



Health Care In India Issues And Prospects

Monika Assistant Professor Faculty of Nursing B.M.U. Rohtak.

Abstract:

Health and health care need to be distinguished from each other for no better reason than that the former is often incorrectly seen as a direct function of the latter. Health is clearly not the mere absence of disease. Good Health confers on a person or groups freedom from illness - and the ability to realize one's potential. Health is therefore best understood as the indispensable basis for defining a person's sense of well being. The health of populations is a distinct key issue in public policy discourse in every mature society often determining the deployment of huge society. They include its cultural understanding of ill health and well-being, extent of socio-economic disparities, reach of health services and quality and costs of care. and current bio-medical understanding about health and illness.

Keywords: health, well being, disparities, services, quality, illness.

INTRODUCTION

Health care covers not merely medical care but also all aspects pro preventive care too. Nor can it be limited to care rendered by or financed out of public expenditure- within the government sector alone but must include incentives and disincentives for self care and care paid for by private citizens to get over ill health. Where, as in India, private out-of-pocket expenditure dominates the cost financing health care, the effects are bound to be regressive. Health care at its essential core is widely recognized to be a public good. Its demand and supply cannot therefore, be left to be regulated solely by the invisible hand of the market. Nor can it be established on considerations of utility maximizing conduct alone.

What makes for a just health care system even as an ideal? Four criteria could be suggested- First universal access, and access to an adequate level, and access without excessive burden. Second fair distribution of financial costs for access and fair distribution of burden in rationing care and capacity and a constant search for improvement to a more just system. Third training providers for competence empathy and accountability, pursuit of quality care and cost effective use of the results of relevant research. Last special attention to vulnerable groups such as children, women, disabled and the aged.

Forecasting in Health Sector

In general predictions about future health - of individuals and populations - can be notoriously uncertain. However all projections of health care in India must in the end rest on the overall changes in its political economy - on progress made in poverty mitigation (health care to the poor) in reduction of inequalities (health inequalities affecting

access/quality'), in generation of employment /income streams (to facilitate capacity to pay and to accept individual responsibility for one's health), in public information and development communication (to promote preventive self care and risk reduction by conducive life styles) and in personal life style changes (often directly resulting from social changes and global influences). Of course it will also depend on progress in reducing mortality and the likely disease load, efficient and fair delivery and financing systems in private and public sectors and attention to vulnerable sections- family planning and nutritional services and women's empowerment and the confirmed interest of the state to ensure just health care to the largest extent possible. To list them is to recall that Indian planning had at its best attempted to capture this synergistic approach within a democratic structure. It is another matter that it is now remembered only for its mixed success.

Available health forecasts

There is a forecast on the new health challenges likely to emerge in India over the next few decades. Murray and Lopez <World Bank B 2000> have provided a possible scenario of the burden of disease (BOD) for India in the year 2020, based on a statistical model calculating the change in DALYS are applied to the population projections for 2020 and conversely. The key conclusions must be understood keeping in the mind the fact that the concept of DALYs incorporates not only mortality but disability viewed in terms of healthy years of life lost. In this forecast, DALYs are expected to dramatically decrease in respect of diarrhoeal diseases and respiratory infections and less dramatically for maternal conditions. TB is expected to plateau by 2000, and HIV infections are expected to rise significantly up to 2010. Injuries may increase less significantly, the proportion of people above 65 will increase and as a result the burden of non- communicable disease will rise. Finally cardiovascular diseases resulting any from the risk associated with smoking urban stress and improper diet are expected to increase dramatically.

Under the same BOD methodology another view is available from a four - state analysis done in 1996 <World Bank B 2000> these four states - AP, Karnataka, W. Bengal and Punjab - represent different stages in the Indian health transition. The analysis reveals that the poorer and more populated states. West Bengal, will still face

a large incidence of communicable diseases. More prosperous states, such as Punjab further along the health transiting will witness sharply increasing incidence of non-communicable diseases especially, in urban areas. The projections highlight that we still operating on unreliable or incomplete base data on mortality and causes of death in the absence of vital registration statistics and know as yet little about how they differ between social classes and regions or about the dynamic patterns of change at work. It also highlights the policy dilemma of how to balance between the articulate middle upper class demand for more access to technologically advanced and subsidized clinical services and the more pressing needs of the poor for coverage of basic disease control interventions. This conflict over deployment of public resources will only get exacerbated in future. What matters most in such estimates are not societal averages with respect to health but sound data illuminating specifically the health conditions of the disadvantaged in local areas <Gwatkin A 2000> that long tradition of health sector analysis looking at unequal access, income poverty and unjustly distributed resources as the trigger to meet health needs of the poor. That tradition has been totally replaced by the currently dominant school of international thought about health which is concerned

primarily with efficiency of systems measured by cost effectiveness criteria.

Future of State Provided Health Care

Historically the Indian commitment to health development has been guided by two principles-with three consequences. The first principle was State responsibility for health care and the second (after independence) was free medical care for all (and not merely to those unable to pay),

The first set of consequences was inadequate priority to public health, poor investment in safe water and sanitation and to the neglect of the key role of personal hygiene in good health, culminating in the persistence of diseases like Cholera.

The second set of consequences pertains to substantially unrealized goals of NHP 1983 due to funding difficulties from compression of public expenditures and from organizational inadequacies. The ambitious and far reaching NPP - 2000 goals and strategies have however been formulated on that edifice in the hope that the gaps and the inadequate would be removed by purposeful action. Without being too defensive or critical about its past failures, the rural health structure should be strengthened and funded and managed efficiently in all States by 2005. This can trigger many dramatic changes over the next twenty years in neglected aspects or rural health and of vulnerable segments.

The third set of consequences appears to be the inability to develop and integrate plural systems of medicine and the failure to assign practical roles to the private sector and to assign public duties for private professionals.

To set right these gaps demanded patient redefinition of the state's role keeping the focus on equity. But during the last decade there has been an abrupt switch to market based governance styles and much influential advocacy to reduce the state role in health in order to enforce overall compression of public expenditure and reduce fiscal deficits. People have therefore been forced to switch between weak and efficient public services and expensive private provision or at the limit forego care entirely except in life threatening situations, in such cases sliding into indebtedness. Health status of any population is not only the record of mortality and its morbidity profile but also a record of its resilience based on mutual solidarity and indigenous traditions of self-care - assets normally invisible to the planner and the professional. Such resilience can be enriched with the State retaining a strategic directional role for the good health of all its citizens in accordance with the constitutional mandate. Within such a framework alone can the private sector be engaged as an additional instrument or a partner for achieving shared public health outcomes. Similarly, in indigenous health systems must be promoted to the extent possible to become another credible delivery mechanism in which people have faith and away fond for the vast number of less than fully qualified doctors in rural areas to get skills upgraded. Public programs in rural and poor urban areas engaging indigenous practitioners and community volunteers can prevent much seasonal and communicable disease using low cost traditional knowledge and based on the balance between food, exercise medicine and moderate living. Such an overall vision of the public role of the heterogeneous private sector must inform the course of future of state led health care in the country.

KEY ACHIEVEMENTS IN HEALTH

Our overall achievement in regard to longevity and other key health indicators are impressive but in many respects uneven across States, The two Data Annexure at the end indicate selected health demographic and economic indicators and highlight the changes between 1951 and 2001. In the past five decades life expectancy has increased from 50 years to over 64 in 2000. IMR has come down from 1476 to 7. Crude birth rates have dropped to 26.1 and death rates to 8.7.

At this stage, a process understanding of longevity and child health may be useful for understanding progress in future. Longevity, always a key national goal, is not merely the reduction of deaths as a result of better medical and rehabilitative care at old age. In fact without reasonable quality of life in the extended years marked by self-confidence and absence of undue dependency longevity may mean only a display

of technical skills. So quality of life requires as much external bio-medical interventions as culture based acceptance of inevitable decline in faculties without officious start at sixty but run across life lived at alt ages in reduction of mortality among infants through immunization and nutrition interventions and reduction of mortality among young and middle aged adults, including adolescents getting inform about sexuality reproduction and safe motherhood. At the same time, some segments will remain always more vulnerable - such as women due to patriarchy and traditions of infra-family denial), aged (whose survival but not always development will increase with immunization) and the disabled (constituting a tenth of the population).

Reduction in child mortality involves as much attention to protecting children from infection as in ensuring nutrition and calls for a holistic view of mother and child health services. The cluster of services consisting of antenatal services, delivery care and post mortem attention and low birth weight, childhood diarrhoea and ARI management are linked priorities. Programme of immunization and childhood nutrition seen in better performing stats indicate sustained attention to routine and complex investments into growing children as a group to make them grow into persons capable of living long and well Often interest fades in pursuing the unglamorous routine of supervised immunization and is substituted by pulse campaigns etc. Which in the long run turn out counter-productive. Indeed persistence with improved routines and care for quality in immunization would also be a path way to reduce the world's highest rate of maternal mortality.

In this context we may refer to the large ratio-based rural health infrastructure consisting of over 5 lakh trained doctors working under plural systems of medicine and a vast frontline force of over 7 lakh ANMs, MPWS and Anganwadi workers besides community volunteers. The creation of such public work force should be seen as a major achievement in a country short of resources and struggling with great disparities in healthstatus. As part of rural Primary health care network lone, a total of 1.6 lakh subcenters, (with 1.27 lakh.' ANMa in position) and 22975 PHCs and 2935 CHCs (with over 24000 doctors and over 3500 specialists to serve in them) have been set up. To promote Indian systems of medicine and homeopathy there are over 22000 dispensaries 2800 hospitals Besides 6 lakh angawadis serve nutrition needs of nearly 20 million children and 4 million mothers. The total effort has cost the bulk of the health development outlay, which stood at over Rs 62.500/- crores or 3-64 % of total plan spending during the last fifty years.

On any count these are extraordinary infrastructural capacities created with resources committed against odds to strengthen grass roots. There have been facility gaps, supply gaps and staffing gaps, which can be filled up only by allocating about 20% more funds and determined ill to ensure good administration and synergy from greater congruence of services, but given the sheer size of the endeavor there will always be some failure of commitment and in routine functioning. These get exacerbated by periodic campaign mode and vertical programme, which have only increased compartmentalized vision and over-medicalization of health problems. The initial key mistake arose from the needless bifurcation of health and family welfare and nutrition functions at all levels instead of promoting more holism. As a result of all this the structure has been precluded from reaching its optimal potential. It has got more firmly established at the periphery/sub-center level and dedicated to RCH services only. At PHC and CHC levels this has further been compounded by a weak referral system. There has not been enough convergence in "escorting" children through immunization coverage and nutrition education of mothers and ensuring better food to children, including cooked midday meals and health checks at schools. There has also been no constructive engagement between allopathic and indigenous systems to build synergies, which could have improved people's perceptions of benefits from the infrastructure in ways that made sense to them.

One key task in the coming decades is therefore to utilize fully that created potential by attending to well known organizational motivational and financial gaps. The gaps have arisen partly from the source and scale of funds and partly due to lack of persistence, both of which can be set right. PHCs and CHCs are funded by States several of whom are unable to match Central assistance offered and hence these centers remain inadequate and operate on minimum efficiency. On the other hand over two thirds cost of three fourths of sub-centers are fully met by the Center due to their key role in family welfare services. But in equal part these gaps are due to many other non-monetary factors such as undue centralization and uniformity, fluctuating commitment to key routines at ground level, insufficient experimentation with alternatives such as getting public duties discharged through private professionals and ensuring greater local accountability to users.

Health Status issues

The difference between rural and urban indicators of health status and the wide interstate disparity in health status are well known. Clearly the urban rural differentials are substantial and range from childhood and go on increasing the gap as one grows up to 5 years. Sheer survival apart there is also the well known under provision in rural areas in practically all social sector services. For the children growing up in rural areas the disparities naturally tend to get even worse when

compounded by the widely practiced discrimination against women, starting with foeticide of daughters.

In spite of overall achievement it is a mixed record of social development specially failing in involving people in imaginative ways. Even the averaged out good performance hides wide variations by social class or gender or region or State. The classes in many States have had to suffer the most due to lack of access or denial of access or social exclusion or all of them. This is clear from the fact that compared to the richest quintile, the poorest had 2.5 times more IMR and child mortality, TFR at double the rates and nearly 75% malnutrition - particularly during the nineties.

Not only are the gaps between the better performing and other States wide but in some cases have been increasing during the nineties. Large differences also exist between districts within the same better performing State urban areas appear to have better health outcomes than rural areas although the figures may not fully reflect the situation in urban and peri-urban slums with large in migration with conditions comparable to rural pockets. It is estimated that urban slum population will grow at double the rate of urban population growth in the next few decades. India may have by 2021 a total urban population of close to 600 million living in urban areas with an estimated 145 million living in slums in 2001. What should be a fair measure for assessing success in enhancing health status of population in any forecast on health care?

Disease Load in India and China:

We need a basis for comparative scenario building. Among the nations of the world China alone rank in size and scale and in complexity comparable to India differences between an open and free society and a semi-controlled polity do matter. The remarkable success in China in combating disease is due to sustained attention on the health of the young in China, and of public policy backed by resources and social mobilization- While comparing China and India in selected aspects of disease load, demography and public expenditures on health, the record on India may seem mixed compared to the more all round progress made by china. But this should also be seen in the perspective of the larger burden of disease in India compared to china and of the transactional costs of an open and free democracy,

Though India and China recorded the same rate of growth till 70s, China initiated reforms a full decade earlier. This gave it a head start for a higher growth rate and has resulted in an economic gap with India which has become wider over time. This is because domestic savings in China are 36% of GDP whereas in India it hovers at 23%, mostly in house-hold savings. Again. China attracted \$40 billion in foreign direct

investment against \$2 billion in India. Special economic zones and relaxed labour laws have helped. Public expenditure on health in China has been consistently higher underlining the regressive nature of financing of health in India. Nevertheless- it is not too unrealistic to expect that India should be able to reach by 2010 at least three fourth the current level of performance of China in all key health indices. India's current population is not a bit more than 75% that of China and India will of course be catching up even more with China into the 21 century. This would be offset by the handicap that Indian progress will be moderated by the fact that it is an open free and democratic society. A practical rule-of-thumb measure for an optimistic forecast of future progress in India could be - that between 2000 and 2010 India should do three fourths as well as China did in 1990-2000 and, after 2010, India should try to catch up with the rate of performance of China and do just as well thereafter. This will translate into, for, instance, a growth rate of about 8% for India till 2010 and as close to 10% as possible thereafter thus enabling doubling first in ten years and doubling first in ten year and doubling twice over every seven years thereafter prior to 2025. keeping this perspective in mind, we may now examine the profile of major disease control effort; the effectiveness of available instruments for delivery and financing public health action and assess factors relevant to the remaining event of vulnerability within JOUT emerging social pyramid over next two or three decades,

MAJOR DISEASE CONTROL EFFORTS

A careful analysis of the Global Burden of Disease (GBD) study focusing on age-specific morbidity during 2000 in ten most common diseases (excluding injuries) shows that sixty percent of morbidity is due to infectious diseases and common tropical diseases, a quarter due to life-style disorders and 13% due to potentially preventable per- natal conditions. Further domestic R&D has been so far muted in its efforts against an estimated annual aggregate health expenditure in India of Rs- 80,000/-crores R&D expenditure in India for public and private sector combined was Rs 1150 crores only. India must play a larger part in its own efforts at indigenous R&D as very little world- wide expenditure on R&D is likely to be devoted to infectious diseases. For instance out of the 1233 new drugs that came into the market between 1975 and 1997 only 11 were indicated specifically for tropical country diseases,

We have already the distinction of elimination or control acceptable to public health standards of small pox and guinea worm diseases. In the draft National Health Policy -21 It has now been proposed to eliminate or control the following diseases within limits acceptable to public health practice- A good deal of the effort would be feasible.

- Polio Yaws and leprosy by 2005 which seems distinctly feasible though the removal of social stigma and reconstructive surgery and other rehabilitation arrangements in regard to leprosy would remain inadequate for a decade or more.
- Kalaazar by 2010 and Filariasis by 2010 which also seems feasible due to its localized prevalence and the possibility of greater community based work involving PR institutions in the simple but time-limited tasks or public health programs-
- Blindness prevalence to 0.5% by 2010 seems less feasible due to a graying population. At present the programme is massively supported by foreign aid as there are many other legitimate demands on domestic health budgets-
- AIDS reaching zero growth by 2007 appears to be problematic as there are disputes even about base data on infected population. On most reckonings, affordable vaccines are not likely to be available soon nor anti-retroviral drugs appear likely at affordable prices in the near future. Further the prevalence curve of Aids in India is yet to show its shape. There is also a larger unresolved question of where HIV/AIDS should be fitted in our priorities of public health, especially in this massively foreign aided programme what happens if aid does not become available at some point.

Unfinished burden of communicable diseases

Apart from the above, there remains a vast unfinished burden in preventing controlling or eliminating other major communicable diseases and in bringing down the risk of deaths in maternal and peri-natal conditions. Endemic diseases arising from infection or lack of nutrition continue to account for almost two thirds of mortality and morbidity in India. Indeed eleven out of thirteen diseases recommended by the Bhore Committee were infectious diseases and at least three of them may well continue to be with us for the next two decades. Barring Leprosy which is almost on the path to total control by 2005, the other key communicable diseases will be TB, Malaria and Aids- to which diarrhoea in children and complicated and high risk maternity should be added in view of their pervasive incidence and avoidable mortality among the poorer and under served sectors,

Tuberculosis:

Tuberculosis has had a world wide resurgence including in India. It is estimated that about 14 million persons are infected, i.e. 1.55% of total population suffer from radiologically active Tuberculosis. About 1.5 million cases are identified and more than

300 000 deaths occur every year Between NFHS 1 and NFHS 2 the prevalence has increased from 4678 per lakh population to 544. Unfortunately, prevalence among working age adults (15-59) is even higher as 675. All these may well be underestimates in so far as patients are traced only through hospital visit. Only about half reach the hospital. Often wrong diagnosis by insufficiently trained doctors or misunderstood protocols is another key problem both public and private sectors. TB is a wide spread disease of poverty among women living and working in ill ventilated places and other undernourished persons in urban slums it is increasingly affecting the younger adults also in the economically productive segments. No universal screening is possible. Sputum positive test does not precede diagnosis but drugs are prescribed on the basis of fever and shadows as a result incomplete cure becomes common and delayed tests only prove the wrong diagnosis too late. Improved diagnosis through better training and clear protocols and elimination of drug resistance through incomplete cure should be priority. Treatment costs in case of drug resistance can soar close to ten times the normal level of Rs. 3000 to 4000/-per person treated. Similarly even though the resistant strain may cover only 8% at present, it could suddenly rise and as it approaches 20% or so, there is a danger that TB may get out of control. The DOTS programme trying for full compliance after proper diagnosis is settling down but already has some claims of success. More than 3000 laboratories have been set up for diagnosis and about 1.5 lakh workers trained and with total population coverage by 2007 cure rates (already claimed to have doubled) may rise substantially. There is reason to hope that DOTS programs would prove a greater success over time with increased community awareness and generation. The key issue is how soon and how well can it be integrated into the PHC system and made subject to routines of local accountability, without which no low cost regime of total compliance is feasible in a country as large as India.

An optimistic assessment could be that with commitment and full use of infrastructure it will be possible to arrest further growth in absolute numbers of TB cases keeping it at below 1.5 million till 2010 even though the population will be growing. Once that is done TB can be brought down to less than a million lie within internationally accepted limits and disappears as a major communicable disease in India by 2020.

Malaria:

As regards malaria, we have had a long record of success and failure and each intervention has been thwarted by new problems and plagued by recrudescence. At present India has a large manpower fully aware of all aspects of malaria but often low in motivation. It can be transformed into a large-scale work force for awareness generation, tests and distribution of medicine. In spite of past successes, there is

evidence of reemergence with focal attacks of malaria with the virulent falciparum variety especially in tribal areas. Priority tribal area malaria stands fully funded by the center.

About 2 million cases of malaria are recorded all over India every year with seasonal high incidence local failures of control. Drug resistance in humans and insecticide resistant strains of mosquitoes present a significant problem. But there is a window of opportunity in respect of DDT sensitive areas in eastern India where even now malaria incidence can be brought down by about 50% within a decade and be beneficial for control of kala-azar and JE. There is growing interest and community awareness of biological methods of control of mosquito growth. Unfortunately diligent ground level public health work is in grave disarray in these areas but can be improved by better supervision greater use of panchayat raj institutions and buildings on modest demonstrated successes. As regards a vaccine, there seems to be no sufficient incentive for international R&D to focus on a relatively lower priority or research. Roll back malaria programmes of the WHO are more likely to concentrate on Africa whose profile of malaria is not similar to ours. The search for a vaccine continues but has little likelihood of immediate success.

In spite of various difficulties, if the restructuring of the malaria work force and the strengthening of health infrastructure takes place, one can expect that the incidence can be reduced by a third or even upto half in the next decade or so. For this it is necessary that routine tasks like timely spraying and logistics for taking blood slides testing and their analysis and organic methods of reducing mosquito spread etc. are down staged to community level and performed under supervision through panchayats with community participation public education and local monitoring. Malaria can certainly be reduced by a third even upto a half in ten years, and there is a prospect of near freedom from malaria for most of the country by 2020.

The case of AIDS:

There is finally the case of HIV AID. The magnitude in the numbers of HIV infected and of AIDS patients by 2025 can be known only as trends emerge over a decade from now. When better epidemiological estimates are available but at present these figures are hotly contested. We can't start with the number infected with HIV as per NACO sentinel surveillance in 2000 a cumulative total 3.86 million, a figure disputed in recent public health debate. We can then assume that about 10% will turn into full-blown cases of severe and intractable stage of Aids. There is as yet no basis to know how many of those infected will become AIDS patients, preventive efforts focused on behavior change will show up firmly only after a decade or so. During this period one

can assume an additional 10% growth to account for new cases every year. The Draft NHP 2001 seeks to stop further infection by educating and counseling and condom supplies to level it off around 2007, which seems somewhat ambitious. We have yet to make a decisive dent into the problem of awareness with the broader population and so far we have been at work only on high risk groups. NFHS2 shows only a third of woman reporting that they even knew about the HIV/AIDS. Further such awareness efforts must be followed by multi-pronged and culturally compatible techniques of public education that go beyond segments easier to be convinced or behaviour changed. There are voices already raised about the appropriateness of IEC mass media content and of the under emphasis of face to face counseling, calling for innovative mobilization strategies rooted in indigenous belief systems.

What it implies is that we may be carrying by 2015 close to 5 million infected and upto a tenth of them could turn into full blown cases. We may not be able to level off infection by 2007 Further these magnitudes may turn out in actual fact to be wildly off the mark. On any account it is clear that AIDS can lead to high mortality among the productive groups in society affecting economic functioning as also public health. Even if 10% of them say 50 to 60000 cases becomes full blown cases the state has the onerous and grim choice to look at competing equities and decide on a policy for free treatment of AIDS patients with expensive anti-retroviral drugs. And if it decides not to, the issue remains as to how to evolve humane balanced and affordable policies that do not lead to a social breakdown. In about a decade vaccine development may possibly be successful and drugs may be more effective but they may not always be affordable nor can be given free.

There would hopefully be wider consultation with persons with caring sensibilities including AIDS patients on how to counsel in different eventualities and to get the balance right between hospital and home care and how to develop a humane affordable policy for anti-retroviral drugs for AIDS patients. Is there a case for providing them with drug free of cost merely to extend their lives for few years? The matter involves a true dilemma, for public health priorities themselves certainly argue for more funds should address diseases constituting bigger population based hazards. Investments made in such expensive interventions can instead be made in supporting hospice efforts in the voluntary and private sectors.

Whatever position may emerge in research or spread of infection or case fatalities, a multi-pronged attempt for awareness, must continue and tough choices must get discussed openly without articulate special, often urban middle class interests denying other views and especially public health priorities of the poor. The promotion of barrier protection must increase but has to relate to a system of values, which would be acceptable to the people's beliefs. We need to strengthen sentinel surveillance systems and awareness effort. We also need sensitive feedback on the effects they leave on younger minds for a balanced culturally acceptable

strategy. All this is feasible and can be accomplished if we are not swept away by the power of funding and advocacy and fear of being accused to be out of line with dominant world opinion.

In any case many of the ill cannot afford the high prices or have access to it from public agencies. The strict patent regimen under TRIPS is bound to prevail, notwithstanding the ambivalently worded Doha decision of WTO that public health emergencies provide sufficient cause of countries to use the flexibility available from various provisions of TRIPS. A recent analysis reveals that the three drug regimen recommended will cost

\$10000 per person per year from Western companies and the treatment will be lifelong. Three Indian companies are offering to Central Government anti retro; viral drugs at

\$600/ Rs. 30,000/per person per year and to an international charity at an even lower price \$ 350/ Rs. 13,000/per year provided it was distributed for humanitarian relief free in S. Africa. It has been public policy in Brazil that the drug is supplied free to all AIDS should be no exception. If drugs are supplied acting on a public health emergency basis and prices can stabilize at Rs. 1000/- or so per year the public health budget should be able to accommodate the cost weighed against true public criteria. But the aim of leveling off infection of 2007 still seems unlikely.

Maternal and Parental Deaths

Maternal and parental deaths are sizeable but the advantage here is that they can be prevented merely by more intensive utilization of existing rural health infrastructure. Policy and implementation must keep steady focus on key items such as improved institutional deliveries better trained birth attendants and timely antenatal screening to eliminate anaemia and at the same time isolate cases needing referral or other targeted attention. After all Tamil Nadu has by such methods ensured closed to 90% institutional deliveries backed by a functional referral. Firm administrative will and concurrent supervision of specified screening tasks included in MCH services can give us a window of opportunity to dramatically bring down within a few years alarming maternal mortality currently one of the highest in the world. From NFHS I data, it was estimated at 424 per lac births it has risen to 540 per lac births in NFHS II, but the WHO estimate puts it higher at 570. There can be a systematic campaign over five years to increase institutional deliveries as near as possible to the Tamil Nadu level, also taking into account assisted, home deliveries by trained staff with doctors at call. For the interim TBAs should be relied on through a mass awareness campaign involving Gram Panchayats too. Over a period of time there is no reason why ANMs entitled benefits of children to help in their growth and not remain as welfare measure. Using the infrastructures fully and with community participation

and extensive social mobilization many tasks in nutrition are feasible and can be in position to make impact by 2010.

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