by five members states possessing largest share holdings and the remaining 15 represent other member nations. A president selected by

the Executive directors conducts operations of the bank and is responsible for supervision of office and appointment of staff. The President is an ex-officio chairman of the Executive director and discharges his functions in co-operation with 4 Vice Presidents and 24 other officers.

The major finance for lending are collected from the financial resources borrowed by the bank from the private capital markets of the world. The world bank is self financing and requires no annual budget or pledging session.

The articles of Agreement have laid down certain basic pre conditions to be fulfilled before a loan is granted to ensure the proper utilisation of loan for "real economic development of the recipient states";

a. The bank must be satisfied that the borrower has failed to obtain a loan from the market under reasonable conditions.
b. The bank has to be assured of regular repayment of loan.
c. The borrower must undertake a well-designed project and the economic evaluation of the project is to be analy-

sed to asses its effective contribution to the economic development of the member nations.

If any project fulfills all these conditions the bank subsequently investigates design and construction plan of the project, commercial implication and financial return expected and actual scheme for management. Generally the bank does not provide total amount of finance required for a project, but only the foreign exchange needed to purchase imported goods and services.

Each year the bank undertakes a review of economic development of 40 developing nations and sponsors widerang-ing programmes for socio-economic development. Many de-veloping countries have encountered serious difficulties in repaying debts. The short term and medium term loans at relatively high rate of interests are responsible for a high debt service ratio in many countries.

World Health Organisation (WHO)

One of the tasks assigned to the newly formed world organisation (UN) after second world war was to "endeavour to take steps in matters of international concern for the

prevention and control of disease".[129] A similar concern was explicit in the formation of League of Nations also. After the first world war, it was proposed that all existing international bureaus on health should be placed under the League, including Office International d'Hygiene(OIHP), which was established in Paris in 1907. USA, which was not a member of League, but an active member of OIHP opposed such a fusion. Thus is the years between two world wars, two important international health organisations co-existed in Europe - the OIHP and Health Organisation of the League of Nations. On the other side of the Atlantic, the Pan American Sanitary Organisation (PASO) constituted a third one.

In 1946, the ECOSOC of UN has convened the international health conference in New York attended by sixty four states and representatives of OIHP, PASO, the League for Red Cross Society and the RockFeller Foundation. On 7th April 1948 the constitution of WHO was ratified by 26 countries and the organisation absorbed the Health Organisation of the League and OIHP with all their assets and liabilities. The WHO began to function as a permanent specialised agency from September 1, 1948.

The basic objective of the organisation is the "attainment by all peoples the highest possible level of health".[129] The following are the functions mentioned in the constitution of WHO;

- To assist in strengthening national health services and to give other forms of technical assistance.
- To maintain epidemiological and statistical services.
- To stimulate the eradication of epidemic, endemic and other diseases.
- To promote the prevention of accidental injuries and the improvement of nutrition, housing, sanitation, recreation, economic or working conditions and other aspects of environmental hygiene.
- To promote co-operation among scientific and professional groups contributing to the advancement of health.
- To propose international conventions and regulations on health matters.
- To promote maternal and child health and mental health.
- To promote and conduct research and improve standards of education in the health profession.

- To establish international nomenclatures and standardised diagnostic procedures and to promote international standards for food, biological and pharmaceutical products.
- To assist in developing an informed public opinion on health matters.

WHO further aims at development of environmental conditions conducive to health.

The membership of the organisation is open to all states and non members of the UN may join it by a majority vote of member states in Health Assembly of WHO. The functions of the organisation are conducted by a Health Assembly, an Executive Board and a secretariat. The Health Assembly consisting of all members of WHO is convened once a year, each member having one vote. The assembly determines the basic policy of the organisation, chalks out annual programme of action and approves the annual budget of the organisation. It reviews the functions of the organisation and issues instructions to the Executive Board in respect of matter on which action and study are required. The Assembly may adopt conventions and regulations in respect of health matters. All members are bound to obey all regulations and

conventions except those who have registered reservation or rejection within a specific period.[127]

The Executive Board consisting of 24 members are elected for every three years. The board meets twice a year and acts as the executive organ of the assembly. It submits advice and proposals and prepares the agenda of the assembly. It is empowered to undertake emergency measures in respect of urgent problems relating to health. The secretariat is headed by a Director General appointed by the Health Assembly upon the recommendation of the Executive Board. He is the chief administrative officer of WHO and serves as the ex-officio secretary of the Assembly, of the executive board and of all conferences of WHO. The Director General conducts the day to day activities of the organisation with the assistance of a large number of staff.

WHO has set up six regional offices and its head quarters at Geneva. WHO works in close collaboration with UNDP, UNICEF and other specilised agencies. The multifarious activities of the organisation can be categorised broadly as general technical activities and specific services to national governments.

United Nations International Childrens Emergency Fund (UNICEF)

The United Nations International Childrens Emergency Fund was created in December 11,1946, to provide massive emergency relief to the destitute young victims of second world war. By 1953, when the General Assembly extended its mandate indefinitely and renamed it the UN Children's Fund, it had begun to focus its attention on the widespread malnutrition, disease and illiteracy affilicting millions of children throughout the developing world.[45] UNICEF is a subordinate body of ECOSOC and reports to it. It depends on donations from governments and various private sources. An Executive Board composed of representatives of 30 states chosen by ECOSOC establishes UNICEF policies and meets annually to review the funds programmes.

UNICEF's primary task is to help governments of developing countries improve the "quality of life of their children, irrespective of race, creed, sex or political persuasion". UNICEF's major work is to help to plan services for children, deliver supplies and equipment and provide funds for training personnel to work with and for the

children. WHO joined with UNICEF in campaigns against communicable diseases. The WHO normally provided technical inputs through international health personnel and UNICEF the supplies to the Third World countries.

The above discussion underlines the fact that the charter, objectives and constitution of various global organisations aims at acting towards the social and economic development of the nations of the world. Article 55 of the UN Charter relates the primary purpose of the UN organisation, the maintenance of international peace and security, in the following words:

> "With a view to the creation of conditions of stability and well being which are necessary for peaceful and friendly relations among nations based on respect for the principle of equal rights and self determination of peoples, the United Nations shall promote;
>
> a. higher standards of living, full employment and conditions of economic and social progress and development;
> b. solutions of international economic, social, health and related problems and international cultural and

educational co-operation".

In accordance with the spirit of the above, UN declared 1960s as 'Development Decade'. The UN wanted all member states "to unite in a sustained effort to break through the cycle of poverty, hunger, ignorance and disease that afflicted much of the globe". Though there were certain gains in this decade, they were over shadowed by heavy debt burdens, unfavourable trade patterns and many other problems. Notwithstanding the failures of the first development decade UN declared the 1970s as the 'second development decade. The General Assembly stated in the resolution proclaiming the 'second development decade' as follows:

> "The ultimate objective of development must be to bring about sustained improvement in the well being of the individual and bestow benefits on all. If undue privileges, extremes of wealth and social injustices persist, then development fails in its essential purpose. This calls for a global developmental strategy based on joined and concentrated action by developing and developed countries in all spheres of economic and social life; in industry and agriculture, in trade and finance

in employment and education, in health and housing, in science and technology."[45]

The second development decade also failed. This leads to the conclusion that a mere articulation of objectives and good intentions would not necessarily make the international bodies as instruments of change and development. The scope of UN and other international organisations are examined further in the next section through scanning the socio-political developments which followed the formation of UN.

B: The Scope of International Organisations:

When the UN Charter was signed in June 1945 by representatives of 50 nations, most of them were western nations. Only four African nations were there, among signatories. By late 1968 the membership had risen to 125, more than half from Asia and Africa. As the executive arm of the UN and the only agency empowered to make decisions and act upon them, the security council was generally recognized for some years as by far the most important organ in the UN system. But when the abuse of the 'Veto Power' limited the council's margin for action and when the 1950 'Uniting for Peace

Resolution' broadened the assembly's powers, a shift in the focus of authority from the security council to the general assembly could be discerned. This threatened the hegemony of western powers in the decision making functions of the UN and it culminated in a debate on "weighted voting". Some asked: "should US and the developed nations accept decisions reached by a body in which a nation with a small and illiterate population and an underdeveloped economy has the same voice as a super power".[56] This lead to the weighted voting proposal to match the voting power with the political and economic power of a nation. The Less Developed Countries objected the objectivity of the criterion for weighing.

Gradually, the developing Afro-Asian countries started challenging the entrenched ways, through isolated attempts. President Sukarno of Indonesia want to the extent of calling for forming a new international organisation composed of the 'new emerging forces' to oppose the 'old established forces'. As early as 1947, the 'cold war' had begun. The divide between communist and non communist countries came to shape the entire thinking and approach of leaders and peoples of major countries. During the days of cold war, the

USA generally had its way in the Assembly, with the help of those countries in to which it had pumped aid and investment. during the major international political, crisis the UN revealed its impotency, especially during the developments in Vietnam and in Dominican Republic. Recently when USA attacked Iraq, UN became a stage for power politics, wherein most of the decisions and resolutions made with favourable consequences to USA.

Among the various blocks in the UN the Afro-Asian nations presented a relatively solid front on issues of colonialism, human rights and ecological and economic development. They often preferred to concentrate international co-operation, development and to eradicate the remnants of colonialism within the political context of neutralism and non-alignment. But the major western powers have been inclined to stress the obligations and the role of the UN in the maintenance of international peace, security and status quo. Time and again the UN organs were used to further the political, economic and military interests of the dominant powers. In 1948, 'The Universal Declaration of Human Rights' was made by the General Assembly. Though this did not become a legally binding instrument, USA has used it to brow beat

nations of the Third World, especially when they are in need to further their commercial expansion.

Neither the Assembly nor the ECOSOC had the power to take decisions with respect to matters of substance within the economic and social field that are binding upon the member states. But their advises and programmes sponsored by various agencies were accepted and adopted by Third World countries due to certain special situations and factors of international interactions that are discussed in the next two chapters. The major developed countries of the North have been for all practical purposes permanent members of ECOSOC and the interests of these states thus have had representation in the council, out of proportion to their actual numbers in the organisation. Over the years ECOSOC has considerably increased its functional areas and it is the most expanded organ of the UN in its five decade long existence.

More than 75% of the UN activities at present are in the social and economic areas, with the involvement of a plethora of specialised agencies that include WHO, UNICEF and World Bank. Recently the Third World Nations had turned

the UN General Assembly in to a forum through which they demanded a fair share of world's goods and resources. This necessitated the developed countries to shift the power centre of international politics to parallel multilateral systems. The World Bank, the International Monetary Fund (IMF) and the General Agreement on Trade and Tariffs (GATT), all conceived in the Breffon woods conference in 1944, have increased their over bearing pressure on the multilateral system and have virtually taken over as the economic counterpart of the security council in the global system, replacing ECOSOC almost entirely.

The major source of strength for the Bretton woods system has been that they control two vital components of global economy, trade and financial flows. The World Bank and IMF were conceived as the funding arm and the GATT as the care taker of the trading system in the post war development process. They were placed under the overall surveillance of ECOSOC. In the original scheme, the UN development programmes and World Bank activities (as the International Bank for Reconstruction and Development) had to be co-ordinated. This however was not to happen because, the World

Bank and the IMF, though technically under the UN system of governance, were run by an independent set of managers not bound by the UN system. GATT received similar functional autonomy in the management of the trading system. The GATT contracting parties met periodically, without any effective surveillance of the UN system, to evolve rules for international trade.[35]

In recent years and especially in the 1980s, the ascendancy of the IMF and the World Bank over the global economy has increased manifold. Although the UN system had set out the plans for a third development decade, in the 1980s, the IMF - World Bank prescription for the management of global economy gained over riding importance. Consequently the IMF - World Bank suggestions have been made operational while those of the UN have been put on the back-burner. Recently World Bank came out with reports which prescribe ways to invest in health through privatised clinical packages. The recently concluded GATT has tried to promote the view that free trade alone would ensure the development of the nations. The newly created World Trade Organisation which will come in to existence by 1995 would further activate the processes of sidelining the UN initia-

tives which may be inimical to the western interests.

C: Conclusion

This chapter reviewed the major international official agencies involved in realising social and economic well-being. Their objectives are ideal and desirable as articulated in their charter and constitution. But their very structures, administrative arrangements and decision making systems facilitated the perpetuation of under development and unequal integration of the 'North' and 'South' which was precipitated by Colonialism and Imperialism. The results of their existence in terms of their impact on third world countries are not at all inadvertent dysfunctions, though they could not be empirically proved as the result of a deliberate conspiracy.

The programmes sponsored by these bodies along with other socio-economic forces which include the medical-industrial complex and the political and military ambitions of national and international ruling elites created, increased dependency and side stepped the fundamental causes of poverty and ill health. They legitimised the class

nature and assumptions of those in power; as will be evident from the next two chapters. Later, when the third world countries started speaking for themselves, the big powers increasingly resorted to out of UN agreement and created new powerful regional trade blocks and cartels.

It has been already mentioned about scope and limitations of bilateral agencies, and private international voluntary organisations. After the second world war and decolonisation, the western governments felt the need to draw the newly emerging nations away from the socialist block. This prompted them to mould assistance programmes that may determine the political and economic structures within the receiving country. The Third World countries received these programmes partly out of their necessity and dependence on technology, skills, goods, and financial institutions and also due to the inherent benefits to the dominant classes of recipient countries. Carty and Smith brilliantly summarised the motives underlying international assistance programmes in the following words;

1. Providing short term relief for Third World financial crisis.

2. Silencing some of the Third World demands for structural reforms (as embodied by the New International Economic Order Proposals) by offering instead more aid and only minor adjustments to international institutions.
3. Building a new net work of political alliances to support the west in its renewed conflict with the East.
4. Helping Northern economies export their way out of the economic slump".[23]

The scope of localised NGOs need to be analysed as they deliver most of the initiatives and programmes sponsored by multilateral organisations. Although publications of World Bank and WHO identify advice, design, implementation, monitoring and evaluation as roles that NGOs would play, studies of 'Development projects' sponsored by them show that in majority of the cases NGOs participated as project implementions. Earlier, governments were unresponsive towards the demands of social movements for a more participatory and transparent development process. But today, most of the governments are not in a position to repress the rising demands for health and development due to the presence of certain committed groups and activists. A response by the

government to this situation was either to create or patronise NGOs to channelise and streamline the demands for health and development.

It is hoped that NGOs can compensate for any reduction in the size of public sector by implementing programmes and actions that would normally have been the responsibility of the government; specifically aimed to ease the socially regressive impacts of structural adjustment. Studies have showed that the donors and governments do not really want NGOs to organise and empower the poor as they normally keep on increasing the service delivery work and reducing the time available to them for organisational strengthening. By drawing the NGOs more closer to donors and governments, they are made more accountable to the latter than to the masses. More over the contribution of NGOs to democratisation is doubtful as their own relationship with the rural poor is far from democratic and the rhetoric on participation exceeds reality as most NGOs are self appointed rather than elected bodies which control institutional resources from within. All criticisms they make against state may apply to them also. Their socio-cultural origins lie more in the dominant than dominated groups in society.

Their limited research, dissemination capacities and localised nature rarely enable them to address wider structural factors that underlie poverty and ill health in the third world. Above all the development action of NGOs stems from their dependence on non-local processes and decisions which lie beyond their small scale project focus. They are excluded from the definition of policies. Their inability to finance infrastructure make them further dependent on donors and government. By appreciating the limitations and scope of international official organisations, multilateral agencies and NGOs, the next chapter examines the international health initiatives and their influences in the third world in the context of the Primary Health Care paradigm enunciated in the Alma-Ata Declaration and the role played by multilateral organisation towards contributing to health and development.

CHAPTER III

GLOBAL INITIATIVES IN HEALTH SINCE ALMA-ATA DECLARATION, 1978

A. Introduction

The purpose of this chapter is to take a closer look at the global initiatives, evolved after Alma Ata Declaration which articulated the PRIMARY HEALTH CARE paradigm. To appreciate the post Alma Ata developments, a brief survey has been made into the broad antecedents of the International Conference on Primary Health Care which include consequences of the war in the Middle East, changes in the conceptual understanding of 'development' and 'underdevelopment', North-South dialogue and the continuing struggle between developed and developing countries for a fair share of the world resources. The next section examines the concept of Primary Health Care and its democratic and egalitarian moorings. Towards this end, the development of the above concept has been traced from the Bandung Conference of 1937 and from the developments thereafter.

Thirdly, the developments after AADhas been analysed in the context of changes in technology especally after second world war and the apparent success of technology dependent programmes and the gradual emergence of a new theory and world view which advocated selective interventions to achieve health. The changes in the drug industries which are owned by Transnational corporations, various international conferences held at the behest of powerful donor agencies and papers published in influential journals facilitated the evolution of this approach. The fourth section examinines the ideology, scope and limitations of important programmes initiated based on the above framework.

The fifth section on Global Programme on AIDS investigates through its dependency on information technology and social marketing, its racial ramifications and commercial dimensions. The development of initiatives in the field of environmental health and its changing aspects in the global fight for sustainability in development amidst consumerist free market ideologies and attempts of a few to use the Third World not only as sources of raw materials and dumping grounds for finished products but also as sinks to their

pollution, are analysed in the sixth section. Finally an attempt is made using empirical data to assess the impact of the World Bank directed SAPs in the Health Sector of the Third World.

The above exercise is meant to assert the hypothesis that the international initiatives after AAD-1978 not only discarded the principlees outlined in the PHC paradigm but also served the interests of the commercial as well as imperialist aspirations of a few developed countries. It also emphasises the need to be cautious in accepting the packages of multilateral agencies and the need for epidemio-logically sound scientific research to develop the healthsystems of the Third World.

B. The Broad antecedents of the International Conference on Primary Health Care held at Alma-Ata in 1978

As against the economic boom which prevailed before 1970, the early 70s were a period of international economic crisis. This was precipitated by the Arab-Israeli war ("Yom Kippur") which started in October 1973. The oil producing Arab countries made an oil embargo against USA and its

allies. The resultant hike in the oil price led to inflation and zero growth in most countries of the developed West. The International Monetary System, known as "Bretton Woods System", instituted in 1944 had broken down. The conditions of Less Developed Countries (LDCs) were also not that much satisfactory. They became even poorer due to their oil import and they became trapped in a 'Debt Crisis'. Rising prices of oil and other commodities including manufactured goods, shortages of food and depletion of reserves, trade imbalances etc. threatened the stability of world economic relations. The debt servicing ability of developing nations considerably deteriorated.

There were severe cut backs in the developmental aid by developed countries to the LDCs. "The share of official development assistance in net capital flow fell from 43% in 1970 to 35% in 1979."[21] Due to decrease of foreign aid in the social sector and due to the recession in the domestic economy, the developing countries had to cut their public spending in social sector including health. This led to a "health crisis" not only in the Third World but also in the developed West.

A WHO study[128] reported the health crisis of this period in the following words. "There appears to be widespread dissatisfaction of populations about their health services for varying reasons. Such dissatisfaction occurs in the developed as well as in the Third World. The causes can be summarised as a failure to meet the expectations of the populations, an inability of the health services to deliver a level of national coverage adequate to meet the demands and the changing needs of the different societies, a wide gap (which is not closing) in health status between countries and between different groups within countries; rapidly rising costs without a visible and meaningful improvement in service and feeling of helplessness on the part of the consumer who feels rightly or wrongly that the health services and personnel within them are progressing along an uncontrollable path of their own which may be satisfying to the health professional, but which is not what is most wanted by the consumer."

Meanwhile, there was a growing awareness among the intellectuals of the Third World of the role of international capitalist system which created an international division of labour where the Third World countries suppy raw materi-

als to the developed centre and act as markets for manufactured goods from that centre. They argued that the surplus created in the peripheries is extracted by repatriation of profits. So the peripheral countries are locked in a "development trap".[42] This followed a questioning of the existing development paradigm with a consensus along the following lines.

(i) Underdevelopment is structural and it arises from:

(a) the structure of international relations resulting dependency in LDCs,

(b) the power structures and values of the elite groups within developing countries.

They proposed a re-distributive model of development[19] with social justice and egalitarianism. They called for the development of the poor and politically powerless. Accordingly 1970s were declared as the "Second United Nations Development Decade". The U.N. General Assembly articulated the goals of the second development decade and they included the following along with other development objectives.

"Each developing country should formulate a coherent

health programme for the prevention and treatment of diseases and for raising general levels of health and sanitation.

Levels of nutrition should be improved in terms of average calorie intake and protein content, with specialemphasis on the vulnerable population groups.

Housing facilities should be expanded and improved especially for low income groups with a view to remedying housing problems, stemming from unplanned urban growth and rural poverty.

The well being of children should be fostered, the full participation of youth in the development process should be ensured and the full integration of women in the total development effort should be encouraged."[4]

Representatives of Non-Aligned countries at a meeting in Algiers in September 1973, declared that the second development decade had failed and in January 1974, the then president of Non-Aligned countries, President Houri Boumedienne ofAlgeria called for a special session of the Assembly to discuss "the problems of raw materials and development". Subsequently from April 9 to May 21, U.N. General Assembly convened a special session on "raw materials and

development" from which emerged two major resolutions.

(a) Declaration on the establishment of a "New International Economic Order".

(b) A Programme of Action on the establishment of "New International Economic Orde" (NIEO).

The establishment of NIEO was expected to correct inequalities and redress existing injustices, make it possible to eliminate the gap between developed and developing countries.

A "Charter of Economic Rights and Duties of States" was adopted by the General Assembly of UN, on December 12, 1974, during its regular session. The vote was 120 in favour to six (USA, Britain, Belgium, Denmark, West Germany and Luxemburg) against with ten abstentions. The 'charter' declared that every state had the right to exercise full sovereignty over its wealth and natural resources; to regulate foreign investment within its national jurisdiction and to nationalise or transfer the ownership of foreign property.

At its regular sessions in 1975 the Assembly associated the UN with the proposed conference on International Econom-

ic Co-operation - also known as 'Paris talks' or the 'North-Soutth dialogue'. Convened at the initiative of the French President, Valeri Giscard d' Estaing, the Paris-talks were held intermittently from December 1975 to June 1977 with participants from 27 developing countries and developed western nations. They discussed problems of energies, raw materials, finance, trade and development. In September 1977, the Assembly discussed the talks, but could come to no agreed assessment of their results. The majority of developing countries felt that the talks had failed to make a contribution to the goals of the NIEO.[4]

There was a serious discussion on the concept of health during this period wherein developing countries were fighting for justice and equity. Health was understood in congruence with development and there was a realisation that health could not be attained through mere reforms in the health delivery system. In 1973, WHO conducted an "Organisational study on methods of promoting the development of basic health services."[128] This study rejected the paradigm of administrative changes as solution to health crisis of this period. It argued that health services delivery needed

to be considered as part of the whole social and economic development of a nation and that any improvement in services needed to be taken into acount all national structures, priorities and goals. That is, health was too important to be isolated and major discussions on health during this period were focussed on poverty and other developmental issues of the Third World.

There was also an increased understanding that causes of poorhealth were not primarily the common diseases, but rather low health status, which was a product of the prevailing socio-economic conditions, political structures and philosophies and environment.[97] There was a questioning of the purpose, relevance and social significance of health care within the broader context of social and economic development. It led to a longing for fundamental changes in the way health was perceived, promoted, protected and provided. The period before 1978was thus a period of struggle of developing nations to achieve an international order in which justice and equity play an important role. Banerji obseves: "the failures of western technocentric approaches and the concurrent democratic movements among the masses of peoples of the world generated increasing pressure on inter-

national institutions like the WhO and UNICEF to look for alernatives."[11]

In 1975, the World Health Assembly had directed that an International Conference on PHC should be convened as soon as possible. Accordingly the International Conference on Primary Health Care was held from 6-12 September 1978 at Alma Ata in the erstwhile USSR which was attended by 134 government delegations and representatives of 67 international agencies. It adopted Declaration of Alma Ata on the 12th of September, 1978. The Declaration spelt out health in its social and economic context; declared Primary Health Care (PHC) is the key to attain the social targets of government for the goal of health for all by the year 2000 A.D.[141]

C. The Concept of 'Primary Health Care' (PHC) as enunciated in Alma Ata Declaration (AAD), 1978

Though the term 'Primary Health Care' was in use before Alma Ata Declaration, it meant different things to different people. Parker et. al. write that they needed 92 definitions when they tried to assess how different groups viewed PHC in an American community.[102] The origin of the concept

of PHC can be traced back to as long ago as 1937, when the League of Nations Health Organisation convened a Conference as Rural Hygiene in Bandung, Indonesia. This conference passed resolutions "to bring medical and health services as near to the population as possible" and to "implement land reforms to facilitate rural reconstruction" which is the "primary responsibility of every governmentt". It also called for co-ordination of activities of various agencies and formation of village committees. The conference suggested that a good water supply and facilities for proper disposal of excreta should be provided in all rural areas.[133]

After the second world war and the inevitable decolonisation which followed, the newly independent and developing nations of the Third World adopted the health care models of the western developed countries in order to meet the health needs of the poor rural population. During the colonial period, the colonial rulers identified tropical medicine as a special entity in the tropics and introduced a western model mainly for the military than for the natives. there was a considerable momentum in planning, construction and

renovation of hospitals to provide sophisticated health services, by highly qualified personnel.[9]

Along with thse, especially during 1965-70, considerable efforts were made in developing countries to establish adequate basic health services. On the basis of the emerging experiences of a number of developing countries which had initiated new approaches to meeting the health needs of their people during the early seventies, the 'Basic Health Services' approach was conceptualised. Here the emphasis was on acceptability, affordability and appropriateness of health services. One such innovative project was the 'Comprehensive Rural Health Project, Jamkhed (India). 'A report by this project goes as follows: "The project is based on the recognition particularly by the project leaders of the priorities determined by the community. To the community, 'Health' is not a number one priority; agriculture, water supply, housing are more important.... In effect it appears that in such communities, which have a low economic status and per capita income, doctros and health services need to identify themselves with the community's priorities in order to fulfill health objectives."[133]

Inspitte of all innovative projects, Basic Health Services continued to rely on technologies which are economically, geographically and culturally unacceptable to large sections of the population. till early 70s, basic Health sevices existed as isolated islands providing a limited range of disease control programmes to uninvolved populations having failed to establish close, co-ordinated working relationships with the other sectors of the society, such as the educational, economic and agricultural sectors. In 1973, WHO made the following observations about the global public health scenario:[128]

(a) There is a failure to meet the expectations of the population.

(b) There is an inability of the health services to deliver a level of national coverage adequate to meet the stated demands and the changing needs of different societies.

(c) A wide gap in the health status betwen countries and different groups within countries.

(d) Rapidly rising costs without a visible and meaningful improvement in services.

(e) A feeling of helplessness on the part of the consumer.

The above study concluded that these are symptoms of a

wide and deep seated error in the way health services are provided. Consequently a revised system of health services under the code name PHC was described[140] in a joint paper prepared by WHO and UNICEF (titled Alternative Approaches for meeting Basic Health needs in Developing Countries). This paper was presented in the World Health Assembly of 1975. The important aspects of PHC proposed in this paper are given below.

(a) Many primary causes of ill-health are based on factors such as poverty, deprivation and environmental abuse.

(b) There is the need for total health systems designed around the life paterns of population, to support the needs of periphery on the principles of equity and active participation of the local population.

The above principles were accepted and this lead to the International Conference on Primary Health Care at Alma Ata in 1978.

The Alma Ata Conference defined Primary Health Care as "care which is universally accessible to individuals and families in the community through their full participattion

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."[141] Furher, the 'Health For All by the year 2000 AD' resolutions passed in the conference stressed the following aspects:

(a) The main social targets of governments and WHO in the coming decades should be the attainment by all the citizens of the world by the year 2000 AD of a level of health that will permit them to lead a socially and economically productive life.

(b) All countries should urgently collaborate in the achievement of this goal through the development of corresponding health policies and programmes at national, regional and inter-regional level and the generation, mobilisation and transfer of resources for health so that they become more equitably distributed particularly among developing countries.

The AAD, 1978 emphasised democratisation of health services and starting from the people and implies giving due consideration to the indigenous mechanisms which people have developed through the ages to cope with their own health

problems. Intersectoral action in health, the social control of medical technology, involvement of people in policy formulation, planning, programming and implementation of health services which are required by the people to strengthen their coping capacity and offering them assistance whenever they are unable to cope with their health problems in their own are implied in the declaration.

The primary health care concept outlined at the conference recognises certain values and principles as requisites of good health care as follows:

(a) PHC recognises the basic right of every individual to health. It calls for reduction of gaps between those who have access to health and other resources for maintaining health (e.g., income, food, employment and education).

(b) PHC emphasises an overall development strategy that gives high priority to social goals in addition to economic ones.

(c) PHC expects people to be empowered with a strong sense of self-reliance and a control over their own lives exercising responsibility over their own health. Thus

the role of government and other agencies is not to act on people's behalf to deliver health, but rather to support their efforts and take joint responsibility for health.

(d) PHC looks forward the emergence of a new international order coupled with a new international development strategy.

From the preceding discussion it is clear that the concept of PHC was at first essenttially an expansion of the ideas contained in the concept of Basic Health Services i.e. acceptability, accessibility, availability, affordaability and appropriateness of health services. But AAD-1978 broadened this restrictive concept of PHC to encompass a philosophy which went much further than the simple provision of first contact health services and provided it a political dimension. By putting multisectoral approach in the forefront it recognised the role of environmental factors in creating health. It pleaded for appropriate technology and requires community participation which sets people free to develop their own destiny. The AAD underlined the principle of equity and by which it addressed the root causes of poverty and questioned the existing distribution of re-

sources. To it, the main criterion for moving towards PHC was the increase in social and economic justice.

D. Developments after AAD - Selectivism, Technocentrism and the Sabotage of Alma Ata Spirit

Right after Alma Ata Conference, the spirit behind the concept of PHC has diluted and 'selectivism' and 'technocentrism' had crept into the discourses on health. These later interpolations deprived the developmental ingradients as pre-requisites for health. This in no way means that he paradigmatic shift occurred all on a sudden due to the efforts of a few organisations or individuals within a short span of time. Even when the struggle by developing nations for a New International Economic Order and for a people oriented health paradigm was in full swing, the forces of imperialism and technocentrism were very much active to contain the former. These forces tried to link up microorganisms and diseases on a one to one cause-effect relationship and offered technological and chemical solutions to wipe out diseases. The roots of these attempts could be traced in the history of the development of Science and Technology which was patronised by Trans National Industrial

Houses.

There were remarkable achievements in the field of Science and Technology in 20th century. Innovations in the continuous production method for the manufacture of penicillin discovery of DDT (Dichloro Diphenyl Trichloro ethane) and many other drugs for tropical diseases as well as tropicalisation of equipment took place during this time. The pharmacological revolution which took place changed the treatment and outcome of many diseases, particularly those caused by starting off with the introduction of prontosil (the first of the sulpha drugs) in 1936 for treatment of bacterial diseases and the later development of new drugs.

The isolation of penicillin in 1940 heralded the era of anti-biotics. The big pharmaceutical laboratories unravelled the chemical structure of penicillin and with molecular manipulation a range of penicillins of therapentic value were produced. Subsequently the antibiotics such as Streptmycin (1944), chlorophinicol (1947), Aureomycin and Cephalosporin (1948) were marketed. Drugs for parasitic diseases (such as malaria), for viral diseases and for mental disorders underlined the superiority of chemical formulation and

diseases and illhealth were taken out of the social milieu to tackle them witth newly discovered 'magic bullets'.

Vaccines were developed for Poliomylettis, Rubella, whooping cough, tetanus and diphtheria and this took the discipline of Immunology a long way. Introduction of contraceptive pills for birth control was a significant contribution of endochrinology. Anaesthetics found out ways of replacement of blood and fluids and helped in the control of infection and conducting of surgery. The introduction of sophisticated diagnostic instruments for X-ray analysis and CAT scanning, surgical revolutions such as heartt transplantations and the birth of first test tube baby (1978) by in virto fertilisation emphasised the technologically determined paradigm on health.

The 'Intensified Programme on Smallpox Eradication' began in 1967 which was dependentt on freeze-dried vaccine, the jet gun innoculator, the bifurcated needle and laboratory technologies for the diagnosis of smallpox became successful in 1978. By the end of 1979 the Global Commission for the Eradicatioon of Smallpox certified that smallpox have been totally eradicated. This incident not only saved

the face of WHO and many countries who were struggling to explain the implications of the failure of Malaria Eradication Programme but also prompted the international bodies to go for more selective and technical programmes to deal with the health problems of the Third World.

It was in April 1979, John Knowles, President of Rockfeller Foundation held a meeting in Bellagio on 'Health and Population Development'. He was very much concerned about "policy options in the health sector that would succeed." A paper[126] (titled 'Selective Primary Health Care, an interim strategy for disease control in developing countries') evolved as a result of deliberations of this conference and subsequently published in 1979 itself in New England Journal of Medicine. As this paper became the cornerstone of later policies and programmes of international agencies, it needs to be studied in detail.

Walsh J.A. and Warren K.S. who authored the paper, listed major infectious diseases of the South in order of priority based on prevalence. The data used for this prioritisation is questioned by critics later.[8] A programme was formulated to tackle these diseases using immunisation, oral

rehydration therapy, breast feeding and antimalarial drugs. The paper proposed that "until comprehensive health care can be made available to all, effective services aimed at the few most important diseases may be the best means of improving the health of the greatest number of people." Through their paper they introduced two terms - comprehensive primary health care and selective Primary Health Care which are antithetical in content and they slipped over from 'health care' to 'health services'.

In fact the paper talked aboout five interventions, viz. Comprehensive PHC, Basic PHC, Multiple disease control measures, Selective PHC and Research. But it is to be noted that every country has a health system containing a mix of all the above. Isolation of the above ideal types and subsequent use of them to draw conclusions is invalid.

To the authors, "Leprosy and Tuberculosis require years of drug therapy and even longer follow up periods to ensure cure. Instead of attempting immediate, large scale treatment programmes for these infections the most efficient approach may be to invest in research and development of less costly and more efficacious means of prevension and therapy." This is nothing but ignoring the years of re-

search in the above field in developing countries. The authors pretends to be more knowledgeable about the more fashionable, externally supported disease control programmes and TB and Leprosy do not fall in this category.

They again ignore the health care intrastructure that already exists in most of the Third World countries, they could not directly address the nature of wider development process and they fail to draw adequately upon the historical experiences of Africa, Asia and Latin America with regard to health and health care questions as evidenced from their following proposition. "The selective approach to controlling endemic diseases in the developing countries is potentially the most cost effective type of medical intervention On the basis of high morbidity and mortality and of feasibility of control a circumscribed number of diseases are selected for prevention in a clearly defined population.... The principal recipients of care would be the children up to 3 years old and women in the child bearing years. The care provided would be measles and Diphtheria, Pertusis, tetanus, DPT vaccination for children over six months old; Tetanus Toxoid to all women of child bearing age, encouragement of

long term breast feeding, provision of chloroquin for episodes of fever in children under 3 years old in areas where Malaria is prevalent and finally oral rehydration packages and instruction."

"Health planning for the developing world to the authors require two steps which are essential. They are "selection of diseases for control and evaluation of different levels of medical interventions from the most comprehensive to the most selective". That is, some goals or needs are to be defined at first, usually in terms of diseases and techniques and standards devised as practiced in industrialised countries. "Once the diseases are selected for prevention and treatment the next step is to devise intervention programmes of reasonable cost and practicability." Thus even after selecting certain diseases, they are likely to be discarded on cost consideration.

The paper has certain studies to quote to substantiate their argument. But the inividual studies referred are isolatted projects often carried out by external agencies, their costs and benefits varied greatly. As Gish O. observed results, with World Bank or other global estimates,

with their own data based upon their African model area and applied to other parts of the world."[54] The paper reaches negative conclusions about virtually all activities other than those preferred by the authors and projects isolated litle areas as models reference points for the entire Third World.

The criticisms voiced against Selective Primary Health Care (SPHC) forced Rockfeller Foundation to invite a gathering in collaboration with WHO in February 1983 in Bellagio. But the consensus report prepared at the end of the conference virtually re-emphasised the aspects mentioned in the Walsh and Warren paper propagatting SPHC. In the meantime UNICEF declared a 'Children's Revolution'[66] (1982/83). In May 1983, Robert MacNamara and Jonas Salk met with James Grant (executive director of UNICEF) to suggest that immunisation should be the spearhead of the proposed UNICEF initiative. In March 1984, another meeting at Bellagio, sponsored by WHO, UNICEF, UNDP, World Bank and Rockfeller Foundation discussed the issue of "protecting World's Children: Vaccines and Immunisation within PHC."[111] In agreement with the deliberattions of this meeting A 'Task force for Child Survival' was organised to co-ordinate the immunisation

efforts.[112] India and China were the firstt to accept the programmes suggested here, with fanfare.

In April 1985 yet another meeting in Bellagio discussed the issue of "Good health at low cost." Technocrafts from Kerala, Costa Rica, Sri Lanka and China reported on their societies. A report on the proceedings of this meeing remarked as follows: "The impetus for this conference emerged from the interest of some of us in developing a global strategy for 'Health for All' by targeting for action an essential short list of diseases."[73] This was another attempt to isolate the above societies and their achievements, to project the importance of selectivist and technocratic approaches which is in no way near to the truth as the gains of these societies were the result of accumulated efffects of various social and historical processes.

By this time, certain trends were visible in the nature of relationship between the drug industry and the countries of the Third World. The share of Transnational Pharmaceutical companies rose up to 75-85% with more or less the same leading products in the majority of the developing countries. Generally not more than 25-30 pharmaceutical produc-

-ers supply about 80% of the drugs consumed in developing countries. The price transfer practices varied from country to country and the deciding factor depended on the nature of relationship between the host country and the guest company. The drug composition pattern in developing countries do not always correspond to the pattern of the most common prevalent diseases. Moreover the pharmaceutical sector became a captive market which has an effect on health care system and especially on the cost and type of drugs supplied. The lack of a National comprehensive drug policy as part of National Health Planning create in most developing countries a gap between drug demands and the actual health need for essential drugs. As a result, in many developing countries 60-70% of the population, mainly in rural areas do not have ready access to the most essential drugs.

A most disturbing trend in recent years, has been the attempt by the transnational corporations to exploit the Third World malnutrition by promoting unsustainable solutions and remedies for their major public health nutrition problems. The attempt to push iodised injections (which is expensive and beyond the technological capabilities of poor

countries) as an answer to the problem of iodine deficiency disorders, in preference to salt iodisation (which is well within their reach) and the attempt to push massive dose of synthetic vitamine A even in infants as an answer to the problem of vitamine A deficiency in countries where in there is an abundance of inexpensive carotine-rich food available are examples of inappropriate technologies imposed on the Third World by vested interersts.

From the above it could be inferred that a selective approach to health care through technology governed strategies which are devoid of any development orientation is the result of processes abetted by certain forces which desired to sustain the consumerist lifestyles of a few by keeping the masses of the Third World in perpetual ill-health and underdevelopment.

E. Initiatives based on Selective Primary Health Care Strategy

By the mid 1980s, the donor agencies had accepted the line of argument provided by SPHC and resources were increasingly directed in to vertical programmes that sought quick technical solutions to health problems. In addition

to the Unicef's 'Child Survival and Development Revolution' (CSDR) which selectively focussed on Growth monitoring, oral rehydration, breast feeding and immunisation there were others named 'Global programme on immunisation',[70] 'Polio Plus',[130] 'Acute Respiratory Infections Programme'[132] and 'Safe Motherhood Initiative'[131] which was co-sponsored by World Bank and WHO.

To appreciate the genesis of Unicef's Children Revolution, it would be worthwhile to study its annual 'World Children's Reports' after the Alma Ata Conference. There was a gradual change in the attitude of Unicef towards Health after Alta Ata Declaration. Up to the year 1981, Unicef recognised certain basic aspects about 'Health' as evidenced from its 'World Children's Report 1981'. It highlighted the following three points:[65]

(i) Economic growth is a necessary but not sufficient condition for the elimination of poverty.

(ii) Policies aimed at directly meeting the needs of the poor are a more promising way forward than reliance on the trickle down of growth.

(iii) The distribution of resources and incomes implied by

such policies need not detract from and even may enhance the prospects of economic growth itself.

The 1981-82 report entitled "Children in dark times" took its background in African poverty where the food production was declining in the tenth successive year and food shortages and massive refugee movements threatened the very existence of the people of this continent. Unicef observed: "the optimism of the 1960s which gave ground to the realism of the 1970s has now receded even further to make room for the doubt and pessimism which seems to be settling in to the 1980s."[67] When Unicef introduced the 'Child Survival Revolution' in its 1982-83 report it had the following arguments:[68]

(i) Financial and human resources for PHC are scarce and growing scarcer due to the recent decade of international financial crisis.

(ii) Simple, low cost widely accessible technologies for saving children's lives exist.

(iii) Means for popularising these technologies at low cost also exist.

The above report has never touched issues like food, shelter

and sanitation. K.W. Newell has argued that the SPHC proposals of Unicef and other agencies are ideologically similar to Malaria Eradication Programme and are a regression to the very qualities of imposed systems.[99]

Unicef writes: "An adverse external environment is likely to raise the number of absolutely poor to one billion by 1990."[65] But the fact is that, what is "external" to some may be comfortable "internal" to some developed countries. Unicef invokes world economic crisis as a fact of life. Something happened to poor nations, like a natural disaster! Thus Unicef naturalised poverty and concerned about too many poor pressing the nature too hard.

With the initial strategy of Growth monitoring, Oral Rehydration Salt, breast feeding and Immunisation, Unicef added family spacing, female education and feeding programmes through its 1984 report. Thus the revised causes of poverty now include population growth and women's ignorance. Population growth is thus seen as a cause and not as a symptom. It is to be remembered that PHC was developed as an approach at a time, there was wide agreement that the causes of poverty were non natural and that social justice

was a requisite for health. By naturalising poverty once again by its emphasis on external uncontrollable economic forces, population growth and ignorance of women, Unicef located health action wholly outside the realm of socio-economic rights and responsibilities.

By advocating so called "appropriate technologies for social transformation, international agencies want to put means as ends. Because fuel efficient charcol, wood burning stoves, improved mud construction techniques, agroforestry and other appropriate technologies would not be equivalent to social transformation. The oral rehydration salt could not be a substitute for clean water to which parents and children have a right.

Unicef feels "community organisations, para professional development workers, primary schools and primary health networks, the people's movements" etc. are "the missing link between the knowhow of science and the needs of the people". Thus grass roots organisations are understood by an agency backing CSDR, which formulates its limited packages of interventions outside the local situation and mobilises resources to diffuse that package campaign style at national

level. The kind of community participation has been referred as "instrumental" rather than transformative.

The above mentioned delivery approach is in full agreement with the 'Basic Needs Approach' which imposed an external expert definition of 'need' on community. As local organisations are only for delivery of goods and services, conflict and struggle are neither understandable nor encouraged. Even the participation in delivery seems impossible as T.V. and media advertised pre-packed ORT salts in cities instead of parents make their own ORT salts at home. Breast feeding slogans were coined outside the country and marketted by advertising agencies. Unicef, here, attempts to limit the potential of indigeneous local organisations for channelling protest and health demands by their conversion to mere conduits for the delivery of GOBI package.

In an article regarding "Marketing Child Survival",[69] Unicef remarks that its "function is to serve as advocate of relevant information from outside and see that supplies are made available and within effective reach." "What is needed is to communicate the information and knowledge to bring about that change, thereby converting latent demand into

articulate and putatively effective demands to which supply is the response."

It has been argued tht CSDR/GOBI scheme is dangerous as the individualising orientation of GOBI elements and their implied model of disease causation focusses not in social causes but on ignorance and fault of individuals. As did in some African countries, the use of police and paramilitary forces for campaigns symbolically re-inforces the status and importance of central state, urban hierarchy and structures of dominance. CSDR is a minimal package in the face of failure of parents to achieve a revolution in the power relations determining health and failure of poor nations to win a New International Economic Order.

The Global Programme on Immunisation aims to ensure that the six immunisable diseases diphtheria, whooping cough, tetanus, childhood tuberculosis, poliomyletis and measles cease to be public health problems, if not truly eradicated from the globe. The World Health Assembly also adopted a resolution committing to a programme of eradication of poliomyeletis. In 1982 WHO initiated Acute Respiratory Infection (ARI) programme world wide. WHO documents on

ARI says; "ARI programme stresses the benefits of vaccination for the prevention or morbidity due to Acute Respiratory Infection."[132] It adds that ARI programme must be seen as an important part of efforts towards child survival and as an essental component of PHC.

The Safe Motherhood Initiative (SMI) intends to reduce maternal mortality and morbidity. The target is to reduce maternal deaths by at least half by the year 2000. The initiative places emphasis on the need for extension of family planning education, maternal health services, improving the status of women and increasing awareness of the problem. But the reports about SMI reveals that the programme is obsessed with Family Planning education at the cost of other aspects outlined in the programme. Critics asked why a "Safe Motherhood" only and why not a "better motherhood?"

The Diarrhoea Disease Control programme makes use of the Oral Rehydration Package and its social marketing. The WHO literature regarding this programme talks about water supply and sanitation also as a part of this programme.[82] Yet, at the implementation level the programme is depended

on prepacked ORT salts for all practical purposes in most countries of the Third World.[95]

The dependency is more pronounced in the case of GPI which had designed to make people dependent on North for funds, vaccines and equipment. They are launched with out collecting the basic data about the incidence rates of the targetted diseases. According to Banerjee, there was no analysis on variations in different regions and the ecological cultural social and other factors which affects the incidence rates in different countries. Neither UNICEF, nor the countries which enthusiastically implemented these programmes considered the trends in the epidemiological behaviour of the different diseases over a time period. The questions of efficacy of the vaccines and salt under controlled conditions and under widely divergent conditions prevailing in the field were over looked.[14]

UNICEF and its beneficiary countries never took in to account the lessons from the failures of vertical programmes for malaria eradication, trachoma, leprosy, filariasis, cholera and STDs. In large and hot countries like India, formation of an effective nationwide net work of field

workers, ensuring timely supplies, development of cold chains etc. are unrealistic targets. More over the general health services of the developing countries may suffer in the process of busy target achievement of imminisation. After the failure of the Indian Immunisation programme, public health activists called GIP as an example of technological totalitarianism of North, aided by planned disinformation campaign, imposed on Third World countries.[14]

Unger and Killingsworth in a critical review[123] of methods and results of programmes based on SPHC concept attracted major donor agencies as it encourages private sector to be involved in health service delivery to large populations. The programmes promoted use of advanced technologies which benefit multinationals and maintain the financial and institutional status quo. It has an appeal to donor agencies due to its cost effectiveness. An analysis of the SPHC programmes prompted Banerjee[8] to conclude as follows, about SPHC.

i. It neglected the concept of community participation with programmes planned from 'bottom up'.

ii. It gave allocation only to people with priority dis-

eases leaving the rest to suffer.

iii. It reinforced authoritarian attitudes.

iv. It had a fragile scientific basis.

v. It had a questionable moral and ethical value in which foreign and elite interests over ruled those of the majority of the people.

The "Antwerp Manifesto[12] for Primary Health Care" which came out after a gathering in Antwerp in 1985, called SPHC programmes as 'Selective Health Status' interventions. The academicins and community health specialists gathered here argued that "these interventions purport to offer quick solutions and instant success for which they divert scare resources from the solution of the real underlying and continuing problems, thus helping to maintain ill health.

F- Initiative based on Information Education and Communication

Tests on stored blood samples in 1978 revealed the advent of a new disease called AIDS. It appeared both in Africa and America more or less the same period. But the Western media reported that AIDS originated in Africa, with out any scientific proof. Media and white researchers

attempted to locate the virus in 'Haiti' and then in Africa. Even in 1991, Jonathan Man from WHO, in an article named "How AIDS has changed epidemiology[88] has identified Haitian Blacks along with gays, drug users and prostitutes as 'High Risk Groups' who are prone to spread AIDS. Thus from the very outset, the origins and spread of HIV virus has been blamed on certain communities which the white heterosexual society see as being deviant.

In the absence of a vaccine or cure to contain this disease, the first steps adopted by U.K. government were racist immigration policies, practices and visa restrictions.[76] In 1986, British government suggested that Africans should be subjected for AIDS tests at the first point of immigration. U.K. foreign office required all visitors from Central Africa to carry certificates of non contamination. It will be informative to note that similar measures were not introduced on American visitors to U.K. despite 75-80% AIDS carrying people came from USA. Even after only 35 Haitian immigrants were tested HIV positive out of 700 in 1986, Haitians were targeted and victimised for AIDS spreading.[76]

On 20th November 1986, the Director General of WHO announced the WHO considered the AIDS to be an unprecedented challenge to public health. Later in 1987, G.P.A. (Global Programme on AIDS) was established to "unity national responses to AIDS epidemic".[134] The programme was initiated "to provide global leadership in the fight against AIDS" and "to promote and support the development, implementation and evaluation of National AIDS control programmes. The world summit of ministers of health on programmes of AIDS prevention held in London in January 1988 was jointly organised by WHO and U.K. government. The 'London Declaration' which was made at the and of the summit states as follows, "In the absence at present of a vaccine or cure for AIDS, the single most important component of national AIDS programmes is information and education".[134] Jonathan Mann, Director of GPA (Global Programme of AIDS) in an article titled "Global AIDS, Epidemiology, impact, projections, global strategy" out lines the four important components of national information and educations programmes as follows:[134]

i. Programmes for general public such as broad public

information campaign.

ii. Information and Education targeted to groups which are prone to AIDS.

iii. Conselling to persons with high risk behaviour, not only to inform and educate them but also to support them in the difficult process of changing their behaviour.

iv. Health workers must not only educate others but also provide infected people with humane care, ensure safety of health care procedures but also to form an enlightened public opinion.

Presently IEC (Information, Education and Communication) is the strategy of global programme on AIDS.

The strategy calls for the wide use of information technology which when put in to practice, as Manoff. R. writes, is actually media technology and manipulative social psychology which was developed to sell Green Revolution to the Third World countries in the 60s. As practicised in the case of earlier international initiatives the chosen information technology is 'social marketing'. The 'social marketing' focuses on "products" not "processes" the products

were immunisation, ORT and family planning. Here it is social marketing of AIDS slogans. The communications is a one way affair through media and goes against all definitions of "Communication". The ability to tap local knowledge and skills are virtually zero. Characters from Disney land (like "Dennis the menace") were used in anti AIDS campaigns in schools of Delhi, which do not have any appeal to the students, as reported in a local news paper. News papers also reported about social marketing of condoms as an attempt to exterminate the Black majority from that part of the world.[89]

A WHO document on AIDs education published in 1989 states as follows:[136]

"Unlike AIDS education programmes for the general public, which address people at many different levels of risk, programmes for homosexual and bisexual men, for prostitutes and for intravenous drug users are directed specifically at those most likely to engage in high risk behaviour". There was no effort in this document to define the size and distribution of the risk group in a scientific and biasproof way. Not even a single WHO document cared to analyse the

socio-economic and political compulsions which made them risk groups though there was acceptance of the fact that AIDS is part of a big problem which is characterised by poverty, lack of adequate health care, discrimination and disfranchisement.[15]

The WHO AIDS series on "Prevention of sexual transmission of Human Immuno-Deficiency Virus"[136] lists out HIV antibody tests apart from education, counseling and provision of condoms and spermicides. A study argues that "Compulsory testing is likely to cause unnecessary suffering and harm. The decision to test one group of people rather than another, is usually based on unproven assumptions about which sectons of the population are spreading the disease. There is a danger that all those not singled our for screening will consider themselves to be not at risk".[136]

Another WHO publication titled "Guidelines for conselling about HIV infection and disease", consider "conselling a person can avoid acquiring HIV infection or transmitting it to other by changing behaviour". This is questionable and it should be doubted whether conselling could make any impact on the behaviour of the poverty stricken, discrimi-

nated victims who form the risk groups.

Leading news papers came out with stories which reveal the role of market forces in the aftermath of various National AIDS control programmes. Pioneer reports: "nearly 60% of the $100 million World Bank loan to India to fight AIDS will go back to the companies which sell test kits and equipment. Banerjee in a well presented article argues as follows:

"While the intrinsic public health relevance of problems such as AIDS, drug addiction, non communicable diseases like cancer, cardio vascular diseases and aging must be measured scientifically and given proportionate place in the overall strategy of public health practice. It is also necessary to note there is a real danger of the responses to such diseases becoming disproportionately greater simply because they also threaten the lives of the privileged few and/ or they are of interest to the market forces".[13]

From the above discussion it is evident that the World Bank and WHO sponsored AIDS control programme took its origin in blatant racialism, ethnocentrism and poor planning and depends on information technology and social marketting

of AIDS slogans, condoms and spermicides. The people are relegated to the position of subjects for the business, technology and political interests of an expanding national and international bureaucracy.

G- Initiatives in the field of Environmental Health:

Ecology was brought to the centre stage of political and economic decisions, scientific research and geopolitics by the structural changes in the post second world war society.[22] These changes include the increasing economic inequality in both developed and developing world and the selective rolling back of 'welfare statism'. When political parties have declined to special interest groups, the influence of trade unions in industrial relations and national politics too have declined. Corporations and market transactions have become increasingly trans-national in scope and political cultures have shifted from an emphasis on mitigating the impacts of private accumulation to ensure the sanctity of entrepreneurship. The industrialisation during this period contributed severe environmental problems and to local and international initiatives against many of the

industries and production processes that lay at the heart of the post world war economy.

The international response towards the 'environmental crisis' evolved through three major phases[22] as listed below;

i. 'Population bombism' of Paul Ehrlich and others during 1960s : The Neo Mathusianism in this approach was severely criticised by the Third World delegates at the 1974 UN world population conference, at Bucharest.

ii. Limits to Growthism' of Meadows (1970s): This notion was an utter failure as it threatened so many groups on account of its imperative to achieve a steady state economy i.e. to reduce the rate of accumulation to zero.

iii. Global environmental and climate change frame work (1980s on wards): This approach is closely related to 'sustainable development' and side steps the issue of 'limits to growth' through its implicit assumption that growth and accumulation can be consistent with environmental conservation.

Today, 'sustainable development means "development

which meets the needs of all the present population with out compromising the ability of future generations to meet their own needs".[142] It calls for a strategy that combines environmental conservation, social justice and economic growth. This is an out growth of internationalisation of the environment movement and its origins are in the critique of prevailing development practice by groups external to official development circles. But a happy marriage between sustainable development and social justice in the Third World is in trouble as the dominant development institutions in the world are mainly interested in global capital accumulation, promotion of liberal trade arrangements and maintenance of Third World debt repayment schedules.

The development initiatives sponsored by international development agencies have the following impacts:

a. Their loans and credits goes to environmentally sensitive areas such as agriculture, forestry, dams and irrigation.

b. They determine the development policy, pattern and resource use.

c. International finance in the economic development of

the Third World countries change the natural resource management strategies in a drastic way.

The contribution of international development aid and loan to the process of ecological distruction of the resource base for survival in the Third World has provided the platform for a joint global response by Ecology Movements in both developed and developing countries.

In 1971, the 24th World Health Assembly adopted a programme for environmental health, in anticipation of the United Nations Conference on Human Environment (Stockholm, 1972). The UN conference on Human settlements held at Vancouver (1976) stressed the importance of water supply and sanitation as essential to health and subsequently WHO endorsed the recommendations of UN water conference (Mar del Plata, 1977) which gave priority to provision of safe water supply and sanitation for all by the year 1990 and designated the decade 1981-1990 as 'International Drinking Water Supply and Sanitation Decade'. WHO has initiated four special projects in 1990-91 viz. Environmental Health Assessment and Forecasting Systems, Healthy Cities Project, Environmental Health Support to countries in greatest need, Global network to strengthen education, training and re-

search in Environmental health.[138]

A detailed analysis of all the above projects is beyond the scope of the present study. However a remark is to be made about "Healthy Cities Project" which is operational in European countries since 1986 and is planning to be implemented in developing countries. The urbanisation problems of the Third World has roots in rural distress and destitution. Any attempt to counter urbanisation problems in these countries should start from the rural push factors in which exploitative agrarian relations play a major role. The thrust of Healthy cities project is in awareness campaigns, information exchange and technology transfer and improvements in health services,[137] There can not solve social and ecological problems attacked with urbanisation and broader policy measures are required in the special context of developing countries.

A 'Global Environmental Facility' was set up during the count down of UN conference on Environment and Development (Rio de Janeiro, 1992). This is a pilot programme to facilitate the disbursement of loans or grants to the South to encourage projects relating to protection of global ecology.

The global environment fund is to be administered jointly by World Bank, UNEP and UNDP.[1] Given the track record of funding the environmental disasters, there is substantial reason behind the anxiety of the South that Environmentally disastrous aid packages will emanate from GEF, notwithstanding the fact that India had given the Chairpersonship of GEF. Moreover proposals to give the South more funds for sustainable development and as a compensation for environment damage will likely to remain unfulfilled not only because of the economic decline and recession of developed countries but because of the administrative set up of GEF.

There was not sufficient information regarding the adverse effect on human health of the developmental and environmental crisis even at the outset of 90s. WHO has set up a high level expert committee on health and environment "to make an inventory of what is known and what is not known" and to asses "where more research is needed".[139] On the basis of the findings of this commission WHO intends to "develop responsive programme strategies. The 'WHO commission on Health and Environment' was to prepare an assessment of the consequences to human health of present and foreseen

environmental determinants associated with or arising from socio-economic development" and to issue an authoritative statement regarding their importance as well as priorities and approaches to dealing with them". Therefore this particular report[137] needs a closer look.

The report of WHO commission on Health and Environment (Our planet, Our health) analyses the relationship between health and environment in the context of development. The analysis of the socio-ecological issues in the report is carried out in isolation from the dynamics of the international economic system. A multi dimensional politico-economic approach which synthesis micro level reality with the global perspective is conspicuous by its absence.

According to it, Biological and chemical agents along with the expanding population are the root causes of the global environmental crisis. "In developing countries, where population are still expanding, pressure on scarce resources has made it difficult to improve living conditions..."[137] Further, "the pressure on resources of growing populations and growing consumption levels is so severe that to wait for economic expansion to reduce fertility

would be disastrous".[137] Accordingly the report prescribes that; "from the purely environmental point of view, the direct and immediate concern of developing countries is population size". Thus for the report, development can wait, but fertility control can not.

The report outlines strategies to be followed, in the years to come by national and international bodies. The enlisting of global objectives to be achieved with tools, such as cost benefit analysis (CBA) constitute the concluding part of the report. It is to be remembered that the CBA in most world bank/UNDP projects normally do not take in to account the cost of human elements involved in the projects and hence there is no scope for a social audit in majority of the cases. To the international agencies, sustainable development objectives could be attained using a kind of environmental managerialism i.e. using environmental and resource management considerations in a cost-benefit formulation in to be national and subnational planning methodologies to help Third World countries to control their economies.

The dominant view of development in the international

scene accepts the intrinsic superiority of industrialisation and urbanisation over more indigenous mode of organising livelihoods and production supported by an assumption that nature is an inanimate entity to be appropriated, controlled and acted upon by man using technology. But an emerging paradigm in the Third World rejects this characterisation of the nature and techno managerial and socio-political option which emanate from it. The proponents of this paradigm confront the vision of managing society and argues that nature is animate, a provider of resources and surplus and that lifestyles and livelihoods can be sustainably protected only if the regenerative capacities of renewable resources are respected.[118] They support the victims of the above exploitative development paradigm in which the poor are unable to stand up to the combined forces of the state, the traditional vested interests and the modern market under the impact of corporate world capitalism.

The capitalist reaction to the above kind of awakening is the new packaging of the old development model co-opting the language of these movements to decorate the contents of old development programmes guided by market and biased in favour of those who already enjoy economic superiority.

Funds are pumped to the professionally managed "delivery NGOs",[16] for new forestry programmes and droughts protection programmes as if leaving matters to these NGOs means a new conceptual frame work. The current initiatives in the field of Environmental Health should be seen in this context.

The WHO report proposes for 'Primary Environmental Care' as another tool which it defines as "a process by which local groups or communities organise themselves often with outside support, so as to apply their skills and knowledge to the care of their natural resources and environment while also satisfying their livelihood needs". This is essentially a local initiative which incorporates "protection and optimal utilisation of the environment", "satisfaction of basic needs" and empowering of groups and communities. In the context of the proposed 'Primary Environmental Care (PEC), three important points should be noted:

i. Optional utilisation of local resources are under threat due to the invasion of commercial capitalism in the mode of natural resource utilisation of the local people. Here, the conflicts between basket weavers and

paper manufacturers; plough makers and sports good makers and fishermen who use locally made fishing nets and food exporters who use machanised bottom trawlers can be taken as examples. Such kind of conflicts which are going on in different parts of the Third World could not be solved in the PEC frame work.

ii. Satisfaction of basic needs would not abolish the vulnerability of the poor towards ill health poverty, famine and drought. A paternalistic provision of 'basic needs' can only be a temporary solution of envi ronmental crisis which the Third World are in presently.

iii. "Empowerment" is a desirable project. In the practical field only "authority" can be shared and power is something which is to be acquired forcefully by the incumbent from the power structure. Thus the "empowerment projects of international bodies are framed on people's aspirations to have their just positions in the power structures of local and national politics. This is especially true when more and more people are displaced from their natural habitats for constructing big dams to provide irrigation facilities to money crop

growers etc.

The section on 'global challenges to health and environment' examines the question of global poverty in detail and suggests that "the nature of poverty and the relative importance of the factors contributing to it within a country vary between individuals and social groups, in some cases influenced by seasonal and meteorological circumstances, in other cases reduction of purchasing power due to economic contingencies in others still by war and civil strife. "Such a simplistic explanation of contributing factors of poverty stems from the traditional knowledge that famines are natural disasters created by drought or that they are an inevitable result of exploding populations, of too many months beyond the capacity of local food production to feed. One can not deny the fact that a famine is precipitated by a failure of rain, crop failure or prolonged war. But famines affect only the poor countries and not the rich. Moreover, it is not always the food shortages that causes famine but the poverty of the victims who do not have the wherewithal to buy the food they need. In most cases a country's poverty is linked with trading practices in which rawmaterials are exchanged with finished products. Notwith-

standing this, the international bodies go for curing the famines after they have occurred, rather than preventing famines from occurring.

The section on 'trans boundary and international problems' does not identify potential conflict areas such as creation of 'biosphere reserve forests' as the common global property and efforts of put them under a global authority. It will definitely deprive the third world countries their right to use their own forests for their sustainable development. After spoiling their own forests, the first world wants to use the Third World Forests as sinks for their pollution. The consistent stand taken by India and other Third World Countries is that "forests are an inalienable national resource and countries will choose, use of their forest resources according to national priorities and strategies". When the north wants to replace ozone layer depleting chemicals with other substitutes, they are not ready to give the technology for which, at subsidized rates, to the Third World countries.

The above exposition of initiatives in Environmental Health and inherent conflicts in global environmental action

and the evolution of 'environmentalism' shows the ideology of Primary Health Care and the spirit of Alma-Ata were discarded by the decision makers of international bodies. Equity and justice and thus health and development are evading most of the African, Asian and Latin American countries whose struggle for the above are further crippled by the Bretton Woods system through its prescription for structural adjustment and globalisation. The next section examines these and other related issues.

H- Impact of World Bank Sponsored Structural Adjustment Programmes in the Health Sector of the Third World

It is the World Bank which sponsored or co-sponsored many of the programmes in the Health Sector of the Third World. But the health sector is much affected by the Economic stabilisation and Structural Adjustment Programme (SAP) which are conditions for assistance and to correct the balance of payment and fiscal deficits of the recipient countries. The permanent people's tribunal on the policies of IMF and World Bank observes as follows: "The World Bank and IMF are in breach of the charter of the UN in that they have not promoted higher standards of living, full employment and conditions of economic and social progress and

development, nor have they promoted a universal respect for the observance of human rights and fundamental freedom for all".[105]

In fact the adverse social consequence of the World Bank package and the sheer inability of the ruling regimes of recipient countries to deal with them results in a situation where in the richer sections tend to gain while the large poor sections suffer during adjustment programmes. The historical experience of the countries which have undergone the World Bank directed SAP is that these countries have witnessed a fall in the standards of living of large section of the populations, mostly the urban and rural unorganised workers as a result of slowing down of employment opportunities, increase in open unemployment as well as under employment, fall in real wages, withdrawal of food subsidies, rise in prices of public services, contraction of social expenditure by the government and a decline in capital expenditure.

Paul Strecten after a survey of the issues involved in SAP concludes as follows: "The price rise that follows devaluation and the removal of controls frequently affects particularly the necessities consumed by the poor. Reduction

in government expenditures are often on labour intensive public works, food subsidies and social services..." Monetary and fiscal restrictions raise unemployment and reduce the bargaining power of unskilled labour. In all cases it is the poor who suffer more than they would have suffered in a situation of repressed inflation where demands for labour is high, the prices of necessities are controlled and social services are generous".[122] To the extent that the axe falls on social expenditure like education and health and social security nets the standard of living of the poorest section is directly hit. This is also a sequel of expenditure switching to facilitate measures like devaluation, reduction of tariffs, removal of price distortions etc.

The government documents usually argue that at some undefined point in time the economy will "pick up momentum" and the growth generated would" trickle down" and improve the lot of the poor and the poor have to "tighten their belts" for the time being. But as Loewenson pointed out, the "belt tightening" "has been a euphemism for a fundamental attack on the basic elements of social well being".[87] Most of the Third World countries undergoing SAPs have been

reported to have experienced rising rates of ill health and mortality in both the urban and the rural poor. Diseases that had reportedly been eliminated such as yaws and yellow fever in Ghana reappeared during SAP period.[79,81] There was a marked increase in the IMR, which had actually begun to decline in many African countries, rose by 4-54% in the SAP period as evident in the table given in Appendix.

Increases in child (under 5 years) mortality rates of 3.1 to 90.0 per cent were observed in all the countries mentioned in the table during the same period.[27] In Bangladesh, higher prices of rice resulted in higher child motility.[122] These types of undesirable effects would cause irreparable long run damage to the affected people, even if economic stability is restored. As Eshaq remarks: " It is not however always realised that cuts in current social expenditure notably on child welfare, health, nutrition and education also significantly influence the productivity of future generations. The future costs of such cut backs are likely to be particularly high in the poorer developing countries where the standard of living is already very low and where a relatively large proportion of children suffer from malnutrition and poor health".[4]

The decline in the share of social security expenditure has been particularly sharp in Latin American countries and West Asia - from 36.0 per cent to 24.3 per cent and 20.3 per cent to 17.2 per cent respectively between 1980 and 1987.[53] Within capital expenditure, investment in social infrastructure has suffered most. In Sri Lanka the spending on health, education and food subsidies declined from 38% of current expenditures in 1977 to 22 per cent during the years 1980-82 which coupled with limited growth in earnings among the poor resulted in an overall decline in the levels of consumption of the poorest expenditure classes.[114]

In Turkey, Guyana and Sudan there was a relatively sharper reduction in social expenditure. In Somalia and Tanzania primary education's share in expenditure actually declined. Ginnekan reports that in Tanzania cut on spending on drugs etc. resulted in drastic deterioration in the quality of rural health care provided.[53] Plenty of empirical evidences are available to show the adverse impact in the health sector of the Third World during SAP.

The impact on nutrition and food security should be

understood in the context of real wage reductions, rising prices and cut back in public subsidies. In Mozambique, removal of food subsidies caused a real increase in food prices of 400-600%. In January 1989, a kilogram of tomatoes or onions cost 5% of an office workers' wage.[26] In Ghana, the mid 1980 average wage in Ghana was sufficient to buy only 30% of food needs.[30] Most often the households try to cope with their declining purchasing power by shifting food consumption to poor quality, high bulk and low energy food, leading to chronic nutritional deprivation, particularly in young children. Generally, there are no incentives for food crop production, which provides for a substantial part of rural food security. More over, if at all certain incentives are given, they are in terms of credit facilities which tend not to be used by the poorest section of the peasants.[86]

The impact on Health care is marked in the case of Latin American and African countries. The per capita expenditure on health had fallen by 40% in Jamaica, 23% in Ghana and 8% in Brazil.[29] The government hospitals and clinics were asked to charge fee as part of the World bank strategy of "cost recovery". This fee charging to the world bank is

to improve the quality of services and to provide drugs. But it has reduced the accessibility which was the corner-stone of the proposed health delivery systems in Alma Ata Declaration and of the earlier Basic Health Services Schemes. In Mozambique, for example, fee charging was reported to depress out patient visits in Maputo by 24% between 1986 and 1987, while contributing to a minimal 1.6% of the State Health Budget.[26] Due to cut backs in salaries, public sector health personnel migrated to the private sector or to developed countries. In Ghana, for example, of 1,700 doctors working in the public health sector in 1982, only 665 were in post in 1987, most having left for Nigeria and Saudi Arabia.[3]

Health workers in the public sector are increasingly pressured to perform private work for extra income and use public resources to support these practices. At the same time there were a number of "studies" about government sector health services naming them "inefficient, bureau-cratic, and incapable of reaching beneficiaries". Many skilled and experienced professionals in health and other GRsectors moved to donor agency employment where their in-

comes, conditions of work and facilities are much better. Donors in their turn provide selective support to specific programmes under their own management, many without addressing broader infrastructural support of the public sector.[143] As against the public sector, private sector demonstrated efficiency, cost effectiveness and ability to execute anything succesfully. This resulted to offer a primary responsibility to private sector in the development of health in developing countries as evident in the document 'investing in Health' published by World Bank.

Rene Lowenson, in an illustrated article on SAP and health policy articulated the features of a profound change in health policy due to SAP in the Third World. These are:

"A proactive health policy is replaced by health sector measures to accommodate the SAP.

- There is a widening gap between affected communities and policy makers leading to alienation and social tension with the social response ranging from individual coping mechanism to social resistance.
- Health as a right with its inherent principles of equity is changed to health as a commodity (for the rich) or a charity (for the poor).

What Loewenon observed about Africa is true for other countries also ministries of health are not being asked to shape policies for the health sector, but rather to define ways of making the health sector accommodate to the economic policy measures in the SAP.

A central aspect of Alma Ata Declaration which was also embedded in the health policy of almost all decolonised Third World countries has been the importance of peoples organisation and community mobilization. But SAPs have taken away this social element by placing a greater emphasis on the individual household's ability to buy services or to find way of dealing with economic problems. The declined role and reduced credibility of the state left the ordinary people in bewilderment without effective social organisations to protect their interests. Further, SAPs have distanced the policy makers from the community. Planning became the prerogative of the very few who sit and discuss with multilateral financial institutions. Civil Servants became "executors" of policies developed by donor agencies, whose exposure to local needs and conditions is practically nil. The secrecy attached with SAP packages makes a state

totalitarian tendencies to express in its peak.

In some countries, especially in Africa, programmes aimed at mitigating the effects of adjustment are introduced some time after the introduction of an SAP. These programmes, as Baldwin[6] puts it, had only a marginal effect at best and at worst obscuring the fundamental causes of poverty and ill health. They regard vulnerable groups as targetable at a time when 50% or more of the population is living in poverty. They direct resources to the poor as an act of charity and not as a basic right. Without challenging the patterns of distribution of wealth, these programmes are criticised as being unstable in the long term and for increasing dependence on outside financing. By reinforcing two-tier systems, Health was transformed from a social right to a marketted commodity for one section of the population or charity for another.

I- Conclusion:

The present chapter elaborated the ongoing struggle between an Elite oriented health model and a people oriented model in the global arena where in the commercial interests and the imperialist designs of international as well as

national regimes defined the epidemiological and ecological determinants, the choice of technology and the targets to be attained in a health system. The global economic crisis in the early seventies precipitated a health crisis which called for global action based on the principles of participation, equity and sustainable development. The Alma Ata Declaration of 1978 addressed the root causes of poverty and questioned the imbalance in resource sharing which is a marked feature of international inter actions.

But, unfortunately the later developments nullified this earlier emphasis and went for a model which could perpetuate ill health and under development. The proposed models under estimated the causes of poverty to the level of natural disasters and exploding populations. The development inputs were isolated from the concept of health and measures were advocated using selective health status interventions. The selective strategies failed to bring about health as they were based on ethnic prejudices and meant to subjugate people to the level of subjects of business, technology and political interests of a few developed countries which tried to propagate free market dogmatism and consumerism.

The so called 'development programmes' should be analysed in the context of the other activities of the sponsoring agencies e.g.: the SAPs of the World Bank, which would make clear that they are not meant for realising health and development but to perpetuate ill health and under development. The third world has to look for alternate platforms to achieve the former. This will be more clear when we make a closer look on the influences made by international health initiatives in the health systems of the Third World. The next chapter analyses the international health initiatives as implemented in India.

CHAPTER 4

Global initiatives and PHC in India

Introduction

The assumption which is to be examined in this chapter is that India's involvement in initiatives sponsored by international agencies resulted in the inclusion of inappropriate structures, concepts and policies in the governance of the health system of the country at the cost of the PHC strategy outlines in the Alma Ata Declaration. It will be illogical to divide India's health initiatives taking the Alma Ata conference as a partition point and to say that India picked up the PHC ideals just from the Alma Ata declaration, as man of the aspects enunciated in the declaration were explicit in the various committee reports and studies before 1978. Moreover, the precarious position of India in the international political economy, dates back from the growth of European Colonialism and spreads through the hegemony of USA and other western countries in the post second world war politics. But to keep the same pace with the previous chapter, such a division is followed in this

chapter too.

The first section of the present chapter examines the major developments which affected the health situation of the country before 1978. Secondly the nature and contents of the National Health Policy and the possibility of its implementation in the existing and emerging political and economic scenario of the country is studied followed by an assessment of various programmes which are being presently implemented at the behest of global multilateral agencies. Care has taken to raise larger theoretical issues rather than pointing out specific mistakes or failures of these programmes. The impact on health which are precipitated by the various ecological initiatives and development schemes, the expected impacts of ongoing SAPs and the efficacy of the suggested palliative measures by the government are examined in the final part of this chapter; conclusions are drawn accordingly.

A. Antecedents of Alma-Ata Conference - The Colonial Legacy, Development initiatives and International Influences.

The health initiatives in the Third World during the post second world war period were shaped by almost similar influences. This view is supported by the research findings

of Bryant,[20] Morley,[94] Djukanovic and Mach[36] and Newell.[99] A study conducted by Djukanovic and Mack observes as follows: "Owing to the high cost of sophisticated equipment and other requirements, it tends to absorb for the benefit of a minority of the population, a substantial share of limited resources.... In many developing countries over half the national health budget is spent on health care in urban areas".[36] The other writers mentioned above also argue that in the developing countries too little is spent on health, while urban curative tertiary services received undue support. Cassen[24] in an illustrated book on population, economy and society of India, concluded, "India's health system shares several features of the pattern of health services in other developing countries (including) a large share of health budgets devoted to major hospitals in urban centres and a consequent relative neglect of rural health infrastructure".

The factors which shaped the colonial health initiatives and policies in colonies were its concern for the troops and the European civil official population. The international influences manifest their impact as increased

dependency, growth of inappropriate health service patterns and programmes with Malthusian intents. Health aid is perceived by donors as extension of foreign, industrial and trading policies designated to benefit the donors themselves. It was well known that most of the US aid to India during the cold war period was to contain the spread of communism to South Asia through India. But before analysing the international influences in the independent India, there should be a proper assessment of the colonial legacy of the country. The following section examines this in brief.

The Colonial Legacy:

In 1901, Lord Curzon, the then Viceroy of India wrote: "As long as we rule India, we are the greatest power in the world. If we lose it, we shall drop straight away to a third rate power".[107] This statement is very revealing about the British rule in India. The health system in India was moulded to maintain the colonial rule. The health services were designed to serve th Indian Civil Services and the Army. Urban hospital's and dispensaries were established to cater the needs of th British and of the Indian elites who played a facilitating and subservient role to the colonial

masters. Like the other colonies of that time the minimal health services existed at the time did not correspond to the health needs of the masses as the colonial health system was racially skewed and focussed on curative service toward th benefits of larger colonial interests.[107]

The training of medical practitioners were mainly to provide subordinates to Europeans in the Indian Medical Service. The masses were denied any substantial services. The potential of the health services were very limited due to its irrelevance to the local culture. Imperialism destroyed existing balance between people and their environments including coping mechanisms like indigenous healing traditions. Lack of patronage resulted in the gradual degeneration of local medical traditions. The preventive and sanitary measures were available to European troops and European quarters in towns. The demand for excessive land revenue and unfavourable trade practices resulted in decline in living standards as indicated by low income levels, growth of slums and rural distress.[84] Consequently development potentials were thwarted and limited the scope for social change in India.

Large scale commercial exploitation of India's nature affected India's health and environment. This include mining for minerals and metals to sustain the industrial revolution in Europe, deforestation to make battle ships and railway sleepers[47] etc. For the smooth passage of raw materials, the Britisers not only constructed roads and railways but also digged canals. Malaria followed the canals in to Punjab in the 1840s and later after 1890. It caused several districts of western and central Bengal and several district of U.P. to lose population in the fifty years between 1871 and 1921. Most of these districts had some villages almost totally destroyed by the scourge. As the canals in south India were on a much smaller scale with far less water logging the occurrence of malaria was sparse there.[83]

From 1920 onwards the Indian National Movement picked up momentum. Some of the colonial health initiatives contained some elements of primary health care, though they were essentially determined by the demands made by the rising political class who were the urban educated middle class, the perceptions of the medical bureaucrats and the demands in the market for medical services and education.

There was also a need to defend the state from accusations of exploitation. there were attempts to use local people as the bottom tier of the medical and sanitary services.[86] Schemes for village masses and for school masters as medical workers were not merely proposed but were implemented by British doctors working within the government.

In 1938 a National Planning Committee was established under Nehru's prompting. The committee, chaired by Colonel Sokhey included prominent leaders like Dr. B.C. Roy, Dr. G.V. Deshmukh and Dr. J.C. Roy who were freedom fighters with a popular base. The report[96] which was ready by 1940 pointed out that nutrition and general living standards as the major determinants of health and argued that preventive measures should be the most important. The report attributed the responsibility for health of the people to the state. The committee's goal was "an organised public service discharging a common obligation of society towards its members". It also pointed out that health services should be within the easy reach of the people and the unit of health administration should be "as small as is compatible with practical considerations". The report relies broadly on

a perspective on rural health which has been developed under the League of Nations Health Organisation and implemented in Yugoslavia and China.

With political independence in 1947, the difficult and long term task of achieving economic freedom became compelling. The two century long colonial exploitation, the second world war and the partition of the country resulted in shortage of food grains and manufactured goods, inflation and a 'scarcity psychosis' in every field of the economy. India adopted a comprehensive economic planning to mitigate the problems of that time. India had the example of Soviet Union at that time; the country which had built a strong economy within a brief span of 14 years to the extant that it frustrated the designs of Hitler to humble. The framers of the constitution had accepted 'Socialism' as one of the major goals of India, as borne out by some provisions in the Directive Principles of State Policy. India's planning had four major objectives viz. growth with stability, modernisation, self reliance and social justice.

The Health Survey and Development Committee[58] (popularly known as 'Bhore Committee') gave the directions and

guidance towards the establishment of Rural Health Services in India. It also recognised the inter sectoral efforts required to provide basic health services to the community. Besides suggesting a health system design for the future development of health services in the country, Bhore Committee laid special emphasis on certain basic essentials like suitable housing, sanitary surroundings and provision of safe drinking water. Development of health services was considered as an essential part of the socio-economic development and as such among their recommendations, the committee also recommended Govts. effort towards elimination of unemployment, provision of minimum wages for all and improvement in agriculture and industrial construction. In fact Bhore's phrasing was very similar to the 'Beveridge Report' which foreshadowed the National Health Services in U.K. that "no individual should be unable to secure adequate medical care because of inability to pay for it". The recommendations of the Bhore Committee guided the health planning in the later years though it could not make the anticipated impact due to reasons which may be analysed later.

Community Development Programme

In 1952, the Community Development Programme was launched with the expert advice provided by foreign agencies and professionals. In this programme, health was a major component. A primary health centre which is to act as a nerve centre from where the primary health care would radiate through sub centres over the country side was to be established for every community development block covering a population of about 60,000. A later report of the Ministry of Health and Family Welfare[93] admits as follows; "Primary health Centres and sub-centres were designed to make primary health care and Family Planning Services available through out the rural areas. Though most of Primary Health Centres and sub-centres were established according to the norms, they were not able to effectively cover the entire population under their jurisdiction.... The organisation also did not fulfill its promise to providing primary health care to rural population within easy reach. Banerji[10] had argued that the major reasons for the failure of the concept of "PH Centre" are the country's obsession with single disease campaign and birth control programmes which were imposed by international agencies.

The goals of Community Development programme included improvement of agricultural production, transportation and communication and providing more facilities for rural health, hygiene and education by promoting self help and individual and collective welfare of rural people. It also aimed at imparting a development consciousness through people's participation. It was successful in providing technical and material assistance to a section of people. In actual practice the programmes favoured the land owning sections of the rural society and left landless agricultural labourers and artisans to suffer. Till 1959, the programme was mainly ran through centralised administration. During this period, the institutional innovations introduced under these schemes failed to reflect their philosophies and benefits of these schemes went to the privileged than the under privileged. It unleashed un-anticipated functional consequences such as increasing dependence than self help. It gave greater expectations to rural poor at ideological level, but promoted and consolidated the interests of big and medium peasants and land owners. Agricultural activities received the lion's share and consumed a substantial portion of development funds, maximum time and attention of exten-

sion workers.[33]

Balwant Ray Mehta committee (1957), was appointed to assess the extent to which the Community Development Programme had succeeded in utilising local initiative and in creating institutions to ensure continuity in the process of improving socio-economic conditions. It recommended statutory, elective local bodies giving them resources, power and authority and accordingly Panchayati Raj Institutions (PRIs) came in to existence.[33] Within few years of its establishment the PRIs began to crumble due to lack of resources and political will, bureaucratic apathy and dominance of the rural elite who cornered all benefits of the development schemes. PRIs served as a medium of interest articulation for entrenched groups in rural areas than as a medium of upward mobility for rural poor. When the dominant castes consolidated their position the weaker sections were bypassed. The respective state governments have not transferred substantial authority to PRIs. They are neither ready to part with their authority, nor confident in the ability of PRIs. The state governments restricted their autonomy by introducing checks and balances at all levels.

Indiscriminate suspension and irregular or no elections of these bodies became common features and consequently these institutions remains in perpetual dormancy, though there are periodic efforts by governments to revitalise them.

Single Disease Control Campaigns

The era of single disease campaigns coincided with the time of the above developments. It was in 1953, a national organisations was established for malaria control with WHO and USID assistance and a vertical programme was introduced. Vertical programmes for filariasis, small pox, tuberculosis, leprosy, trachoma, schistosomiasis and yellow fever followed. These campaigns were designed according to the British model consisting of a 'preparatory phase', an 'attack phase' a 'consolidation phase' and a 'maintenance phase'.[10] It involved an "above down" approach which expects technological interventions with weapons like DDT spraying or administration of penicillin, hetrazen and dapone would lead to defeat of these diseases.

Later, it was invariably proved that Malaria Eradication Programme was a grant failure.[52] Several factors con-

tributed to this failure. When in 1965, U.S. government came to know that India is in a defiant mood against the will of USA, especially during the Indo-Pak war, it stopped DDT supplies and reduced aid to India. The two poor harvests compelled India to import food and its foreign exchange position was in difficulty. Supplies were further reduced due to health budget cuts, disruption of trade through Suez Canal after 1967 and rise of defence expenditure mainly due to purchase of weapons from the West.

The effects of other vertical programmes were also not very exciting.[133] Some diseases have offered slow and persistent resistance (for example, leprosy). Some have developed new facets for which new solutions will have to be found (for examples, drug resistance malaria, non-gonorrhoeal urethritis, resistance to DDT by mosquitoes etc.). Some linger on in small foci ready to disappear when favourable conditions arise (plague). Some are prevalent in fairly well circumscribed pockets (for example, schistosomiasis, Guinea worm). There are relatively new ones (NANB hepatitis, DHF). The campaign against cholera have not made any impact on the basic conditions for its transference i.e. unsanitary water supply and food handling conditions, though

cholera became less virulent due to reasons which are not yet clear.[133]

In 1961, Mudaliar Committee[59] opined that it is neither possible nor desirable to have separate agencies to deal with separate diseases. WHO also realised that vertical campaigns could not be worked out and it favoured integration of mass campaigns against individual diseases with the general health services.[133] On the recommendation of "Committee on Integration of Health, Family Planning and MCH"[60] (Kartar Singh Committee, 1973), the government decided to have an integrated approach for delivery of health services by progressively introducing multipurpose health workers and supervisors.

Family Planning Programmes:

India's Family Planning Programmes was launched in 1952 with the stated objective of improving the health of mothers and their children in the country. Earlier the International Planned Parenthood Federation had propagated fertility regulation among the poor in the developed countries. Eventually the international groups expressed concern over

the growing population of the Third World which may become a strain over the world resources, most of which are presently enjoyed by the developed countries.[118] The "concerned groups" were able to influence UN and a UN team visited India to review the population situation. On the recommendations of the team a committee[101] was appointed to study the "problem of population" and the foreign experts recommended "behavioural changes" among Indian people. Later Ford Foundation asked India to engage in "Extension Education", as done by the 'extension educators' in the agricultural fields of USA.[101]

The later stages of Family Planning Programme in India were heavily dependent on doctors, drugs, dispensaries and imported clinical products.[10] The interests of medical profession in promoting methods that they feel professionally advantageous laid a ground for development of methods that are technology oriented such as IUDs of various modifications; steroids that could be administered through different routs such as oral contraceptives; injectibles; vaginal rings etc. Thus along with the international developments in technology, in India also there was a shift towards a tech-

nologically determined paradigm on health. The primary health centres that were originally created to cater the health needs of the rural poor were burdened with Family Planning work, especially in achieving allotted targets.[10]

The motive behind the promotion of global population control strategies since the early 60s can be seen as a response to the threat of growing populations of the LDCs in establishing the global political and economic scenario. Doyal,[38] while writing about the political economy of health observes as follows:

"Control over the growth of population in the Third World was first seriously advocated in the USA in the 1950s, with campaigns initiated by private organisations such as the Rock Feller Foundation, the International Planned Parenthood Federation (IIPF) and the Ford Foundation. By the early 1960s very considerable political support had been engendered, resulting in the active involvement of the United States Government". These kind of policies became pivotal to the U.S. foreign policy establishment essentially after the Cuban Revolution.[38] The threat of revolt by the poor of the third world and to provide an economic climate conducive to American investment made U.S. to think that it is important

to control the size of the population in the Third World.

Doyal adds that through out 1960's the idea of population crisis was further elaborated and fertility control became a major priority in the funding of both research and aid. Provision of aid was held to the acceptance of a prescribed family planning programme. America managed to entrust the responsibility of fertility control to various international agencies by 1960's. Through this exercise she could diffuse the hostile reactions of Third World intellectuals to the bodies such as UNFPA and USAID. Before 1977, two third of all U.S. foreign health assistance and 50% of U.K.'s multilateral health aid were devoted to population control. In this context, George's remark on population control would be informative: "The mere fact that the rich and the powerful have shown such enormous interest in limiting the birth rates of the poor and downtrodden should in itself make us suspicious...could it be that philanthropists would rather have countries like India tailor their populations to existing capacities of agriculture-capacities limited by reactionary land tenure structures than see them undertake the thorough going reforms and overhaul of the

social system that would be necessary to feed growing popu-

lation?"[49]

Green Revolution:

In 1960s the government of India actively involved in a foreign experts prescribed intensive agriculture programme named Green Revolution making use of high yielding variety seeds, chemical fertilisers and pesticides.[28] Though there was an increase in production of food grains it was short lived and has not been shared equally by all crops and all regions. There was a strong correlation between rural poverty and productivity. The Green Revolution resulted in dependence not only on foreign expertise but also on urban and imported industrial products. It also resulted in the existence of a dualism in which a prospering, production oriented, profit oriented, technology oriented, thin crust of big farmers on the one hand and small farmers who lagged behind, on the other. The new technology actually favoured the big farmers as it was in the form of a package and only those who were able to make use of all the items in the package were able to take the advantage of these technologies.[115]

As part of Green Revolution there was an organised disruption of the balanced system of agriculture, forestry and pasture; relentless deforestation; neglect of soil and water conservation measures; rampant growth of monoculture and disappearance of genetic diversity and calculated disruption of watersheds, by large irrigation projects which tend to concentrate water collected from a huge area in a tiny pocket to irrigate the fields of the better-off peasantry. As a consequence of the above, there was disruption of the normal rainfall pattern in region after region and spread of biological drought i.e., depletion of thousands of micro-organisms and other life forms that help soil to retain its moisture and fertility. Two-thirds of Green Revolution land has been in the grip of biological drought in the 80s.[119]

The nitragenous fertilisers and chlorine based pesticides marketed by Multi National Corporations contaminated water and agricultural products. Diseases such as 'Blue Baby syndrome', 'Handigodu syndrome' and even epilepsy outbreak were reported from areas which had undergone intensive cultivation, using the above toxicants. Studies[28] on

the impact of Green Revolution reported upsetting of pollination process in plants, development of secondary pests and pest resistance. Farmer's nutritional intake was affected due to disappearance of fish from the fields. In brief, the Green Revolution generated not only socio-economic and regional imbalances but also affected the biology and ecology of the poor and depleted their traditional health supporting systems.

A 'Green Revolution' will be meaningful with out removing the defects of the agrarian structure which is inherited from the past. As early as 1950s Land Reform measures were proposed through abolition of intermediaries, tenancy reforms, ceiling of agricultural holdings, provision of minimum wages and consolidation of land holdings. As a part of this around 7 million tenants became owner of 8 million hectars of land, most of which are infertile. A heavy price was paid to land lords by way of compensation. Till date, there was no complete reorganisation of the agrarian structure. The land reforms could not be successful as the entire programme was sabotaged by the socio-economic and political power of the land holding elites who systematically used the

prolonged debates in the legislatures, loop holes in the legislations, impotence of the enforcing machinery and costly and cumbersome judicial procedures.[119]

Commodification of Health Care:

The process of commodification of medicine was facilitated by various reasons, during this time. The pharmaceutical companies which operated with a perspective in which health care tends to be identified with the supply of their products, was the major one among them. Further, it is informative to note that from 1947 to 1970, UNICEF provided over 64 million dollars, mostly in the health sector, most of which was in supplies and equipment antimalarial and anti tubercular materials, milk powder, jeeps and so on. A PhD thesis[90] submitted to Pennsylvania University in 1967, observes that in the year after independence the material supplies had came from the USA and WHO provided American technical advisors. The so called "non political' status of WHO made its advice more influential than any other, though its administrative hierarchies were permeable to the commercial and political interests of the big powers as illustrated in the second chapter.

As early as in 1951, the instituting of the Penicillin Enquiry Committee, heralded the entry of government in modern dung manufacture.[109] Notwithstanding the presence of government, the industry was dominated by private companies, most of them were trans-national. From the late 50's pharmaceutical Trans National Companies monopolised control over people's health. The Hathi Committee Report[75] of 1975 proposed radical measures such as nationalising all foreign drug companies, establishing a national drug authority, a phased abolition of brand names and a change in the form of drug price control. The debate which followed was complicated by change of government in 1977. The radical proposals were watered down under strong lobbying from the drug companies and medical profession. The masses could not have an organised support for the proposals.

In 1978, the new drug policy allowed maintenance of equity holding above 40% by foreign companies, proposed a gradual process of removal of brand names and a number of smaller statutory bodies with fewer powers replaced the proposed National Drug Authority. In 1978, there was a Drug Price control order too. But the legal moves by companies

restored their rights for brand names and foreign MNCs still dominate Indian Pharmaceutical market.[85] The nature of drug production and marketing by MNCs hindered people oriented health initiatives in many ways. It led to a failure to provide, crucial basic drugs in large quantities and at low prices to the needy.

There was no looking back of privatisation of the health care systems in India after the entry of pharmaceutical MNCs.[39] As against the government sector, the private sector proved their efficiency, cost effectiveness and ability to execute anything successfully. The credibility established by the private sector tempted government to frame policies that favour private sector. The governmental health services were discredited due to poor services and its malthusian obsessions with birth control. The private sector further assured the failure of government health programmes by monopolising and controlling pharmaceutical manufacturing suited to their profitability by straining the government resources through import of essential drugs, by recruiting doctors and health personnel who could not establish private practice and forcing the governments health structure vigorously for population control. The private

sector could also push the government to involve public resources in building infrastructures and heavy industry to facilitate the growth of the private capital.

Minimum Needs Programmes

By 1970, the government realised that the frutis of development would not "trickle down" with out an attack of the institutions that generate poverty and ill health. From 1971 the government went for a 'Minimum Needs Programme' to provide thebasic necessities of health, education, housing and social welfare. During the fifth plan period (1974-79), establishment of PHCs and sub-centres, upgradtion of PHCs and construction of buildings for PHCs/Sub-centres and staff quarters were included in theminimum needs programme. The "provision" ofminimum needs could not only solve the health problems of the people but also betrayed a paternalistic attitude inherent in this approach as a devlopment strategy".[144] Zurbrigg argues that "the thrust of this approach can be interpreted as an atempt to stave off a fundamental reorganisation of society which would eliminate that dependincy - a new social order which would make the "false generosity" of a dominant class unnecessary".[144]

The idea that basic needs of hundreds of millions ofpeople can be externally provided is unrealistic. This is especially when "the society remains so structured as to perpetuate not only vast unproductivity through unemployment and underemployment, but as well the existing distortions in the use of national resources and skills by their being channelled in to luxury concerns and items intended only for the small elite". The health field is one example of such a distortion. "This national waste and unproductivity can not be conveniently" made up "by distributing basic needs" to those left out by the system".[144]

Thirty yars of experiementation in health and health services could not acheive the primary health care ideals which were explicit in various committee reports and recommendations. The health situation in India before 1978 was alarming as evident from the above discussion. The health services were not integrated with wider economic and social development of the country. The government could virtually-make no impact on the basic aspects of disease prevention and health maintainance, such as, nutrition and environmental sanitation. The most vulnerable groups remained largely

excluded from the health services whether vulnerability is indicated by poverty, age, sex, geographical isolation or other factors (such as occupation). The goal of participatory involvement remained as a chimera while health education was virtually non existent. thus realisation of primary health care goals as envisaged by Bhore Committee and National Planning Committee remained as a mirage. Further the failure of PHC is closely meshed with the failure of developmental programmes and planning in India. The next section traces the developments in India after the Alma Ata Declaration, especially, the implementation of international initiatives in the context of 'Primary Health Care'.

B. Developments after Alma-Ata Conference: The National Health Policy, Global initiatives and International Influences:

National Health Policy:

Right after the Alma Ata conference, there was efforts to formulate a National Health Policy for India. But the adoption of National Health Policy (NHP) was delayed till 1983 due to political reasons. In accordance with the frame work outlined at Alma Ata, the government accepted Primary Health Care on the basis for health planning through the

NHP.[61] A commitment was made to provide "Health For All" and the policy recognised that "the existing unsatisfactory health situation has been largely engendered by the almost whole sale adoption of health man power development policies and the development of the curative services based on western models which are inappropriate and irrelevant to the real needs of the people and the socio-economic conditions prevailing in the country". The policy wanted to make a change in the system of health services which served the urbanised upper crust of the society. By accepting the past mistakes, the policy wanted to correct them by incorporating social justice in to the health system of the country.

In order to end the existing unacceptable situation, the NHP aims at "universal provisions of comprehensive primary health care services" which are "relevant to the community, with their participation in an affordable way. for this it calls for an integrated package of services to solve the all range of poor health conditions. The broad approach inter alia include the following important aspects.

(a) A man power development policy which concentrates on imparting a greater orientation to community health and an integrated "health team" approach.

(b) Re-structuring of health services based on decentralisation and to provide the most needed services on time, as closest to the people. The decentralised system should be properly linked to secondary and tertiary levels.

(c) Integrating the health plans with efforts in health releted sectors as with the socio-economic development process.

The NHP has identified eight problem areas: nutrition, food and drug adulteration, water supply and sanitation, environmenal protection, immunisation, maternal and child health, school health and occupational health services. Though priority attention is urged towards all these areas, maternal and child health has given the highest priority because of the "vicious relationship between high birth rates and high infant mortality. The policy proposes several supporting activities which include health education, information systems, essential drug and equipment production, insurance schemes, health legislation and bio-medical research.

An ambitious action frame work is provided by NHP as evident from the following enumeration of the important elements of the action frame work:

1. Provision of a well disbursed net work of prmary health care services, which takes us to account the fact that a large majority of health function can be handled effectviely by people themselves with the organised support of volunteers auxilliaries, paramedics and adequately trained multi purpose workers of various grades of skill and competence.
2. Transfer of knowledge, skills and technology to volunteers selected and accepted by the community.
3. Building up community participation and self reliance.
4. Establishing effective referral systems to suport PHC.
5. Establishing a country wide network of sanitary cum epidemiological stations to tackle the entire range of poor health conditions on a wide front.
6. Encouraging practice by private medical professionals and investment by Non-Governmental Organisations (NGOs) in establishing curative services.
7. Offering organised logistical, financial and technical support to voluntary agencies active in the health

field.

8. Establishing widely dispersed and well equipped speciality and super speciality centres to meet the present and future requirements of specialist treatment.

9. Special efforts to offer mental health and medical care services and physical and social rehabilitation to the disabled.

10. Giving priority to people living in tribal, hill and backward areas and populations affected by endemic diseases.

Thus we would see an elaborate decription of services to be done and thus the emphasis is on health services and not 'health' in its wholistic meaning. A social policy is to be seen as a principle where by members of large organisatins and political parties collectiely seek "enduring solutions" to be problems that affect them.[44] It should be implemented within thecontext of "potential changes in the values, structures and conditions of the groups" affected. A health policy can act as a stimuls for health planners and practitioners to formulate a strategy for its implementation. The action framework of India's NHP lacks specifici-

ties which would enable the action to depart from entrenched ways. More over, it sets its limits to the extent of providing Basic Health Services and does not aim at restructuring the structures which breed ill health in the country. hence the search for "enduring solutions" are beyond the scope of the NHP. The chance for effectively implementing the strategy outlined in NHP was also limited and the reasons for which are discussed in the concluding paragraphs of this chapter.

In spite of the total support to the deliberations made in the Alma Ata Conference and efforts to formulate a National Health Policy, India had fallen in line with other developing countries to avail the 'Benefits" offered by the global initiatives sponsored by International agencies. The analysis made and theoretical questions raised regarding them in the previous chapter is equally applicable to the Indian programmes also. In this chapter, a closer look is made on these programmes and the programmes are chosen not to criticise their particular mistakes or failures but rather to raise more theoretical questions, as done before. No sensible person would argue that the efforts to protect India's children against tuberculosis, diphtheria, tetanus,

polio myletis, measles and mumps are undesirable. But it is quite sensible to examine whether the "Universal Child Immunisation in India by 1990" programme has considered certain fundamental, epidemiological, socio-political administrative, ecological and economic questions which are crucial for implementing such a large scale programme.

Universal Child Immunisation:

The Universal child Immunisation (UCI) programme was launched in 1985 as one of the ten technology missions of the Rajiv Gandhi government. the programme was launched without taking in to account the incidence rates of the targeted diseases in different areas of the country.[12] Banerjee[12] argues that "there ought to have been much more detailed analysis than merely pointing out the incidence rates, as to how different are the rates in different parts of the country and what are the ecological cultural, social and other factors which affect the rates through influencing the balance between the host, the parasite and the environment. Information should have been provided on what are the trends in epidemiological behaviour of the different diseases over a time period, what should be the epidemiological

strategy for intervention in the natural histories of the diseases and so on".

Before implementation, the authorities did not bother to check the efficacy of the vaccines under controlled conditions and under widely divergent conditions prevailing in the field. Consequently, 20-30% of children suffering from poliomyletis, according to a government evaluation report,[92] were immunised against polio. As large as 54.2% of the immunisation centres experienced of the immunisation centres experienced disruptions in immunisation sessions. This is not only because of the poor surveillance but also because of the difficulties involved in developing and maintaining "cold chains" in a country where more than half of the population lives in regions where extremely hot summers and poorly inadequate logistic conditions exist. Moreover it is unrealistic to hope for effectively net working field workers through out the nation to cover "24 million children that are born every year in more than 560,000 villages and towns and cities". As happened in the case of family planning programme, preoccupation with UCI, the other components of the health services are being ne-

glected. The programme could not achieve its targets in 1990 and it is expected to continue till an unspecified time in the future.

Meanwhile the Comptroller and Auditor General of India came out with certain findings: "After cross-checking reported achievements with records of consumption of vaccines showed that the performance reports were not reliable. Either less than the required quantity of vaccines were administered to the beneficiaries in each dose or the achievement had been overstated. The vaccination coverage evaluation survey reports also revealed that the achievements reported were higher in most of the states." The CAG report adds that the vaccines were not administered to children of the prescribed ages and were given after one year of age in many cases. Cases of drop outs were over 70% for DPT and OPV and over 50% for TT during 1985-86 to 1990-91. 314 cases of adverse reaction after vaccination resulting in 68 deaths were reported in 10 states during the same period.

The Indian newspapers reported about cases of inability to preserve vaccines at required temperatures due to power

scarcity, inadequacy of paramedical staff and doctors and deficiencies in logistics to keep 'UIP' alive. In April 1994, according to the 'Tribune',[116] the health department of Himachal Pradesh government had given 1.30 lakh doses of expired vaccines to infants under UIP. The CAG had also found out that during 1985-91, 1.2 million doses of time expired substandard vaccines were utilised in seven states.

The above specific incidents are quoted not to criticise the programme itself but to explain the failure of a pre-packed and irrelevant programme which was introduced from outside in a Third World country. In that very process the people of these countries were made dependent on donors for funds, vaccines and equipments it was not only official agencies like WHO and UNICEF but also many private agencies engaged in the immunisation campaign in India. Many of these agencies were having their own private intentions behind their advent. The Rotary Foundation of Rotary International joined the band waggon with their "POLIO PLUS" programme to protect children in 26 countries. Their purpose was to make an easy issue to celebrate the centenary year of Rotary International in 2005 AD with a success in immunising all the children of a few countries selected by

them.

Safe Mother hood:

Child survival and development revolution, Safe Mother-hood Initiative (SMI), etc. were incorporated in the health services programme of India. It was in 1987, nations of the world assembled at Nairobi to discuss about the growing maternal deaths in developing countries.[31] The 'Safe Moth-erhood Initiative' was conceived in Nairobi and a call for action had given that all member states, with the help of UN agencies would reduce maternal deaths by 50% in 2000 AD. Later on safe motherhood has put on the agenda of WHO, UNFPA, UNICEF, IPPF and other international agencies; many conferences followed. Yet, nearly 3 million women have already died during child birth, by 1994 since the Nairobi meeting.

India officially started SMI at a meeting called at the Rashtrapati Bhawan in 1992, Five years after the Nairobi meeting. Presently the policy makers in India are undecided about the strategy to be followed for SMI. But the interna-tional agencies have definite plans and they want to incor-

porate malthusian birth control strategies and contraceptive propagation as a major component of SMI. Trans National Companies, like 'Upjohn' has already taken up the cause of propagating their methods like prostagladnis, Ru-486 etc. More than 3000 mothers had already administered 'Carboplast' for medical termination of pregnancy under SMI.[17] Very recently WHO and UNDP jointly started a project named "Strengthening National Capacity to reduce maternal deaths and disabilities" with emphasis on 'high risk' and emergency services.[113]

Even if it were possible to save some children and mothers from death through the above emergency measures, they will have to return back to the hostile ecological conditions of their rural and urban habitats. They can definitely die due to other causes which result from other ecological conditions generated by the environment. Thus the risk management and emergency services would not offer any long term solutions. More over, these programmes will give rise to dysfunctional consequences which would thwart attempts of independent health development through self reliance in a country like India or it may result in a virtual mess as we will be seeing in the case of the government

strategy to combat AIDS as a public health problem in India.

AIDS Control

The Directorate General of Health Services (DGHS) formulated a National AIDS control programme in 1987, with the help of an 85 million dollar loan given to it by World Bank. The Indian government added 11 million dollars with it. Actually the World Bank wanted it to be a 100 million dollar programme by mobilising resources from Indian and International agencies, to make it the biggest in the world, though India does not have a high prevalence rate even according to the WHO estimates,[15] Like any other loans, World Bank has conditions attached with; here the conditions are one third of the amount should be utilised for cleaning up blood supply, the next one third for sexually transmitted diseases, condom use promotion and programme management and the rest for education. Accordingly the Indian programme has three major components: (i) Surveillance (ii) Screening of blood and blood products and (iii) Information Education and Communication. The programme is presently being monitored by DGHS.

Under this programme, clinical tests are conducted in seven centres in five cities. The programme had provisions to follow up sero positive cases and offer counseling services to victims. For Human Resource Development as part of National AIDS control programme the "government has sent some clinicians and nurses to Sydney (Australia) and various parts of USA. these expert persons trained abroad have been utilised for holding training and workshops in different parts of the country". A total of 128 countries are functioning in 68 cities of the country for screening blood and blood products out of which 52 centres were provided with testing equipments such as ELISA reader, accessories and testing kits from USAID and the rest by government of India. Promotion and distribution of condoms, sloganeering, poster distribution and lavish use of printed and electronic media for one way communication are also being widely used.

The acute urgency to do something about AIDS made the government of India to set up a separate AIDs Control Board and thereby the government reaction lacked an integrated approach towards dealing this public health problem. In a situation like this the response of government should be

scientific, mature, sustainable, based on community diagnosis and according to the principles of public health. But what one today see with regard to government of India's AIDS programme is a panic reaction, with out considering the epidemiological and socio-economic factors. Banerjee[15] argues that international agencies should be held accountable for irresponsible, unscientific and motivated statements and faulty action programmes. The programme initiated lack social sensitivity and human relevance in the context of pitiful deprivation and exploitation which maintains a perpetual vulnerability towards diseases like AIDS.

The planned interventions are simple and mechanistic based on "one to one" or "direct cause-effect" relationship. To the planners of these initiatives sophisticated equipment, computerised medicine and such, technological excellence provided the final solution. Interventions within the broad health-development spectrum become meaningful only in terms of the totality of the environment. This will be more clear when we examine the ecological consequences of various 'development' initiatives and the later interventions to help the country out of the ecological crisis which resulted from the former policies.

In India, the indigenous modes of natural resources utilisation were sensitive to limits to which these resources could be used. The British colonialism linked the resources of this country with the direct and large scale demands of western Europe and the colonial intervention in the natural resource management in India led to conflicts over vital renewable natural resources like water or forest and induced poverty and deprivation.[91] Even after 1947, the colonial institutional frame work for natural resources management did not change in essence. In place of colonialism 'economic development' became the ruling ideology and the development activities proceeded a resource intensive path, disrupted economic stability and undermined productive potential of natural resources.[47]

Provision of protected water supply occupied the centre stage of environmental health initiatives of WHO and other multilateral organisations in the Third World. In India the National level water supply schemes started in 1954. Efforts were made to identify 'health problem villages' which

include areas which are endemic to cholera and worm infestations and areas where excess of salinity and alkalinity and exposure to toxic substances prevail. Various plans allocated substantial amounts for water supply. But the number of problem villages did not come down and the plan targets remain unfulfilled.[62] Poor maintenance of existing water supply schemes, lack of interest and participation from the people and differences of resources and staff led to the failure of such schemes. In fact the negligence of indigenous water tanks, need for additional water for cash crop cultivation and the resultant shortage of water due to lowering of water table and depletion of ground water resources are the causes of the present water scarcity in India. A mere provision of water does not necessarily improve the health of the people. There was no data to prove how far protected water supply could bring down water born diseases.

Irrigation development schemes, such as the world bank sponsored Indira Gandhi Canal in Rajasthan, has often been associated with an increased incidence of diseases as it increases the transmission of vector born and water related diseases.[137] More than 30 diseases have been linked to

irrigation, the major vector born diseases being schistosomiasis, malaria, onchocerciasis and Japanese encephalitis.[120] The health problems associated with irrigation developments and the environmental changes they produce have been extensively studied by various scholars.

Hunter[78] after studying 13 countries in the Third World proved that projects to develop water resources had resulted in a higher incidence of vector born diseases. Gartz[48] found out that the implementation of a large irrigation scheme in 1970s in Turkey resulted in a resurgence of endemic malaria, due to increased breeding of the vector species in poorly drained ditches receiving the run off of surplus irrigation water. Studies on Indian irrigation schemes also support the adverse health impacts of such schemes.

In the coastal area of India, local fishermen were able to get their sustenance, nutrition and health through their traditional mode of fishing and they lived in harmony with the normal renewal capacity of the ocean. After 1950, especially when the developed world needed more fish and marine products, they came forward to develop the mariculture sector of the Third World. Canada, Norway and other

countries who involved in this sector introduced a new technology which needed the use of bottom trawlers, purseen nets, chilling plants etc. and consequently the 'rowers of the sea' lost their sources of livelihood and 'absentee sea lords' took over the fisheries sector. Presently through their exports, they cater the nutritional requirements of the developed world and deprive the same to the local population. More over the technology introduced, proved inappropriate as evident from the later developments in coastal areas and there remains a continued conflict between the capitalist fish exporters and local fishermen.[104]

In 1952 the Government of India introduced National Forest Policy and through this, state has given the exclusive authority of forests and encourages forest based industries. The commercial forestry not only disrupted the hydrology of forests by reducing the biomass production but also affected the life of the tribals whose sustenance and survival was solely dependent on forest.[37] To counter rampart deforestation by contractors, government initiated programmes like Social Forestry, 'Vana Mahotsava' etc. through which lose of mixed natural forests were compensated

by cultivation of monoculture species which has an allelopathic growth and destructs soil nutrients, water balance and biomass. The programme could help certain industries (paper, pulp etc.) though it did not help the fuel and fodder needs of those who involved in these programmes.

The river valley projects aided by multilateral donor agencies usually ended up in the submission ofdense forests and fertile agricultural lands of the tribals. Destitution of people in the catchment area along with soil erosion, water logging, salinity, earth quakes, health problems and disasters are the ecological consequences of large dams. The rehabilitation of the displaced people were neither taken seriously nor they were given enough compensation to find out an alternative livelyhood.[118]

An analysis of the intensive agriculture development programme of the 60s have been made in an earlier section. The period of the 'Grow More Food Campaign' were the days "when posters, ministers and sundry development functionaries screamed at village folk to grow more food and save more money for the sake of the nation".[32] The governments money could have been better spent if it provided the farmer

with the wherewithal and removing whatever constraints stood in his way.

The current policies governing the natural resource use, which are actively supported by international agencies encourage chemical inputs based agriculture, commercial forestry, mining and industry and are creating serious problems of livelihood, life styles and life not only for those directly affected but also for future generations. Thousands uprooted forcibly by large development projects, desertification due to deforestation, machanisation of traditional occupations like fishing and weaving and disasters like Bhopal Gas tragedy demonstrate the increasingly precarious situation of the rural poor. The health support systems of the poor are clean air, water, forests and land. Threat to these resources is the root cause of emerging ecological conflicts in India and elsewhere.

The major multilateral institutions of the world reflect a consensus on the use of environmental managerialism with little attention paid to the ecosystems and social structures of the Third World.[46] They believe in technical solutions to solve the global environmental crisis and as a

result social justice claims of the Third World has no standing at all. Most often it is the debt stress and the threat of terminating flow of loans which drive the Third World countries to follow practices which degrade environment. Moreover, the estimates of the Third World contribution towards global climate change are overstated.[71]

Health and Structural Adjustment

In 1991, th Indian government formally started the structural adjustment programme (SAP) to liberalise and globalise the economy in order to make it efficient, competitive and integrated to the world market. Since we are midway, one can not evaluate the impact of the policies. But there is no reason to conclude that India's experience will be very different from those which had undergone such adjustments earlier, in the Third World. The adverse impact in the form of economic recession, cut in social expenditures, inflationary trends; and impact in poverty level have been vividly analysed by academics and researchers in India.[18] Here an attempt will be made only to enumerate their findings and there after to examine the efficacy of remedial measures proposed by the government to protect the

well being of the affected.

The production of export oriented cash crops, cut in fertiliser subsidy, devaluation of rupee, cut in subsidy in public distribution systems (PDS) etc. would end up in high food prices and ultimately low nutritional status to those who have limited purchasing power.[117] The low standard of living and hiked poverty levels will be further deteriorated due to high under employment and unemployment rates, low payment for work, wage freeze, withdrawal of welfare schemes to workers, cut in employment schemes and th resultant low income levels.[103] The cut in public expenditure and expensive drugs and health services will lead to the further decline of health services in the country with reduced or no access to the services by the masses and may increase the child mortality prevalence of diseases and ill health.[30]

The housing and civic services would deteriorate due to price rise in land, construction materials and even increases in prices of water, fuel and electricity.[50] This can lead to unhygienic conditions and growth of slums and accumulated health hazards. Further the privatisation and deregulation would lead to retrenchment and unavailability

of credit and ultimately an insecure life and livelihood to the people.[103]

The government of India is well aware of the problems attached with SAP. This is evident from a government document titled "Economic reforms : two years after and the task ahead"[63] which acknowledges that, "Fiscal discipline forces, limits on government spending and this may affect the pace of implementation of programmes in the social sector which are especially critical for the well-being of the poorer section. Economic restructuring may also involve loss of jobs in certain sick and unenviable units as labour is redeployed in to other expanding or new units.

The growing awareness of the consequences of SAP among the masses led the government of India to declare a few palliative measures which include increased allocation to the social sector, revamping the Public Distribution Systems (PDS), introducing social safety sets and moderating the pace of reforms, privatisation and retrenchement.

The increased allocation to the health sector is a myth. In 1990-91, the burden of SAP had fallen on Rural Development programmes and social services as both of which

recorded an actual decline in plan expenditure. The subsequent budgets tried to restore cuts in these two sectors; even then the expenditure on these two items suffered a decline in real terms. Prabhu and Chatterjee[106] argues that considering the already weak social infra-structural base in the country, India needs drastic allocations in favour of primary level facilities. It is true that 50% of the present allocation in the education sector are towards elementary education, but inadequate as according to estimates, India requires over 65-70% allocation in these sectors. Presently in the health sector, less than 20% of the government health expenditures are incurred for public health. Even after including water supply and sanitation the expenditure on an average do not exceed 40% which again is grossly inadequate.

To Howes and Jha,[77] the PDS in operation in India is pro-rich, urban biased and has been found to be inadequate and ineffective in its reach and capacity to assist poverty alleviation. There is no uniformity in the entitlement and allocation of food grains in different states; the lack of purchasing power of the poor do not enable them to avail

their entitlements at the fair price shops. Dev and Surya narayana[34] found that there is a discrepancy between local food habits and available rations; there is over crowding at some out lets and under utilisation at others. Hatekar[74] in a paper titled "The Public Distribution System and Health Policy: Need for Integration", noted that there is no alignment between the nutritional requirements of the population and the PDS. The revamped PDS launched in 1992 also faces the same problems experienced by the earlier PDS. In this context PD systems are unable to act as "shock obsorbers" of SAP.

Not much is known till date about the provision of a 'social safety net' through the creation of a National Renewal Fund which will finance schemes for compensation, retaining and deployment of workers affected by restructuring. UNICEF in its document titled "Adjustment with a human face"[124] advocated that structural adjustment policies should be so formulated that the costs to poor household, are reduced and their capacity to survive the crises be enhanced. Arguing on the same line, the World Bank too emphasised on safety nets through which the vulnerable are sought to protected. The international bodies thus advocate "pro-

tection" rather than "transformation" of social relations of production and reproduction.

"Moderating the pace of reforms" and "slowing down of privatisation" etc. are euphemisms as the efforts towards privatisation through dilution of state's responsibility for health care took momentum in India much before the SAP as evident from the rapid expansion of the private health sector. Recently the eighth plan (1992-97) document[64] emphasised that "in accordance with the new policy of the government to encourage private initiatives, private hospitals/clinics will be supported. Presently a growing proportion of the health care requirements are met by private sources. An FRCH study [43] on this aspect observes that, this (privatisation) hits the poor the hardest because they have to rely on the whims of the market forces to meet their medical care needs." Besides, medical education of doctors at the expense of the public exchequer has grown rapidly, thus helping not only the private health sector, but also the medical personnel needs of the developed countries, to which many of the highly qualified doctors migrate. An estimate shows that as many as 40% of the private sector

medical doctors migrate abroad.

The World Bank, time and again warns, the government to be "market friendly" and to intervene only in those areas in which markets prove inadequate. The history of market is one of struggle over resources and excesses of an uncontrolled private interest and greed. It is the market oriented consumerist, economic and political processes which transformed people's own 'safety nets' based on sustainable use of local resources and have made them vulnerable to the market forces and situations which put them is a state of perpetual ill health. The health system of the Third World are increasingly getting strained by the onslaught of an expanding capitalist market economy.

Conclusion:

The above discussion reveals certain major trends in the development of health system in the country. The colonial exploitation impacted a disruption in the life supporting systems of the people and caused to the decline of indigenous healing traditions and practices of the people. The independant India which adopted a Mixed Economy and a planned strategy for development, initiated various pro-

grammes including community Development Programme, Green Revolution etc. which ended up in favouring the landed gentry leaving the landless agricultural workes, artisans and marginal farmers to suffer. The institutional innovations like Panchayati raj institutions served as a medium of interest articulation of entrenched groups in rural areas than as a medium of upward mobility for the rural poor.

The primary health centres were unable to remain as watchdogs to the peoples health as they were busily involved in the implementation of Single Disease Control Campaigns and fertility control programme which were prescribed and assisted by multilateral organisations. While the single disease control campaigns emphasised the superiority of simple machemistic solutions for a wider developmental problem with an approach which neglects the totality of the environment, the fertility control programmes treated people as a problem and tried to eliminate people themselves to reduce the growing strain upon resources which are presently enjoyed by a minority. The pharmaceutical companies which operted with a perspective in whcih health care tends to be identified with the supply of their products, commodified

the medicine and this process was further underlined by the supply of equipments, drugs and vehicles by global agencies and a national government whcih supported the privatisation process.

The Alma Ata Declaration 1978, could influence the policy pronouncements and plan documents in India, thereafter. But it remained as good intentions while the government went for programmes which discarded the PHC ideals outlined in the declaration. The ecology initiatives precipitated ecological conflicts all over India. The SAPs prescribed by the 'Bretton woods Institutions' further depleted people's health supporting systems. The forgone conclusions (in any way) do not suggest that the Indian people remained as silent victims to the focus of international political economy. There were reactions and movements against these developments, but effectively contained or silenced by the extensive use of means of persuation, coercion, compulsion and communication. The reasons for all these can be analysed at three levels, as follows:

The first and foremost level is the class interests of doctors which are intermingled with those of the Indian

ruling classes and the complexity of Indian state which is integrated in to the world economy. On the one hand, the-technocrats due to their class interests and their aspirations to serve in the international bureaucracies of the United Nations and on the other hand the consequent advantages in the national bureaucracies make them vulnerable to ideas and proposals poorly related to country realities. They are members of the general intellectual elite by virtue of birth, marriage, school education or overseas research careers. They support wholesale borrowing of health care models from abroad without assesing suitability to local conditions and this will result in establishing dependency relationships. Jeffry writes: "The established medical profession maintained its rewards and its access to a world market and its class links helped to perpetuate the imbalances that characterised colonial medicine. International aid and operations of multinational companies re-inforces these tendencies". (reference as before).

The second level is the composition and structure of central council of health which was responsible for health policy making in the initial years of India's independence. The central council of health which was established in 1950

composed of the central health minister as chair person and state ministers, civil servants of health ministry, technical advisors from health directorates, president of medical council of India, representatives of Planning Commission and advisors from international agencies, like WHO, UNICEF, U.S. government representatives and representatives from Ford and Rockfeller foundation. Above all, models based on vertical programmes and Malthusian leaning were insisted upon by WHO and USAID and readily accepted by India, as the former were the providers of funding and technical support.

The final and a broader level is the structure of Indian society itself. In a National Planning Programme, the officials and politicians who initiate and carry out interventions and the social scientists who provide conceptual frame works on which these interventions are based, usually come from the more established affluent and highly educated segments of the society. The target population usually consists of poorer and less educated segments. Thus in terms of caste, class etc; the "change agents" may be an outsider to the target population. The social transformation policies and programmes may have important implications for

the wealth, power and status of his own group. Thus there is more than a real possibility that the "change agents" will view the problem from the perspective of their own group and set goals, that will-often unintentionally accrue to the benefit of their group at the expense of the target population. Thus the world view of the elites who dominated the institutions of the state was decisive to how and even whether a health/development intervention could be implemented.

It is also to be noted that a social structure that is founded on the principles of inequality is time and again forced to introduce palliative measures so as to stem the rising tide of class conflict. Mechanised medicine and technology are two ways in which poverty and exploitation can be explained away. Provision of individualised medial services helps to diffuse pressures for change in the underlying social structures ultimately causing the patterns of morbidity and mortality.

CHAPTER 5

CONCLUSION AND SUGGESTIONS

Conclusions:

The following conclusions could be drawn from this study.

A. The very structures, administrative arrangements and decision making systems of international official agencies of UN and its affiliatiories facilitated the perpetuation of ill health, under development and unequal integration of the 'North' and the 'South'. The results of their existence, in terms of their impact on Third World are not at all inadvertent dysfunctions, though this could not be empirically proved.

B. The various Bilateral agencies have their own special interests; mainly to stabilise the economic and political relations between the donor countries and recipient countries. Though these agencies may provide short term relief to the Third World countries in their financial crisis, they are ultimately aimed at silencing the Third World demand for

a New International Order wherein equity and justice may prevail. The donors want to ensure uninterrupted supply of raw materials and cheap labour from the receivers while dumping their unwanted surpluses which include agricultural products and non competent manufactured goods.

C. The NGOs of the Third World, who deliver most of the 'development' packages of international multilateral and bilateral agencies are, in general, self appointed, far from democratic, more of bureaucratic and their socio-cultural origins lying more in the dominant than in the dominated groups in society. They are unable to address the wider structural factors that underlie poverty and illhealth in the Third World.

D. Right after the Alma Ata Declaration which underlined aspects of 'right to health', 'empowerment of the masses and the 'emergence of an egalitarian global order' (by questioning the existing distribution of resources), there emerged 'Selective Health Interventions' which are devoid of any of these aspects. The ideologies of these selective interventions side-stepped the fundamental causes of poverty and increased dependency on technologies, equipments and experts

of the developed countries. Natural disasters and exploding populations were given as the cause of ill health by the exponents of these interventions; who desired to sustain the consumerist life styles of a few, by keeping the masses of the Third World in perpetual ill health and deprivation.

E. The selective programmes, especially the Immunisation of children have neither considered the epidemiological trends of the targetted diseases nor the efficacy of proposed technologies in the field situation. The Global programme on AIDS, which depends on information technology and social marketing of AIDS slogans, condoms and spermicides, prepared in the west relegated the people to the position of subjects for business, technology and political interests of an expanding national and international bureaucracy. The field of Environmental Health remained as an area of potential conflict between the North and the South and in which the latter remained as a loser and received most of the blames for polluting the environment.

F. The governments of the developing countries readily accepted these technocentric programmes because of the inherent advantages they could have from the selective

interventions.

G. The independent India, adopted a mixed economy and a planned strategy for development, initiated various programmes including community Development programme, Green Revolution etc. But they ended up in favouring the landed gentry leaving the landless agricultural workers, artisans and marginal farmers to suffer. The institutional innovations like Panchayati Raj served as a medium of interest articulation of entrenched groups in rural areas rather than as a medium of upward mobility for the rural poor.

H. The primary health centres were unable to remain as watchdogs to the people's health as they were busily involved in the implementation of Single Disease control campaigns and fertility control programmes which were prescribed and assisted by multilateral organisations. While the single disease control campaigns emphasised the superiority of simple mechanistic solutions for a wider developmental problem with an approach which neglects the totality of the environment, the fertility control programmes treated people as a problem and tried to eliminate people themselves to reduce the growing strain upon resources which are

presently enjoyed by a minority. While the ecology initiatives precipitated ecological conflicts all over India, the SAPs prescribed by the Bretton woods Institutions, further depleted the health supporting systems of Indian people.

I. The Trans National Pharmaceutical Companies which operated in India with a perspective in which health care tends to be identified with the supply of their products commodified the medicine; and this process was further accentuated by the supply of equipments, drugs and vehicles by global agencies and a national government which supported the privatisation process.

J. The reactions and movements against the discarding of PHC ideals and the adoption of technocentric models were effectively contained or silenced by the extensive use of means of persuasion, coercion, compulsion and communication, by the ruling class in India.

K. The failure of health initiatives in the Asian, African and Latin American countries can be analysed at three levels:

1. The first level is the class interests of the doctors

which are intermingled with those of the Third World ruling classes and the complexity of state in the Third World, which is integrated in to the World Economy. On the one hand, the technocrats, due to their class interest and their aspirations to serve in the International bureaucracies of the United Nations and on the other hand, the consequent advantages in their national bureaucracies make them vulnerable to ideas and proposals poorly related to their country realities. They are members of the general intellectual elite by virtue of birth, marriage, school education or overseas research careers. They support wholesale borrowing of health care models from the 'North' with out assessing suitability to local conditions. This result in establishing dependency relationships.

2. The second level is the composition of policy making bodies (like the central council of Health in India) in the Third World, during the initial years of their independence and development. In addition to the ministers and bureaucrats of these countries, their policy making bodies were composed of advisors from official

international agencies and bilateral agencies, representatives of governments of developed countries and Private International Voluntary Organisations. Above all, models based on vertical programmes and Malthusian leanings were insisted upon by WHO, USAID, Ford Foundations etc. and readily accepted by the governments as the former were the providers of funding and technical support.

3. The final and a broader level is the structure of the Third World society itself. In a national planning programme, the world view of the elites who dominate the institutions of the state is decisive as to how and even whether a society transforms. The officials and politicians who initiate and carry out the interventions and the social scientists, who provide the conceptual frame works on which the developmental interventions are based usually come from the more established, affluent and highly educated segments of the society. Thus they are "outsiders" to the target population who are poor, exploited and uneducated, toward whom the initiatives are targetted. The development programmes may have important implications for the

wealth, power and status of his own class. Thus there will be more than a real possibility that these change agents may view the problem from the perspective of their own group and set goals that will often accrue to the benefit of their group at the expense of the target population. This explains clearly why the health and development initiatives failed in the third world.

A social structure that is founded on the principles of inequality is, time and again, forced to introduce palliative measures so as to stem the rising class conflict. Machanised medicine and technology are two ways in which poverty and exploitation can be explained away. Provision of individualised medical services helps to diffuse pressure for change in the underlying social structure ultimately causing the patterns of morbidity and mortality.

Suggestions

Finally, on the basis of the above conclusions, the present study would offer the following suggestions for a more healthy and more developed society within the limits of

the existing international power structure. If the UN and its various organs are to be effective, there should be sufficient place for the aspirations of the developing countries for a fair share of global resources, by adequately representing their governments in the administrative and policy making structures. All the existing debts of the developing countries taken from multilateral and bilateral institutions should be written off, as the creditors of the North have already received more than their principal and interest from the recipients of the south. The consumerist life styles of the privileged classes should be limited to preserve and protect the resources ofthe earth for the progenies. The developing countries should be allowed to grow and develop freely. Environment friendly technologies which are to be substituted in place of polluting technologies should be declared as the common property of the humanity and be given to the south at free of cost. In the Third World countries also, there should be decentralisation, by democratically re-arranging the existing power structures.

When one may look at the above suggestions in the context of the present study, they may appear unrealistic.

But it is to be remembered that, the decolonisation of the Third World was a gradual process and it took centuries to oust the colonisers from the occupied territories. In fact the Alma-Ata Declaration was at least a symbolic victory by these countries towards achieving a "New International Order". The recent developments, such as the failure of implementing a particular ideology, using a particular methodology would not mean that the issues of social justice could be rolled back for ever and free-market, consumerist forces can take care of the masses.

Various grass root level organisations which are active, all over the world give us examples of the relentless struggle between those who offer simplistic, technological, temporary solutions for ill health and under development and those who plead for lasting solutions through sustainable development strategies that may take in to account the needs of the masses and treat them as 'assets' rather than a 'problem' to be eliminated. The organisations of the latter type could act as watchdogs against those policies and programmes which retard their progress towards health and development. They can compel the national governments from signing such kind of treaties and agreements unconditionally

with out regarding the developmental needs of their national communities.

These organisations need effective networking and require theoretical inputs based on people oriented research that utilises the revolutionary potentialities of social sciences. The findings of such research should be communicated to the masses using a language that is intelligible and appealing to them. There is also a need to promote intellectuals from the lower classes, not through "100% literacy programmes" and "paternalistic welfare measures", but through deliberate planning and action. Only with such efforts we could dream "Health For All" some time in the future.

APPENDIX

Table
IMR in African Countries where SAP was introduced

	Infant Mortality rate			Percentage change
	1965	1980	1985	1980-85
Ethiopia	165	146	168	+15.1
Mali	200	154	174	+26.5
Madagascar	NA	71	109	+53.5
Uganda	121	97	108	+11.3
Tanzania	138	103	110	+6.8
Somalia	165	146	152	+4.1
Kenya	112	87	91	+4.6

Source: 'Engendering Adjustment for the 1990's' Commonwealth Secretariate Publications, London, 1989.

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