Old Concerns, New Spaces

In 1984 a group of intrepid health care activists and academics, medical professionals and social scientists. launched a journal for publishing analytical articles on health and health care. The original idea was a modest one, to bring out a periodical that would privately reprint well-known studies and analysis to what was thought to be a humble circle of people with an intense need to understand the dynamics of change in the health system and the political economy of health care. That is, however, not what happened. An unexpectedly large country-wide support group emerged even at the first tentative meeting making for the launch of the *Socialist Health Review* (later *Radical Journal of Health*. the change of name prompted for no other reason than that the Registrar of Newspapers had recorded an earlier title that was still extant even if the journal was not).

But *SHR* was itself standing on the shoulders of giants. Medico Friend Circle, the national organisation of health activists and health workers and its Bulletin that had set the tone for critique and drawn the contours of discourse many years earlier. Then again, *SHR* was not the first effort by any means, an earlier journal with a political economy perspective had been launched by a group of medical professionals/activists working in West Bengal and Bihar who had first seen the need for a platform for exchange and debate. *SHR-RJH* saw vibrant life for 10 years, chalking up an impressive readership.

In that time Health Studies began to take shape in India in large part prompted by social/health activists who were establishing alternative health care institutions and inevitably undertaking studies on a variety of areas. mortality and morbidity; health spending; health organisation; health policy; new models of health care, and so on. In that time too, more and more young professionals became drawn to organisations like the Medico Friend Circle, and as the state's decreasing interest in the provision of health care with the consequent sharp growth of health care institutions outside the government began to throw up issues of quality, regulation and medical ethics. The setting up of the Forum for Medical Ethics Society and the launch of the *Issues in Medical Ethics* (now *Indian Journal of Medical Ethics*) created yet another space for intense debates on sensitive issues. The *National Medical Journal* too with its focus on issues of medical practice also enlarged the dissemination space. A more recent addition to this stable has been the *Journal of Health and Development*. Simultaneously the urgent need to examine the health care system and the delivery mechanism gave rise to some very large studies both in the NGO sector and in the universities and other state-funded institutions.

Today these empirical enquiries, policy and action research in health have created a base for posing important questions related to the theoretical, philosophical, political and social underpinnings of health service, health care delivery, health expenditure, health behaviour, medical education, medical ethics and a range of other topics. All of this comprises Health Studies that is emerging as an independent area of interdisciplinary research.

It is in response to the burgeoning area of Health Studies and the growing research work in this area that the *Journal of Health Studies* has been launched. While there are many social science journals which offer dissemination and publication space for Health Studies, there are hardly any publications that are entirely focused on Health Studies. Indeed the *Journal of Health Studies* marks the coming to age of this new area of social sciences in India as well as in

the region of South Asia. *JHS* makes use of new media and technology, bringing readers and researchers an entirely new platform that combines the best of the online and the print media. We hope that the synergies so created will make for shorter time lags between research output and its dissemination, wider readership because of the open access platform, increasing rigour in academic work resulting from the much larger informed readership, and lively and productive discussions that will not only generate new themes and areas of study but make for a more rational and people oriented resolution of the problems of health and welfare.

It has been seen historically that the launch of a new academic journal in an environment of high research output further enhances both the quantity and quality of research. There is a symbiotic relationship between new journals and new areas of academic pursuit, each nurturing the other. Such a new venture with a sufficiently well-defined and broad based perspective can tweak the direction of research towards areas of social and intellectual concern. *JHS* joins other publications in the field in helping to define the contours of Health Studies in India and South Asia and nurturing it.

— Padma Prakash

Journal of Health Studies

The ***Journal of Health Studies (JHS)*** is a multidisciplinary academic periodical published by eSocialSciences and the Centre for Health and Allied Themes (CEHAT), Mumbai. India.

JHS acknowledges the interdisciplinary nature of health issues and is intended to provide a broad-based, vibrant space for contemporary and historical inquiries on health themes through the publication of research articles, case studies, research briefs, commentaries and, policy notes and discussions. Philosophically, JHS is located within a perspective that prioritises justice and equity. The aim of the journal is to define and help shape the expanding field of health studies in Asia retaining a special interest in South Asia. For this, ***JHS*** will, from time to time, being out special collections in emerging areas. The academic and intellectual needs and demands of academia and social movements will drive the journal.

JHS welcomes conceptual, theoretical and empirical contributions in the broad areas of Economics, History and Philosophy of Medicine, Sociology, Gender Studies, Policy Studies, and others. Also welcome are empirical and field notes and small studies.

While academic formats of research communication are preferred, ***JHS*** will encourage the dissemination of research work in other formats: essays, narratives, personal accounts, short fiction utilising research findings, poems, etc.

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Submissions may be made directly from the webpage or sent as an attachment. All contributions should be in MS Word or other word processing format. For clarifications on any count, do write to us at:
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Does Urban Health Deserve a Peg?

Leni Chaudhuri
Chandrima Chatterjee

India is urbanising at a rapid pace. Of India's total population of 1027 million, 285 million (27.8 per cent) live in urban areas. This has led to an increased demand for housing, transport, and all other basic infrastructural facilities. In most urban areas the infrastructure is not well equipped to handle the pressure. Iniquitous access to basic services has led to a perceptible growth of urban tensions that erupts at times of crises.

The urban slum population is today estimated to be around 60 million in the 2001 census, comprising of 21 per cent of the total urban population. However the actual numbers are much more because large numbers who live in unrecognized squatter settlements, pavements, construction sites etc often go unaccounted. Urban poverty and inadequate infrastructure has compelled people to live in precarious conditions. Inadequate facilities of water, sanitation and proper housing have added to the miseries of the people. The crumbling public health system is not capable of handling the allied issues related to rapid urbanization like the constant inflow of migrants, industrialization, pollution, displacement etc. More immediate needs to deliver health care have prompted the Public Health System to provide only curative health care. Inadequate preventive and promotive health care facilities have also led to deteriorating health conditions among the urban poor.

Since Independence the focus of the government has been around rural health care and this has resulted in complete neglect of health care provisions in urban areas both in terms of policies and actual service delivery. It is surprising that even with an ever expanding urban sector the government has not come up with a dedicated urban health policy in India. Urban health concerns are given token representation either in the RCH II or in the NRHM- urban component. But these inclusions are extremely inadequate and don't take a comprehensive look at the issue.

Urban health is a complex issue and includes several aspects like access to the social determinants of health, i.e., water, sanitation and housing, availability and accessibility of health care facilities, preventive health care related issues like implementation of disease control programs, immunization, supplementary nutrition programs, pollution control measures etc. In addition to these, any initiative on urban health care must sufficiently engage with the issue of urban poverty.

Nor has urban health been a special area of enquiry in academia until recently. It is important to understand that the study of urban health issues in India and south Asia needs a nuanced approach incorporating multidisciplinary perspectives. Most importantly, in this region of rapid growth urban health as an area of study needs must locate itself in the rururban continuum.

This inaugural issue of *JHS* brings together an initial three thought provoking papers that we hope will lead to further studies.

Health Services as Analyser of Urban Governance

A Study of Delhi

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***Abstract**: This paper proposes to consider the provision of public primary health services, as a case study of the changes brought about in urban governance in the past 15 years by economic liberalization, politico-administrative decentralization and the large consensus around the desirability of 'good governance', with a focus on New Delhi, India. The paper successively examines the role played by the several actors as intermediaries between the people and public providers of health services: Elected representatives (municipal councillors but also members of the Legislative Assembly), and civil society organisations, consisting essentially of Resident Welfare Associations (RWAs) and Non Government Organisations (NGOs). How does the presence of these various categories of intermediaries influence the provision of health services? What do they do, with whom, against whom, for whom?*
Email:

This paper proposes to consider the provision of public primary health services, i.e. a major social infrastructure, as a case study of the changes brought about in urban governance in the past 15 years, with a focus on Delhi. Since the early 1990s economic liberalization, politico-administrative decentralization and the large consensus around the desirability of 'good governance' as defined by the World Bank [World Bank 1989] have presumably transformed urban governance. Examining how these phenomena have translated the provision of primary level health services will allow us to document the validity of this assumption. Health services are usually a good analyser of social inequalities [Fassin 2000] which makes them a *priori* a privileged prism to study the social distribution of the costs and benefits of the 'new' urban governance.

Economic liberalization and health sector reforms have obviously been major determinants of the evolution of health services in the past decades. The expansion of the private health sector dates back to the 1980s but it has recently reached new proportions, since 82.5 per cent of health expenditure now goes to the private sector [Priya et al. 2004]. In that context, public health services are mostly used by the poorest sections of society, especially primary health services [Baru 2003].

But studies on the utilization of health services by the urban poor [Sundar and Sharma, Yesudian 2002] have shown that in big cities, characterised by the large availability of private medical practitioners, even slum dwellers display a preference for the private sector, despite the fact that public health care is free – at least theoretically.[1] The causes for such a situation have been well documented: primary health care units (whether Primary Health Centres – PHCs - or dispensaries) have a reputation of being understaffed, inadequately supplied with medical equipment and drugs, and their inconvenient timings translate into long queues. Even though private health care is un-

even in quality, it is preferred by a majority of people, including the poor, because it is perceived as more efficient.

I
Introduction

In Delhi the provision of public health care is typically characterised by a multiplicity of operating agencies and by the overlap of their respective competences.

At the topmost level, a major hospital such as the All India Institute of Medical Sciences (AIIMS), institutions such as the Indian Council for Medical Research (ICMR) as well as dispensaries catering only to the needs of specific clients (i.e. government employees), come under the Central government. The Delhi government operates through the Health Department, the Social Welfare Department, and the Health Directorate whose mission is to coordinate the action of the different health services providers (including private providers), to avoid overlaps and to control the quality of services. A number of hospitals, polyclinics, dispensaries and medical colleges function under the Delhi government. The Municipal Corporation of Delhi (MCD), i.e. Delhi's largest civic body,[2] also manages a series of hospitals, polyclinics, dispensaries, Maternity and Child Welfare Centres, mobile vans and PHCs.

In addition, various parastatal agencies such as the Northern Railways or the Employees of the State Insurance Corporation (ESIC) also provide medical facilities catering to their exclusive clientele. Lastly the voluntary sector runs a few charitable hospitals. To complicate matters, dispensaries (and hospitals to a lesser extent) provide different types of medicine. Besides allopathic dispensaries, one finds ayurvedic and unani dispensaries (classified together as 'Indian systems of medicine', or ISM) and homeopathy.

The crucial need to coordinate the work of these different agencies has been the subject of discussions and proposals for the past decade. It was recently decided that the Delhi government would be in charge of all curative health care except primary health care - which would remain with the MCD along with public health, i.e. preventive care. But since 1999 the proposed transfer of curative functions from the MCD to the Delhi government has evoked recurring tensions between these two levels of government.[3]

A division of labour according to the type of medicine was also proposed: while the Delhi government would be in charge of allopathic medicine, the MCD would provide only ISM and homeopathy. However, according to senior MCD officials, this proposal was never strictly implemented.

The latest coordination proposal, finalised in 2002, is more comprehensive: it plans to make the nine revenue districts of the National Capital Territory of Delhi reference units for the coordina-

1. At the secondary and tertiary level of health services, user fees are increasingly being introduced as part of the health sector reforms.
2. The other two civic bodies – the New Delhi Municipal Council and the Delhi Cantonment Board – are also health services providers for their respective constituencies.
3. In 2000, four out of those seven hospitals which had been taken over by the Delhi government went back to the MCD.

tion of all medical facilities; a chief District Medical Officer will be in charge of coordination, he will check the registration of all medical practitioners, nursing homes[4] etc.; and he will be in charge of total health planning for the concerned district.[5] In that scheme of things, all new dispensaries will offer ISM and homeopathy along with allopathy. An interesting feature of this ambitious plan is that elected representatives have no presence on this plan.

This is in keeping with Delhi's tradition. In terms of governance indeed, Delhi has long been ruled by bureaucrats. Considering Delhi's particular history and political status, the democratic decentralization process in the capital city goes back to the adoption of the 69th Constitutional Amendment Act (CAA) in 1991, leading to the creation of the National Capital Territory of Delhi, with its own Assembly and Council of Ministers. In that perspective, both the election in 1993 of the first Delhi Legislative Assembly since 1956, and the election in 1997 of 134 councillors to the Municipal Corporation of Delhi (which had been superseded in 1989) pertain to the development of local democracy *lato sensu.*

Delhi's peculiar political geography is another ground for considering both Members of the Legislative Assembly (MLAs) and councillors as 'local' representatives: in this mega city (13.8 millions inhabitants, 1483 sq. km.) municipal wards – i.e. the smallest electoral constituency in India's political architecture – were until recently characterised by their huge size.[6] Therefore the municipal and the state levels of government were closer to each other than they are elsewhere in India, geographically but also statutorily. There were only two councillors for one MLA in Delhi (as opposed to 6 to 8 in other mega cities). As a result, a strong sense of competition was perceptible between MLAs and councillors, since every councillor could virtually expect to become an MLA.[7]

Democratic Decentralisation and Health Services

What can we expect from democratic decentralisation in terms of health services provision? Urban governance in Delhi is characterised by its complexity: a multiplicity of agencies work on the same territory, under the responsibility of different levels of government, which translates into overlapping, inefficiency, and reduced accountability. Now the current discourse supporting decentralisation, primarily carried by the World Bank and adopted, with local variations, in a majority of countries in the past two decades, argues that one of its main impact is to make the administration more responsive to people's need. There are several types of decentralization, both in theory [Rondinelli 1990] and in practice, but I will consider here only democratic

4. In 2003, a survey conducted by the Health Department found 1603 illegal nursing homes and only 400 registered ones (*Times of India*, 14/03/2003).
5. Source: interview with a senior official of the Health Directorate, Delhi, November 2004.
6. In Delhi, until 2007, there were on an average 100 000 people in each of the 134 municipal wards, and Wards Committees covered an average population of more than one million people [Shah and Bakore 2006: 27]. But a re-delimitation of wards took place prior to municipal elections in April 2007, making the average population of the new 272 wards closer to 50 000 people – still a large figure by any standard.
7. In terms of competences also, in Delhi the "state" has less power, and the Municipal Corporation has more power than their respective counterparts in other states: the Delhi Chief Minister does not control land, public order and police, while the MCD's list of departments is one of the largest among Municipal Corporations.

decentralisation as embodied in the context of urban India in general, by the 74th Constitutional Amendment Act (CAA) passed in 1992, and in Delhi, in particular, by the 69th CAA.

The main hypothesis is the following: considering the fact that in many cities primary level health services fall under the responsibility of municipal corporations, one may expect that the newly empowered local representatives take some action concerning a basic service used by the urban category with the highest voting participation in local elections, i.e. slum dwellers.

But a simple perusal of newspapers[8] suggests that besides elected representatives (councillors but also MLAs) another category may also act as intermediaries between the people and public providers of health services: civil society organisations, consisting essentially of Resident Welfare Associations (RWAs) and Non Government Organizations (NGOs). What does the presence of these two categories of intermediaries change in the provision of health services? What do they do, with whom, against whom, for whom? These questions have been guiding my investigations.

This paper is based on an empirical survey conducted in Delhi in 2004-2005. Fieldwork was grounded in four municipal wards selected with a view to provide a representative sample of the city in terms of urban landscape, housing pattern and socio-economic profile of the inhabitants: Kalkaji, in the southern, residential area of the city; Seemapuri, across the Yamuna river, where many slums have been relocated; Jama Masjid, at the heart of the dense Old city; and Najafgarh, on the western, quasi-rural border of Delhi. This is a qualitative study based, firstly, on a series of 50 semi-directed interviews with, and direct observation of, the actors concerned with access to health services in India's capital city: elected representatives and officials at the state and at the municipal levels, political party cadres, NGOs' and Resident Welfare Associations' representatives, doctors and public health care users.[9]

Secondly, I collected and analysed archives of the Delhi Vidhan Sabha and of the MCD which provide a diachronic, systematic view of the content and focus of discussions concerning health issues in those two political institutions. These archives do not provide verbatim quotations, but only a lifeless rendition of the issues raised by elected representatives. Yet they are a major information source on the process of agenda setting: what is being discussed is thereby put on the agenda of the Delhi government or of the MCD – even if we do not always know to what extent the agenda was translated into action.

On the basis of these investigations, I offer here a series of micro level, qualitative data, which aim at specifying what is new in urban governance today.

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8. One of the difficulties I met while attempting to assess shifts in the decision-making process concerning health care provision is the high visibility of some actors and some actions. Since good governance has now become an electoral argument, initiatives towards increasing accountability, transparency and participation are given a strong publicity. The Bhagidari scheme is typically a much talked about initiative whose real substance is rather elusive. For politicians as for NGOs, visibility is an end in itself and must not be mistaken for an indicator of the actual importance of the actor/action considered.
9. I attended one House meeting of the Municipal Corporation of Delhi; one Ward committee meeting; one health camp organized by the Delhi government; and one public hearing organized by an advocacy network, the Jan Swasthya Abhiyan.

II
Role of Elected Representatives

MLAs

How far are MLAs interested in health issues, and on which aspect of health services are they most active? How do they influence the Delhi government's health policy? I used administrative archives in order to answer these questions.

Much of the policy making work of MLAs is done through a series of 'House Committees'[10] (there were 22 of them in 2004)[11] which are really monitoring committees. They meet once or twice a month to summon officers of the various departments who will answer their queries. These committees produce reports based on information thus provided and on the subsequent discussions, which they eventually submit to the House. Once adopted, the resolutions contained in these reports are binding on the government. Unfortunately for researchers, the thematic classification of House Committees does not correspond to the various Departments, so that MLAs' policy making on health issues is scattered among a number of committees, whose proceedings were in any case not available.

The Vidhan Sabha sittings' lists of business thus appeared to be the second best source of information. Delhi's Vidhan Sabha does not meet very often: there were 26 yearly sittings, on an average, between 1993 and 1998 (i.e. the First Vidhan Sabha), and 16 yearly sittings between 1999 and 2003 (i.e. the Second Vidhan Sabha). The main purpose of sittings is of course for the government members to answer MLAs' queries.

Table 1: Items discussed in House meetings of First Delhi Vidhan Sabha (1993-1998)

Items	Leg. Prop. 1st VS	per cent	PMBs/ Resolutions 1st VS	per cent	Short Discussions 1st VS	per cent
Slum development			3	3.8		
Unauthorized colonies			9	11.4	5	5.6
Unauthorized constructions			1	2.4	6	6.7
Housing			9	11.4	3	3.4
Land management			6	7.6	1	1.1
DDA			1	1.3	7	7.9
MCD	1	2.3	1	1.3	2	2.2
Roads			4	5.1	2	2.2
Public transport			1	1.3	5	5.6

10. Each House Committee is composed of nine MLAs and is renewed every year.
11. There are three financial committees, 14 regular committees, and an indefinite number of ad hoc committees.

Items	Leg. Prop. 1st VS	per cent	PMBs/ Resolutions 1st VS	per cent	Short Discussions 1st VS	per cent
Water	1	2.3	5	6.3	7	7.9
Sewerage					2	2.2
Electricity			2	2.5	6	6.7
Food control			2	2.5	3	3.4
Public health	8	18.2	2	2.5	6	6.7
Medical relief	3	6.8	1	1.3	3	3.4
Education	1	2.3	7	8.9	3	3.4
Culture	3	6.8	1	1.3		
Sport			4	5.1		
Women's welfare			1	1.3	2	2.2
Personal law			4	5.1		
Labour			2	2.5	4	4.5
Law and order			1	1.3	8	9.0
Constitutional/administrative reforms	4	9.1	3	3.8	1	1.1
Functioning of the VS			1	1.3		
Personnel management					4	4.5
Prisons					2	2.2
Justice	3	6.8				
Taxes	8	18.2	3	3.8		
Budget	5	11.4				
Environment and salary	2	4.5				Status
of MLAs, ministers	4	9.1				
Industry						
Agriculture	1	2.3	1	1.3		
Miscellaneous			4	5.1	7	7.9
Total	44		79		89	

Source: Lists of business of the House meetings, Secretariat of the Vidhan Sabha.

Table 2: Items discussed in House Meetings of Second Delhi Vidhan Sabha (1999-2003)

Items	Leg. Prop. 2nd VS	per cent	PMBs/ Resolutions 2nd VS	per cent	Short Discussions 2nd VS	per cent
Slum development			1	1.8	1	1.9
Unauthorized colonies			3	5.4	2	3.8
Unauthorized constructions			1	1.8		
Housing			2	3.6		
Land management						
DDA			1	1.8	5	9.4
MCD	1	2.6			6	11.3
Roads			4	7.3		
Public transport			1	1.8	5	9.4
Water	1	2.6	1	1.8	4	7.5
Sewerage			1	1.8	1	1.9
Electricity	1	2.6			5	9.4
Food control			1	1.8	3	5.7
Public health	2	5.1	4	7.3	1	1.9
Medical relief			1	1.8	5	9.4
Education			7	12.7	4	7.5
Culture	2	5.1	5	9.1		
Sport						
Women's welfare			4	7.3	3	5.7
Personal law			3	5.4		
Labour					3	5.7
Law and order					2	3.8
Constitutional/administrative reforms	2	5.1	2	3.6		
Functioning of the VS			5	9.1		
Personnel management			3	5.4		
Prisons	2	5.1				
Justice	1	2.6				
Taxes	9	23.1	1	1.8	1	1.9
Budget	8	20.5				
Environment						
Status and salary of MLAs, ministers	6	15.4				
Industry	2	5.1				
Agriculture Miscellaneous	2	5.1	4	7.3	2	3.8
Total	39		55		53	

Sources: Lists of business of the House meetings, Secretariat of the Vidhan Sabha.

Table 1 and Table 2 offer a schematic, quantified view of the nature of issues discussed in the House meetings during the First and the Second Vidhan Sabha. They are based on an exhaustive perusal of the lists of business for each sitting (no minutes were available). The lists of business, drafted a few days prior to each House meeting, are a good indicator of the issues of concern to MLAs, which I have classified into two different categories:

- Private members bills (PMBs) and Resolutions are formal statements of interest, which may to lead to Legislative proposal;

- Short duration discussions (in which I have included those items raised under the "Calling attention" category) are more informal statements, and usually relate to immediate problems;

- Lastly Legislative proposals are a different category altogether, as they are put up by Ministers.

These tables indicate the range of issues dealt with by the Legislative Assembly; the changing priority areas (indicated by the number of interventions on a given issue); and the relative emphasis put by MLAs on various issues (as indicated by their appearance through "Private members bills and Resolutions" or through "Short duration discussions"). They do not, however, present an exhaustive view of what is being discussed in the Vidhan Sabha: I have left out budget sessions, the presentation of reports (because the reporting mode does not provide any detail in these cases) and "motions under rule 107", which are another way for MLAs to make a statement but which are used only exceptionally.

It can be observed that Health Care is a major area of Legislative proposals in the First Vidhan Sabha. Out of the 11 Bills (i.e. one fourth of the total number of Bills) coming under "Public Health" and "Medical Relief", 10 will be passed, half of which aim at regulating private medical practice in the capital city – which might well be an answer to the growing importance of the private health sector. In the same period, MLAs appear to pay less attention than the government to health issues: 10 per cent of "Short discussions" are devoted to the health sector (usually to deplore the "sorry state of affairs in government hospitals"), but only 3.8 per cent of PMBs/Resolutions. In the Second Vidhan Sabha, one finds a reverse situation: health issues are the object of only 5.1 per cent of Legislative proposals, but 9 per cent of PMBs/Resolutions and 11.3 per cent of Short discussions.

More generally, these two tables highlight the main areas of concern of MLAs: unauthorized colonies attract a lot of attention[12] (11.4 per cent of Private member bills/Resolutions in the First Vidhan Sabha) – indeed, much more than slum development (3.8 per cent). The attention paid to housing issues (11.4 per cent of Private member bills/Resolutions in the First Vidhan Sabha) also points at recurring conflicts between MLAs and the Delhi Development Authority (which is the direct subject of 7.9 per cent of short duration discussions in the First Vidhan Sabha and 9.4 per cent in the Second Vidhan Sabha - where 11.3 per cent of such

12. MLAs' interest for unauthorized colonies also appears in discussions about the use of their Local Area Development Fund: most of them want to use their fund to bring basic facilities to such colonies.

discussions are also devoted to complaints against the work of the MCD). Law and order – another domain escaping the Delhi government - make up another important part (9 per cent) of short duration discussions in the First Vidhan Sabha. Lastly, MLAs show a persistent concern with education issues (8.9 per cent of Private member bills/Resolutions in the First Vidhan Sabha, 12.7 per cent in the Second Vidhan Sabha).

These tables inform us on MLAs' action concerning health issues in their policy making capacity; but MLAs also act as errand runners for their constituents: they interact individually - and directly - with the Health Minister, senior officials of the Health Department or even medical staff. These interactions can take different forms: firstly, they support the creation of health infrastructure - according to a senior official of the Health Secretariat; about 60 per cent of infrastructure provision is due to MLAs' initiative. Secondly, MLAs may also help organize health camps, motivate people to participate in immunization drives, or provide recommendation letters to people seeking admission in one of the hospitals managed by the Delhi government (which helps to reduce the waiting period). But users say that MLAs are much less approachable than councilors for this purpose.

Councillors

Indeed councillors too act as errand runners, but also as vigils and as ombudsmen: they may make rounds in the various dispensaries and polyclinics of their ward to keep a check on their functioning; they will report people's grievances concerning medical personnel's misbehavior to the concerned senior officials; and all the councilors I interviewed mentioned the recommendation letters that they provide to people for getting quicker admission into those hospitals managed by the MCD. Councillors wanting to open or upkeep a particular health centre may submit their request individually and directly to officials in the Health department; but the Municipal Health Committee is the privileged site for such demands to be expressed – this is why I have focused my investigations on it.

In case of the MCD, I have used archives to try and capture the changes, if any, brought into the nature and focus of those discussions taking place within the MCD committee in charge of health care, by the implementation of the 74th CAA in 1997 – that is, essentially by the new presence of elected representatives after eight years of supercesion.

The MCD's deliberative wing's organization into a series of thematic 'municipal committees', composed of ten to twenty councilors selected for one year by their respective parties, mirrors the executive wing's organization into "municipal departments". The MCD's Medical Relief and Public Health Committee, like other municipal committees, gathers about once every month to discuss a number of issues. Its role consists in (i) examining recommendations expressed by the executive wing, and (ii) making new recommendations.

Table 3 offers a schematic, quantified view of these discussions, but it cannot be compared with Table 1 and Table 2 – whose equivalent would have been an index of those issues discussed in the monthly House meetings of the MCD. Table 3 does not provide an exhaustive view of discussions relating to health issues in the MCD, since those can also take place both within Ward committee meetings and House meetings. It is based on two types of sources: the

lists of business of the Municipal Health Department (henceforth MHD) before 1997, and both the lists of business and the minutes of the meetings of the Municipal Health Committee (henceforth MHC)[13] after 1997 – these two types of document are essentially similar, since minutes do not contain any verbatim quotations, but only show what part of the list of business, i.e. the meeting's agenda, was actually dealt with.

This table compares two periods of five years each: 1991-1996[14] (when the MCD was a purely administrative civic body) and 1997-2001 (when the MCD became a politico-administrative institution of local self government, as a result of the implementation of the 74th CAA). It shows, firstly, that many more items were discussed after 1997, i.e. after the election of the first batch of councillors under the 74th CAA. Secondly, a clear contrast appears in the focus of discussions in these two periods: 'Personnel management' is the object of 57.8 per cent of officials' discussions, but only of 15.9 per cent of councillors' discussions.[15] Councillors' discussions focus on the opening or upkeep of various types of health centres (21.4 per cent, as opposed to 11.3 per cent of discussions before 1997), and to a lesser extent on their maintenance (6 per cent). These figures suggest that councillors, on the one hand, are keen to create new health care infrastructure, and on the other, confirm that they do monitor the functioning of existing structures.

Table 3: Issues discussed in meetings of Municipal Health Department (1991-1996) and of Municipal Health Committee (1997-2002), MCD

Items	1992-1996	per cent of total number of items	1997-2001	per cent of total number of items
Personnel management	148	57.8	56	15.9
Construction/purchase of medical equipment	15	5.9	21	4.3
Disposal of medical waste	14	5.5		
Opening/upgrade of health centres		11.3		21.4
MCWC	15		11	
Mobile clinics	2		7	
Ayurvedic dispensaries/ hospitals	11		21	
Homeopathic dispensaries	1			
Unani dispensaries			4	
Allopathic dispensaries			21	

13. The new designation of the MHD is Medical Relief and Public Health Department, and for the MHC it is Medical Relief and Public Health Committee.
14. Instead of 1992-1996, because no archives were available for the year 1992.
15. In 2004, the total staff of the MCD amounted to 150 000 employees.

Hospitals			4	
Upgrading			7	
Items	**1992-1996**	**per cent of total number of items**	**1997-2001**	**per cent of total number of items**
Maintenance of health centres			21	6 . 0
User charges	8	3.1	4	1.1
Slaughter houses	12	4.7		
Cremation/burial grounds	2	0.8	17	4.8
Land management	14	5.5	2	0.6
Implementation of a World Bank project	6	2.3		
Election of members of the MHC			5	1.4
Organization and functioning of the Health Department		0.8		18.8
Relationships between MCD staff and councillors			12	
Staff behaviour			8	
ISM			4	
Functioning of hospitals			10	
Functioning of dispensaries			5	
Transfer of colony hospitals to Delhi government	1		8	
Other	1		19	
Unauthorised meat/fish shops and slaughter houses			26	7.4
Licensing			18	5.1
Stray animals			5	1.4
Prevention of water borne and mosquito diseases			18	5.1
Miscellaneous	6	2.3	17	4.8
Total	256		351	

Sources: Lists of business and/or minutes of the meetings, MCD

This table compares two periods of five years each: 1991-1996[16] (when the MCD was a purely administrative civic body) and 1997-2001 (when the MCD became a politico-administrative institution of local self government, as a result of the implementation of the 74th CAA). It shows, firstly, that many more items were discussed after 1997, i.e. after the election of the first batch of councillors under the 74th CAA. Secondly, a clear contrast appears in the focus of discussions in these two periods: 'Personnel management' is the object of 57.8 per cent of officials' discussions, but only of 15.9 per cent of councillors' discussions.[17] Councillors' discussions focus on the opening or upkeep of various types of health centres (21.4 per cent, as opposed to 11.3 per cent of discussions before 1997), and to a lesser extent on their maintenance (6 per cent). These figures suggest that councillors, on the one hand, are keen to create new health care infrastructure, and on the other, confirm that they do monitor the functioning of existing structures.

Another interesting figure is the importance of discussions focusing on the functioning and organisation of the MHD (18.8 per cent): councillors regularly question the status quo – particularly the relationships between the executive and the legislative wings.

This table, however, does not indicate to what extent the issues being discussed have been translated into actions; items mentioned before 1997 are more likely to have been followed with action, since they are already into the administrative process. After 1997, items appear through different types of interventions: it can be a collective resolution or request of the MHC as such (usually addressed to the MCD administrative and/or medical staff[18]), or some individual councillor's resolution, or councillors' observations. The actual consequences of these different categories of intervention are very difficult to assess. "Officials are bound to answer councillors' resolutions, not to obey it", said an official. But councillors do have the means, however illegitimate, to put pressure on officials: they can use their relationship with higher placed party members to threaten officials with transfer.

On the whole indeed, a constant tension is perceptible between councillors and MCD officials, whether administrators or doctors; despite their lifeless character, these archives reveal that councillors struggle to assert their authority, to define their role in an organisation that did function (albeit differently) without them; they constantly demand information, they often suggest coordination mechanisms.

Moreover, the well known contrast between the respective styles of expression of bureaucrats and politicians is striking in the archives of the MCD: while bureaucrats base their demands on previous administrative decisions or norms, politicians always give pride of place to "people's demands, needs or wishes" – usually a very vague notion.[19] Both types of demand always refer to the same set of criteria, i.e. population density and distance to the nearest medical

16. Instead of 1992-1996, because no archives were available for the year 1992.
17. In 2004, the total staff of the MCD amounted to 150 000 employees.
18. Many administrative posts in the MHD are occupied by medical doctors.
19. The reference to people's demand appears only once in the pre-1997 archives – about the need to open a homeopathic dispensary in a locality.

facility, but councillors also display a wish to make available a variety of medicines – i.e. Indian systems of medicine and homeopathy, beside allopathy - to their constituents. Lastly, targets are usually specified in the pre-1997 archives, which often mention *jhuggi jhompri* dwellers, mothers and children or school children, while councillors merely mention 'poor people' or 'the weaker section'.[20]

Elected representatives versus officials

These contrasts find a more violent echo in interviews with officials, both in the Delhi government and in the MCD, who express mostly negative feelings about the impact of elected representatives.

When interviewed about the changes brought up in their own work by the presence of councillors from 1997 onwards, most MCD officials mention a necessary evil. "It was easier before 1997", one of them simply said; "For the officer it's easier to work without the local representative; but for the general public it makes things simpler: they won't hesitate to go to the councillor's house, while they will hesitate to go and meet the official", a Deputy Commissioner said.

Firstly, officials frequently display some contempt towards what they perceive as elected representatives' incompetence: "The MHC is supposed to formulate the guidelines of the [MCD health] policy, and the MHD is supposed to work in collaboration with them, to implement their decisions; but rarely do they make policy on their own", said a senior MHD official.

They criticize politicians' obsession with their re-election: both MLAs and councillors are accused to focus on opening new facilities for the sake of visibility: "Each MLA wants a dispensary in his locality, for electoral and other benefits; they will say that they want health at people's doorstep", said a Health Department official.

More generally, officials complain of the demagogical approach of elected representatives: "Councillors have no good perception of preventive health… They want the government to provide everything. Pulse polio programmes are popular with them; they always go for any formal gathering. But when perceptions have to be changed (for instance to fight mosquito breeding) we receive hardly any support from them, they accuse us of *chalaning* people", said a Deputy Health Officer (MCD).

They also complain of councillors' limited perspective: "Councillors' perception is limited to their ward; they lack in planning capacity for the larger area", said a Deputy Health Officer.

The observation of Ward committee meetings, however, sheds a different light on this argument. Indeed one clearly observes two different types of relationships depending on the decentralization level in the MCD, which are quite perceptible in the contrasting attitude that officials and councillors adopt towards each other in House meetings and in Ward committee

20. However councillors also occasionally display gender concerns, : for instance a lady representative demanded that women be recruited on a priority on a technician post devoted to examine mostly female patients; this might be a consequence of the fact that the MHC is roughly made up of half male and half female councillors.

meetings. In the former, the Commissioner, sitting side by side with the Mayor, faces the House in a chairing position. While councillors present their requests, they are literally obliged to look up to him, who will then answer by looking down on them.

In Ward committee meetings on the contrary, the dozen councillors face zonal level officials representing all MCD departments around a table, and the session is chaired by the Ward committee chairperson (elected from among the ward's councillors). Here councillors take officials to task on specific issues: the nature of discussions reveal that they have a very precise knowledge of local problems concerning civic amenities. "Area officials[21] know that I'm very strict and don't tolerate administrative neglect; if no action is taken, I charge them in Ward committee meetings", said a lady councillor. "At the zonal level, we usually don't counter stand councillors", said a Deputy Health Officer.

The two types of meetings differ in their solemnity, their visibility (journalists usually attend only House meetings), the level of officials facing councillors, and of course the issues and the budget at stake. Ward committee meetings allow councillors to display the minute attention they pay to civic amenities and their maintenance, but no planning activity is conducted at that level and the discretionary spending power is limited to Rs. 500,000.

Another negative feeling often mentioned is that of resentment. "Your tenure is normally for two to three years, but you get transferred as soon as a politician wants you to be," said an official in the Health Department. "In the planning process, the political factor dominates: an influential person can get a dispensary open even if it is not required", added an official in the MHD.

Unlike administrative officials, doctors appear mostly satisfied that the presence of elected representatives is beneficial: "The councillor comes and visits my PHC regularly, to see that everything and everybody is working. We can tell him about our problems, for instance when a water pump is out of order he can use his own fund or get the department to repair it… Corruption is there, but some work is also there," said the Medical Officer of a South Delhi PHC. "The councillor makes it easier to get things done; she conveys requests to the relevant department; whereas the MLA is rarely seen, said a Medical Officer in charge of an MCD dispensary."

Lastly councillors, when interviewed about their action in terms of health issues, hardly mention the role of officials. This fact, in addition to the clear contrast between perceptions of the medical and the administrative MCD staff, suggests that the conflicting relations between elected representatives and officials mostly result from the latter's frustration at having to make do with politicians, in a city where bureaucrats have long been very powerful.

21. That is, officials at the Zonal, or Ward committee level.

III
Civil Society Organizations

Two types of civil society organizations have been given an official role in the delivery of health care in Delhi: Resident Welfare Associations (RWAs) and Non Government Organizations (NGOs).

RWAs

RWAs - a semi-formal grouping of neighbors concerned with the maintenance of local infrastructure - have been in existence at least since the 1970s in Delhi. But the Bhagidari scheme (self defined as a "citizen-government partnership") launched by the Chief Minister Sheila Dixit in 2000 has given a new dimension to these associations, which have multiplied while they acquired a new status, reflected in the frequency of their mention in the media coverage of city news. The Bhagidari scheme, which aims at developing people's participation in the management of local affairs, gives a new status and role to 'citizen's groups', represented mostly by Resident Welfare Associations (RWAs) and Market Traders Associations.

Thus RWAs now enjoy a very official status, provided they follow – at least on paper[22] - a series of rules (like selecting their representatives through a secret ballot election held every three years) – which entitles two of their representatives to become card holding members of the Chief Minister's 'Team Delhi'. RWAs are also given a very official role, i.e. that of representing the inhabitants of a given area when dealing with the administration - be it the MCD, the police or the Jal Board - on a range of subjects, from monitoring maintenance works to managing community halls.

The Bhagidari scheme is a tool for making the administration more transparent and accountable: it provides RWAs with information about public works to be conducted, and about the personal details of the officials in charge, which give them the power to "keep officials on their toes", as several officials said.

As far as health care is concerned, RWAs are considered by the municipal administration as a major channel of communication, particularly useful for its public health mission. Indeed RWAs are a key instrument of communication between local people and the MCD, both ways: they inform the administration about local needs, for instance in terms of anti-mosquito measures; and they convey public health recommendations from the administration to the people. Their role is quite formal in this regard: in each of the 12 MCD zones (each zone encompasses a dozen wards), the MCD zonal health officer, i.e. the Deputy Health Officer (and sometimes the Deputy Commissioner) holds monthly meetings with RWAs in order to exchange information regarding public health issues.

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22. Interviews with RWAs representatives reveal that many different realities co-exist behind this common appellation. RWAs are sometimes formed through co-option rather than election, and they raise resources in a variety of ways which are more or less transparent.
23. Increase of the price of basic goods has often been a theme with a strong mobilising power – for instance it was the spark that lit the second wave of the women's movement in Bombay in the early 1970s.

Yet "the major demands of RWAs are for curative health services: better medicines, a greater availability of doctors and drugs", said a Deputy Health Officer. In this regard, one might be surprised at the fact that RWAs do not use their mobilising power to demand better health services. Considering that the Bhagidari schemes gives RWAs some means to demand that public services be of a certain quality, one may expect them to mobilise their members on such a basic issue as primary health services. But the real mobilising capacity of RWAs, revealed in the past two years by their interventions against the new house tax calculating method or the raise in electricity tariffs[23] – which embarrassed the MCD and the government of the National Capital Territory of Delhi (GNCTD) respectively – has not so far applied to health issues.

One likely explanation for this is that RWAs are essentially a feature of middle class colonies - whether legal or unauthorised - whose inhabitants are more likely t be using private health services. When I asked a South Delhi RWA representative whether his association had put any pressure on the local councillor with regard to the dilapidated state of the local dispensary, he replied: "We are not concerned with that dispensary; we don't use it, only the servants go there."

RWAs, however, do play a role in the provision of health services, for instance through the organization of an informal ambulance service, or the setting up of a health camp in their locality. But these local initiatives can hardly qualify as 'public health care', for they rely on a series of private resources, and are directed at a very specific set of beneficiaries – usually the colony's inhabitants.

NGOs

In a context where the poor, supposed to be the main users of public health care, are deprived of the mobilising capacity to demand a better quality of such services, the advocacy role played by some NGOs deserves attention. NGOs' dependency on the administration to get paid contracts is not conducive, a priori, to their playing an advocacy role. Yet some of them act as vigils on health issues, build cases and actually obtain legislative action, as did for instance the Centre for Science and Environment, fighting air pollution in Delhi.

The Jan Swasthya Abhiyan (JSA), self defined as "a coalition of the networks of voluntary organizations and people's movements involved in health care delivery and health care policy", has been organizing, for the past four years, a national campaign demanding that access to basic health care be given the status of a constitutional right. In this "Right to Health Care Campaign", the JSA proceeds by organizing public hearings on the denial of the right to health care in different regions, and on different scales (they can involve lay people or community representatives). The demand to recognize access to health care as a basic human right is legally justified, in the JSA's manifesto, in reference to the Alma Ata Declaration, signed by India at the end of the WHO conference held in that town in Kazakhstan in 1978, which took the pledge of achieving "Health for all by the year 2000".[24]

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24. The JSA is part of a global 'People's Health Movement', born from an Assembly of representatives of 93 countries who met in December 2000 in Dhaka, calling to renew that pledge.
25. Yet there were also a few middle class attendants, who explained that they had come because they knew that the doctors in charge would be from a nearby corporate hospital; these private doctors had indeed been mobilized by the Chief Minister's Principal Secretary, who is a member of that hospital's board.

But most NGOs active in the field of health care are service providers hired by the central, state or municipal administration to implement a number of schemes pertaining to public health (particularly immunization programmes). Moreover some NGOs provide curative health services to the most precarious populations, for instance through their involvement in health camps.

I attended one such camp, organised by the Delhi government in the framework of the 'Stri Shakti' programme, aiming at offering health services to those women and children living in areas deprived of basic health infrastructure, through monthly health camps held in each of the nine revenue districts of the NCTD.

I could interview a random sample of 12 attendants of that camp, and most interviews pointed at the crucial importance of a minimum of 'rootedness' to have access to the intermediaries mentioned above. Firstly – and this confirms existing studies - the majority of interviewees, even though they were obviously poor people (most of them were recent migrants),[25] said that they usually preferred to use private medical facilities, because they found it not much more expensive than the public facilities (they complained that in dispensaries they would be requested to pay a registration fee anyway), and providing better quality drugs; moreover, they said the dispensaries' staff would request them to provide a ration card, which they don't have, being essentially precarious people.

When I asked them about their relationships with councillors or RWAs, they said that as new immigrants, they were not registered on the electoral rolls and did not know the councillor. They also explained that there were no RWAs in their area, and that as tenants, they had no interest in the maintenance work.

III
What Forms of Coordination/Collaboration?

How do MLAs, councillors, RWAs and NGOs connect with each other? Listing the mechanisms and opportunities for some coordination linking their respective roles is a first step towards assessing their cumulated impact on the provision of health services in Delhi.

As far as the relationship between MLAs and councillors is concerned, coordination seems rather rare. Institutionally, 15 MLAs are nominated each year by the Assembly Speaker to be members of the MCD – but without voting rights. Individually, the collaboration between MLAs and councillors catering to the same territory appears to be the exception: "If they belong to different parties, they will clash at the party level; if they belong to the same party, they will clash at the individual level", as a knowledgeable observer put it.

What about relationships between the respective officials of the GNCTD and the MCD? The only systematic form of coordination between the state Health Department and the MHD is devoted to preventing water borne and mosquito driven diseases on a seasonal basis: from March till November, the Delhi Health Department calls a weekly meeting with the Municipal Health Officer,

26. The Trans-Yamuna Development Board is an exception, as it includes MLAS and councillors, as well as senior officials from both the GNCTD and the MCD.

the Health Secretary, the Health Directorate, as well as officials from the MCD sanitation department and representatives of the Delhi Jal Board, in order to monitor the development of these diseases.[26]

There are also established coordination mechanisms between RWAs and both the MCD and the Delhi government officials (which pre-dates the Bhagidari scheme).Today, RWAs participate in monthly meetings with the Deputy Health Officer at the Ward committee level, and they have also monthly meetings with the District Commissioner, which testifies to their established role as communication channels between the administration and the people.

The relationship between RWAs and councillors seems to be generally good, even though it remains informal: "Since 1997, we have a representative close at hand; he is more approachable to us, more accessible; before, we used to approach the MLA… We approach whoever can be of help, depending on the case; most of time it is the councillor," said a South Delhi RWA representative.

The Bhagidari scheme, however, might somewhat alter this relationship. "Since we are part of the Bhagidari programme, we don't go to the MLA or councillor any more [in case of health problems]. We talk directly to the Medical Superintendent, who talks to other officials," said a representative from an East Delhi RWA.

Lastly there seems to be little relationship between NGOs and elected representatives or between NGOs and RWAs; but NGOs regularly interact with officials insofar as the administration out sources part of health services provision to them.

Yet through my interviews I came across a number of piecemeal initiatives characterised by the informal collaboration between officials, elected representatives, RWAs, NGOs and doctors (including from the private sector). I was told, for instance, of a RWA which financed the rehabilitation of a municipal community hall and obtained the services of a private doctor - with the help of the local MLA - to function as a part-time homeopathic dispensary – on the condition that access be limited to the colony's senior citizens.

These collaborations usually take the form of health camps, which always involve the cooperation of several of the actors observed so far: the state or municipal administration (who may provide the venue, medical personnel, and anganwadi workers to mobilize local people); elected representatives (who will rely on party workers to mobilize people); RWAs (who may provide the venue, mobilize local private doctors and local people); and NGOs (who will assist in running the camp).

Typically, health camps are public initiatives in poor areas, and semi-private initiatives in middle class areas. They may be the modus operandi of a public health scheme – such as the Stree Shakti programme of the GNCTD - or they may be the result of ad hoc initiatives launched by RWAs or by councilors in middle class localities, where they are not so much a substitute to basic health care as a sign of the growing concern for one's health; in that case they will usually offer preventive health services – to detect blood sugar or cholesterol, for instance.

Health camps offer health services as a form of patronage [Tawa Lama-Rewal forthcoming]. Beyond the variety of actors usually involved in their organisations, health camps always appear to be the product of a benevolent patron – whether the Chief Minister, the local MLA, the local councillor or the local RWA – who duly visits the camp when it is most crowded. The patron then designates more or less implicitly its clients, through the targeted beneficiaries: the local RWA members, the area's voters, etc.

Conclusion

The first conclusion of the series of observations mentioned above is that there has definitely been an increase, in the past 15 years, in people's participation in the management of local affairs. Political and administrative reforms such at the 69th and the 74th CAAs, but also the Bhagidari scheme and the Right to Information Act (used by some NGOs to control MCD's work through public hearings) have resulted in a multiplication of the channels usable by people to express their grievances. State and municipal officials now have to interact on a regular basis with MLAs, councillors, RWAs and (to a lesser extent) NGOs. This new diversity of actors brings changes in the issues being put on the political agenda, and it increases transparency and accountability.

But there are two major limits to these modes of participation. Firstly, participation excludes the most precarious sections of population. Indeed class appears as a major element of urban governance, insofar as participation bypasses migrants and tenants to empower the middle classes: only registered voters and house tax payers[27] have a stake in the new role played by MLAs, councillors and RWAs.

Secondly, participation as exercised through the Bhagidari scheme is limited to the implementation level. RWAs are given the means to keep a check on how decisions are implemented – even though the impact of their mobilization on the issues of house tax and electricity tariffs suggest that they might go beyond that limit; they have no impact on the agenda setting. Only councillors and MLAs - that is, political parties - have the power to intervene at the policy making, decision-making level. Moreover one might wonder whether there is a risk that too many channels of participation lessen the impact of participation: do RWAs compete with councillors? Several RWA representatives were proud to mention that as such they have "direct access to the Chief Minister's office," is the Bhagidari scheme a way for the Delhi government to bypass more legitimate local representatives, i.e. councillors and MLAs?

Can participation, then, undermine representation – still the only way for people to intervene in the policy making process, through political parties and elected representatives? The currently fashionable emphasis on the participative aspect of democracy has indeed often been accused of hiding a will to depoliticise decision-making.

27. Citizenship (in the widest sense) seems in this regard to be conditioned by land ownership (including illegal ownership, if one considers how keen MLAs are to regularize unauthorized colonies).
28. The capacity of RWAs to mobilise private doctors to participate in their health camps might be a result of class connivance, considering that most doctors are from the middle classes [Baru 2003].

Lastly, the study of health services provision suggests that universality is not a principle of action any more. Besides the growing importance of the private health sector, the semi-privatisation of health services through health camps,[28] whatever their actual effectiveness in improving people's health status, contradicts that principle. The fact that those urban actors who have a capacity for mobilisation and can put some pressure on the administration, i.e. the RWAs, are not interested in primary health services, is certainly the sign of further decline of the latter. Among all the actors I met in the course of my fieldwork, only those NGOs active in the JSA were referring to the Alma Ata declaration of "Health for All", promoting a universalist ideal of public health.

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Preventive Health Care and Indian Industry

Roles and Responsibilities

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Abstract: The study tries to analyze the relationship between preventive healthcare and the productivity and profitability of Indian companies. An online survey of Indian companies and their employees was conducted to gauge their views on preventive healthcare. The results show that Indian companies are aware of the importance of preventive healthcare and most of them have some provision for regular health checkups. They are increasingly considering prevention as an investment for human capital to improve efficiency and creativity of the employees. While liberalization of the Indian economy has expanded opportunities for employment and additional incomes, it has also brought with it urbanization and changes in lifestyles. These changes have had a profound impact on the epidemiology of diseases and healthcare demands of the people. The rising demand for healthcare has brought into focus the inadequacies of the present healthcare system, public as well as private. With this background, our study tries to suggest certain initiatives that can be taken by the government, such as tax incentives for companies practising preventing healthcare.
**Email:*

I
Introduction

Health is a basic fundamental right of all citizens and health promotion forms an intrinsic part of health care. According to the World Health Organization (WHO), "Health is a state of complete physical, social and mental well-being and not merely an absence of a disease or infirmity." In recent years, this statement has been modified to include the ability to lead a "socially and economically productive life". Preventive health care[1] is an important determinant of health since prevention means avoiding or slowing the course of a disease which is essential for a good quality of life. Investment in human capital leads to a healthy and educated populace which is in a better position to contribute to the growth of the economy through its employability, creativity and productivity.

According to industry analysts, there has been a growth of 25 per cent in the preventive health care market over the past five years. There is a growing consciousness about health-related issues among people, giving a boost to preventive health check-ups in hospitals. Annual health check-ups, which were largely the privilege of corporate executives, are now being sought after by the middle class as well. Most hospitals routinely cater to walk-in patients that

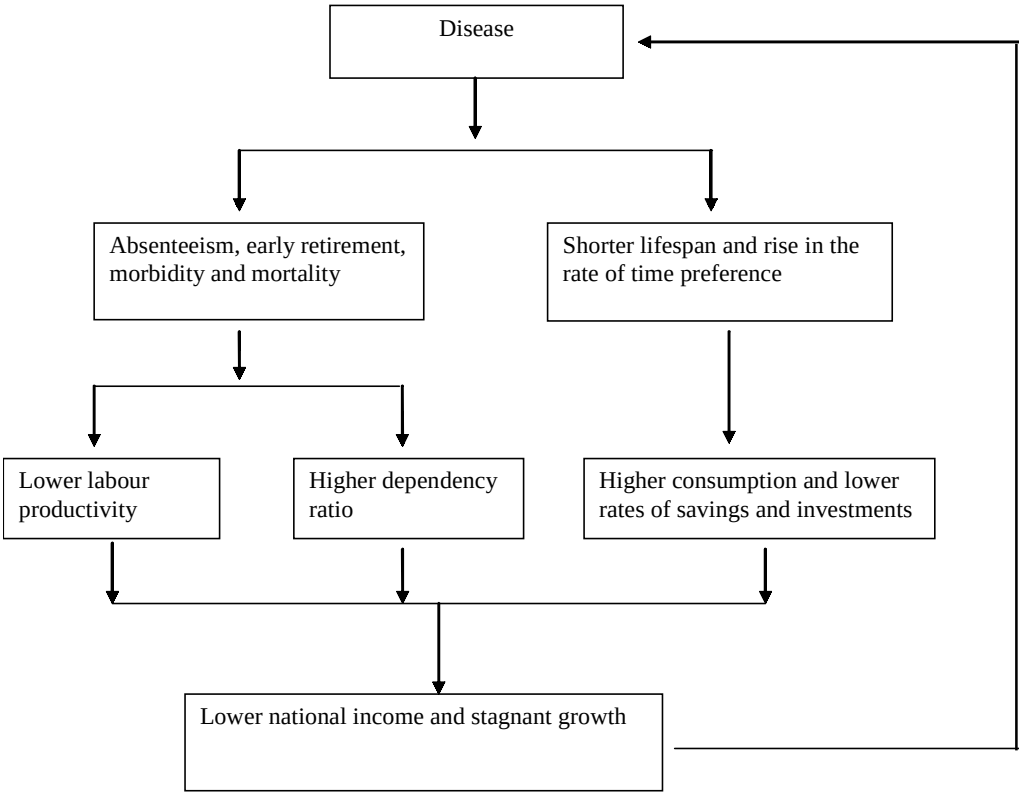
1 In this paper, preventive health care refers to the individual and relates to preventive health check-ups and a healthy lifestyle that includes exercising.

avail of the tailor-made packages for all age groups. There are even cases of people gifting test packages to their parents. Apollo Hospitals, which pioneered the concept of preventive health packages, gets around 100 patients a day. Fortis, on the other hand, mainly works on the basis of corporate tie-ups with 73 companies and gets around 15 patients a day.

A healthy society reflects the well-being of a nation and the quality of human capital is an important contributor to economic growth. India's future health care needs will be determined by population growth and economic growth aspirations. Figure 1 depicts the simple linkage between disease and economic growth. The burden of disease leads to a sense of deprivation regarding health and productive potential. The incidence of chronic diseases not only depletes household income and savings but also diverts resources away from other investment activities. The relationship between health and economic growth is straightforward: Disease reduces life expectancy and economic productivity adversely affecting the number and quality of the country's workforce. This may, in turn, result in the lowering of national income thereby fuelling the spiral of ill health and poverty. The most worrisome aspect of ill-health and disease is the persistence of its impact across generations. The next generation is more vulnerable to diseases owing to poor nutrition or insufficient hygiene and sanitation. In order to take care of the sick, it is often the case that older children have to drop out of school, with adverse impact on their long-term economic prospects.

As opposed to this scenario, good health positively affects human capital, productivity and economic growth. Labour productivity increases as a result of lower mandays lost and the reduction in disability and incapacity. This frees resources that would otherwise have been used for treatments and helps to break the poverty trap. Further, poor health conditions can have a debilitating impact on the economy in terms of lower investment flows and reduced tourist traffic. Besides, in knowledge-based economies, many of the businesses rely on intellectual capital including creativity and innovation which is critically dependent on the health of employees. Moreover, the management of employee health has the potential to directly impact on the reputation of a company in this age of free information where corporate reputations are increasingly becoming fragile. Thus, for modern business organizations, it is important to maintain and improve the health of its human resources so that the employees feel that their company looks after their well-being.

Figure 1: Relationship between disease and economic growth



The purpose of this study is to generate awareness about employee well-being and engage the private sector in taking steps to improve health standards of their employees through preventive health care. Given that employees are increasingly spending more time at work than at home, it is leading to situations of stress or mental pressure to complete a task within a given deadline. Besides job stress and burnout, new types of occupational hazards are affecting the youth owing to lack of physical activities like muscular pain, cervical, spondilytis, slip disk, hypertension, depression, high blood pressure, osteoporosis, acidity, diabetes, obesity, arthritis and sleeping disorders. Hence, the workplace has become a critical place for successful prevention strategies and the employers have an important role to play in changing the sedentary lifestyles of employees by providing a facilitating environment and infrastructure to motivate employees to undertake physical exercise and stress-relieving measures like yoga or gym together with regular check-ups and counselling for preventive health care. While the private sector has been quick to realize the benefits of preventive healthcare, policy has lagged behind and there is a need for fiscal or other incentives to encourage prevention.

The rest of the paper is organized as follows: Section II describes the drelevant theoretical literature on preventive health care, Section III outlines the prevailing system of health care provision in India, Section IV carries out a SWOT analysis of vouchers versus cash payments,

Section V deals with the survey and results, Section VI gives a comparison with other countries and Section VII concludes with a summary and policy suggestions.

II
Literature Review

In the literature on health economics, theoretical models analyse prevention in terms of human capital models and insurance models. Models of consumer demand for health prevention can be seen as an individual's decision to invest in health just like investing in other forms of human capital. According to Grossman's (1972) seminal model, the individual's health capital stock determines the utility flow as well as the time available for market and non-market productive activities. The demand for health inputs is derived from the demand for health capital which is viewed as a household health production function with time and medical care as inputs. In these models, prevention is taken as an investment decision to add to the health capital stock since the higher the health stock, the lesser the time spent ill. However, this model does not distinguish between preventive and curative care. Grossman and Rand (1974) treat prevention and cure as separate inputs into the household health production function. They assume that groups with low depreciation rate of the health capital stock demand preventive health care and groups with high depreciation rate of the health capital stock demand curative health care. This allows for prevention and cure to be treated as substitutes by consumers.

A higher endowment of health increases demand for health investment, so differences in endowed health are magnified in terms of attained longevity. In Grossman's (1972) model, health capital is assumed to depreciate at a higher rate as people get older. Thus, if the price elasticity of demand for health is lower than unity, the derived demand for curative medical care increases with age. Cropper (1977) gets the same results for preventive health care with endogenous length of life and depreciation rate rising with age. In general, since the risks of different illnesses show different lifecycle patterns, the demand for prevention depends on the specific intervention, where intervention is defined as any attempt to intervene or interrupt the usual sequence in the development of a disease. For some preventive actions like exercises, the health benefits are realized much more quickly by older people and so will be not as heavily discounted as when young people consider the intervention.

In addition to models that take the human capital approach, models of insurance and behaviour under uncertainty also analyse prevention decisions. Intuitively, health is an irreplaceable commodity given the incompleteness of the technology of cure. Despite insurance for curative care, prevention is attractive because the choice is between completely preventing the illness and incompletely curing it. Many large firms pay the health care claims of their employees. These firms have an added incentive to invest in prevention for improving employee productivity and reducing absenteeism. According to the study conducted by the Public Health Service (1992) for the United States, 81 per cent of worksites with 50 or more employees offered at least one health promotion activity such as curbing smoking, health risk assessment, blood pressure control, weight control and exercise. More than 25 per cent of the firms surveyed claimed the reduction in health insurance costs as one of the top two or three reasons for health promotion programmes.

However, market failures may lead to too little preventive from the point of view of the society [Kenkel, 2000]. In the case of infectious diseases, externalities arise from 'herd immunity' where an individual's chance of getting an infectious disease falls when others in the society have already been vaccinated. Thus, the marginal benefit to society of a vaccination exceeds the private marginal benefit and this means that private vaccination decisions will result in a less than socially optimal vaccination rate. Thus, intervention is required to correct the market failure.

According to the WHO (2005), the estimated loss in India's national income due to heart diseases, stroke and diabetes in 2005 was US $9 billion compared to US $3 billion for Brazil. These losses are projected to exceed US $200 billion in the next decade, unless preventive measures are taken in which case, an accumulated economic growth of US $15 billion can be expected. Another study by Abegunde and Stanciole (2006) in nine countries using a growth accounting framework found that deaths due to chronic diseases will adversely impact labour supplies and savings and hence countries will lose large amounts of national income. As more people die every year, these losses tend to accumulate over time. Table 1 shows the estimated average loss in national income as a result of three chronic diseases namely cardiovascular, stroke and diabetes. It is projected that India will lose US$23 billion annually in foregone income over the decade 2005 and 2015 owing to deaths relating to just three chronic diseases.

Table 1: Estimates of Losses in National Income due to Chronic Diseases (US$ billion, 1998 prices)

	Loss in 2005	Loss in 2015	Average annual loss	Income loss as a per cent of GDP in 2015
Brazil	-2.7	-9.3	-5.1	0.48
China	-18.0	-13.0	-53.5	1.18
India	-8.7	-54.0	-23.0	1.27
Nigeria	-0.4	-1.5	-0.8	0.65
Pakistan	-1.2	-6.7	-3.0	1.02
Tanzania	-0.1	-0.5	-0.2	0.86
Canada	-0.5	-1.5	-0.9	0.15
Russia	-11.0	-6.6	-29.8	5.34
U.K.	-1.6	-6.4	-3.4	0.32

Source: Abegunde and Stanciole (2006)

These losses when compared to what GDP would have been in the absence of chronic diseases indicate large absolute losses. In particular, the income loss as a percentage of GDP for populous countries like India will be high, around 1.27 per cent in 2015 (see Table 1). This loss in income is attributed to labour units lost on account of death from chronic disease as well as

the medical expenditure to treat these conditions. Medical expenses are covered from current consumption to begin with but in later stages eats into the savings and investments of households particularly in developing countries that do not have provisions for health insurance. In fact, the study has estimated that a 2 per cent reduction in chronic disease death rates annually between 2005 and 2015 will result in an accumulated income gain of $15 billion in India.

III
Preventive Health Care Providers

India is witnessing rapid economic growth and as per capita incomes rise, it is expected that consumers' demand for health care will rise and they will be willing to spend more on quality of care. Consumers aspire for greater fitness and well-being as they move up the income ladder. In 2004, the richest one-third of the population accounted for three-fourths of the total private health expenditure [Ernst and Young, 2006]. Further, as the disease profile shifts from infectious to lifestyle diseases, health care expenditures will rise still further. Inpatient expenditure is likely to rise from 39 per cent to 50 per cent of the total health care expenditure. While the share of infectious diseases is expected to decline, lifestyle diseases are expected to rise concomitantly. To make matters worse, there is increasing evidence that these lifestyle diseases are also affecting the poor due to low resilience to infections, malnutrition and stress. There is a growing need to address the demand for new skills such as counselling, psychiatry and trauma.

Government expenditure on health care in India is very low at only 0.9 per cent of GDP as compared to 3 per cent of GDP for developing countries and 5 per cent of GDP for developed countries. With the role of the government declining in health care, private initiatives have stepped in to fill the gap in the ever-increasing demand for health care services. The bulk of the health care services in India are catered to by the private sector, which is one of the largest in the world since it accounts for 80 per cent of all physicians, 75 per cent of all dispensaries and 60 per cent of all hospitals in India [Ernst and Young, 2006].

Preventive health care activities are offered by private hospitals that involve measures to identify and minimize the risk of disease, improve the course of an existing disease and screening for early detection of disease. A preventive health care check-up usually involves a complete physical examination to make sure the health of an individual is in good condition. The physician analyses the risk factors that may lead to a disease or health condition in the future and runs tests for early warning signals for these. Hence, preventive health check-ups help in bringing down the cost of medical emergencies by catching them early. They are complementary to health insurance since if good health is confirmed, then the individual can choose to have lower health insurance cover for contingencies like hospitalization and may avoid critical illness coverage. A typical comprehensive health check-up includes tests for blood, sugar, cholesterol, urine, digital chest X-ray, liver profile, proteins, lipid profile, renal profile, pulmonary function test (PFT), stress test or ECG, PSA, gynaecology consultation, physician consultation, dental consultation, ophthalmology consultation and dietary recommendations. For instance, a heart check-up consists of echocardiography, blood test, general test, haemogram and consultation by a cardiologist and this can go a long way in ensuring a healthy heart. Preventive health care

plans that screen every part of the body meticulously are mainly offered by hospitals or larger diagnostic centres where the costs range from Rs 500 up to Rs. 5,000.

As a part of the study, health care providers were contacted to give their viewpoints. The Apollo Hospitals Group has packages for preventive health care that are availed of by mainly the middle and senior management employees as well as the potential employees for their pre-employment check-ups. It has detected diseases like stroke, hypertension and diabetes which are all lifestyle-related. It said that early detection helps the consultant initiate timely corrective measures to ensure better management and outcome of the treatment. It emphasized the need for regular check-ups since a disease can develop at any stage in life.

K.G. Hospital also has packages for preventive health care to minimize risks of disease and has detected chronic diseases like anaemia, hypertension, cancer, diabetes, heart disorders and high cholesterol among employees. It said that preventive health care is like an 'annual maintenance certificate' for an asset- life. Prevention and not just early detection is required to ensure that symptoms are treated long before they develop into a serious ailment. Late decision means higher expenses and misery and anxiety for the patient's family. Jaslok Hospital has check-ups for all grades of employees as it suggests that stress depends on the personality of a person and is independent of his management grade. It also suggested that preventive health care is required to reduce not just absenteeism but also 'presenteeism' whereby employees can improve on-the-job performance. All health care providers were in favour of government action to promote awareness about the cause of prevention and some financial incentives like tax exemptions.

Table 2: Distribution of People Hospitalized by Ailment Type in Urban Areas (Per 1,000)

Ailment	Proportion
Diarrhoea/dysentery	62
Gastritis/peptic ulcer	39
Hepatitis/jaundice	22
Heart disease	80
Hypertension	32
Respiratory ailments	30
Tuberculosis	17
Bronchial asthma	30
Disorders of joints and bones	26
Diseases of kidney	49
Gynaecological disorders	50
Neurological disorders	32
Psychiatric disorders	6
Cataract	24

Diabetes	24
Malaria	36
Fever of unknown origin	67
Locomotor disability	9
Accidents/injuries/burns	88
Cancer and other tumours	32
Other diagnosed ailments	166
Other undiagnosed ailments	15

Source: Government of India (2006).

A staggering 80 per 1,000 persons are hospitalized due to chronic diseases of the heart, another 32 per 1,000 persons due to cancer and 24 per 1,000 due to diabetes (Table 2). These hospitalisation cases can be easily prevented by early detection and simple preventive steps like exercise and dietary changes. Similarly, communicable diseases like malaria (32/1,000) and tuberculosis (17/1,000) can be prevented by health care education and promotion regarding clean and hygienic ways of living. Preventive health care measures can go a long way in saving valuable resources in terms of time and money by avoiding extreme morbidity conditions that ultimately lead to hospitalization. The importance of prevention assumes even more urgency looking at the future projections of some of the diseases. HIV/AIDS cases are likely to triple and cardiovascular diseases and diabetes will more than double by 2015, along with a corresponding increase in the prevalence level of tuberculosis and a rise of 25 per cent in cancers [Government of India, 2005].

IV
SWOT Analysis of Vouchers versus Cash Payment

A SWOT (Strengths, Weaknesses, Opportunities and Threats) analysis is a helpful tool for comparing and strategy planning for any business initiative. A SWOT analysis of paying for preventive health care measures in cash as compared to vouchers shows that vouchers are beneficial for the employer, employee and the service provider. Since there are enormous pay-offs in the long term for investments in health care and business entities are in a better position to identify health care needs of their employees, they can sign efficient contracts with health care providers.

A voucher system has the potential to result in better health care, lower costs, greater savings and emerge as a new payments solution for consumers. To begin with, keeping in mind the current trend of a cashless credit-card economy where people prefer to use all sorts of cards or coupons instead of currency, vouchers are particularly well suited for the plastic economy of today. Thus, vouchers are not only more convenient but are more efficient since they will ensure that the beneficiary will go for a health check-up before the expiry of the voucher. Further, another reason why vouchers will ensure that employees go in for regular check-ups as opposed to cash payment is that cash payments may result in employees filing fraudulent claims with false medical bills when they are reimbursed for medical expenditures. Moreover, vouchers can act as a low-cost way of introducing preventive health care to employers and

their employees. They can be lured into going for check-ups if the vouchers are offered at a slight discount when the company buys vouchers in bulk. From the viewpoint of a person looking for jobs, it is likely that his decision to join a particular job would be influenced by non-monetary perks besides the basic salary. Therefore, perks that include preventive health care vouchers may help in attracting high-quality workforce for the company. From the point of view of the service provider, vouchers can turn out to be the ultimate marketing tool since vouchers mean repeat customers and that translates into loyalty for a particular service provider.

However, it would require a lot of effort to generate awareness about vouchers and how they work. One way of doing this is by making the industry leaders adopt vouchers and once they realize the benefits, it would be easier for the others to follow the voucher scheme. In addition, if the government offers tax exemptions to the companies that give vouchers for preventive health care as part of their corporate social responsibility, it will be an added incentive for employers to maintain employee health care.

V
Survey and Results

In order to assess the impact of preventive health care on the Indian economy, we undertook an online survey of firms belonging to the manufacturing and services sectors (refer to the Annexure regarding the survey methodology). The questionnaire asked the firms the type of preventive health care activities offered by them. At least 64 of the 80 respondents offered some sort of preventive health care measures to their employees. An overwhelming 67 per cent of the respondents assumed preventive health care as a part of their corporate social responsibility and agreed that regular health check-ups increase company productivity. More than half the firms offered preventive health check-ups to their employees.

Figure 2: Preventive Health Care Measures Offered by Companies

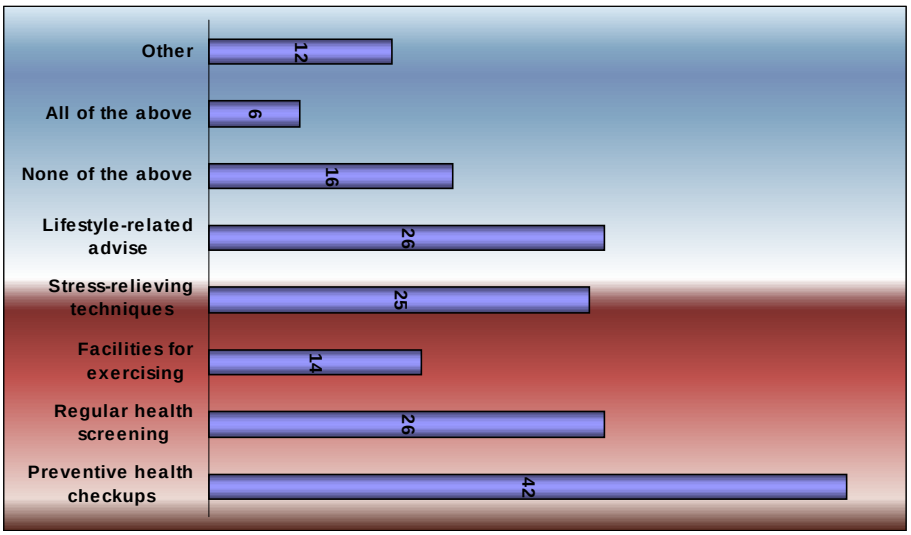
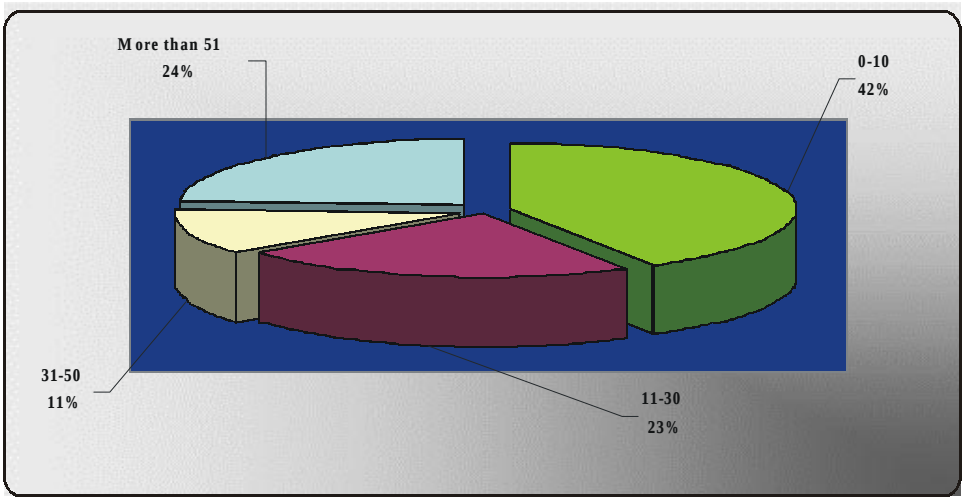


Figure 2 shows that more than 30 per cent of the respondents made available other facilities for prevention of disease like regular health screenings, stress-relieving techniques like yoga and lifestyle-related advise like diet and nutrition counselling. In addition, of the firms that offered facilities for preventive health care, 46 per cent had corporate tie-ups with hospitals[2] to deliver these services indicating corporate discounts that are generally offered to firms as compared to individual packages. Some of the firms also subscribed to the provision of preventive measures through third party insurance providers or the Employees' State Insurance Scheme (ESIS). While the responding firms confirmed the importance of preventive health care and regular check-ups, only 33 firms provided for annual check-ups and 8 firms biannual check-ups. Further, 26 firms were unsure about the interval of preventive health check-ups for their employees which was reaffirmed when the respondents were asked if there was a company policy for follow-up action on the preventive health check-ups of the employees and more than half the respondents gave negative answers. This is where corporate intervention is required to make the employees go in for routine check-ups given the uncertainty of disease and the need for early detection. The expenditure incurred by firms that offer preventive health care ranged from zero to over a million rupees. There is a possibility that some respondents may have mentioned their general health expenditure or reimbursements and insurance payments. Most of the respondents spend between Rs. 20,001 and Rs. 2,00,000 on preventive health care of their employees.

Figure 3: Mandays Lost Owing to Sickness

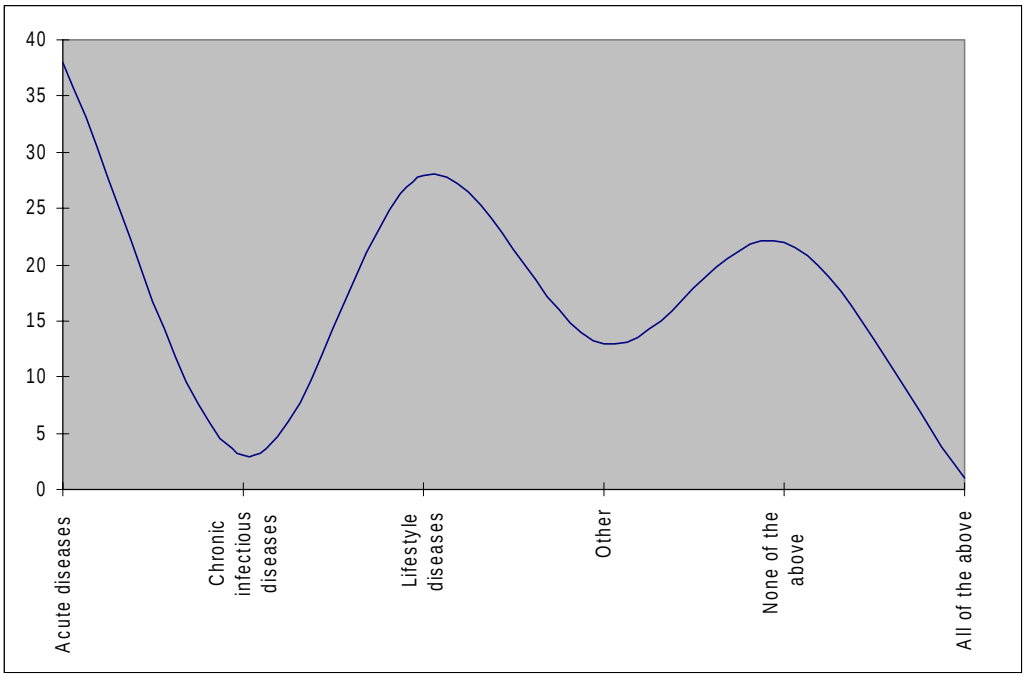


To analyze the impact of disease on company performance, the respondents were asked about the mandays lost owing to sickness. The direct impact of employee sickness is reflected in mandays lost as a result of it. From Figure 3, it is clear that almost a quarter of the companies lose approximately 14 per cent of their annual working days (more than 51 days in a year) due to sickness, and one can expect an equal percentage of loss in their productivity and profits which is a cause for concern. This corresponds with the fact that over 1 per cent of the firms

2 In this paper, preventive health care refers to the individual and relates to preventive health check-ups and a healthy lifestyle that includes exercising.

recorded sick leave for more than 20 per cent of their employees. This absenteeism was mainly owing to acute diseases like diarrhoea, influenza, malaria and dengue, followed by lifestyle diseases like cardiovascular diseases, diabetes, stroke and mental disorders (see Figure 4). Chronic infectious diseases like tuberculosis and HIV/AIDS do not seem to be a major burden for the companies surveyed. Depending on the proportion of employees in different management grades that availed of sick leave, blue-collared workers were at a high risk of disease compared to the medium- and senior-level employees since the former spend a lesser proportion of their income on health care.

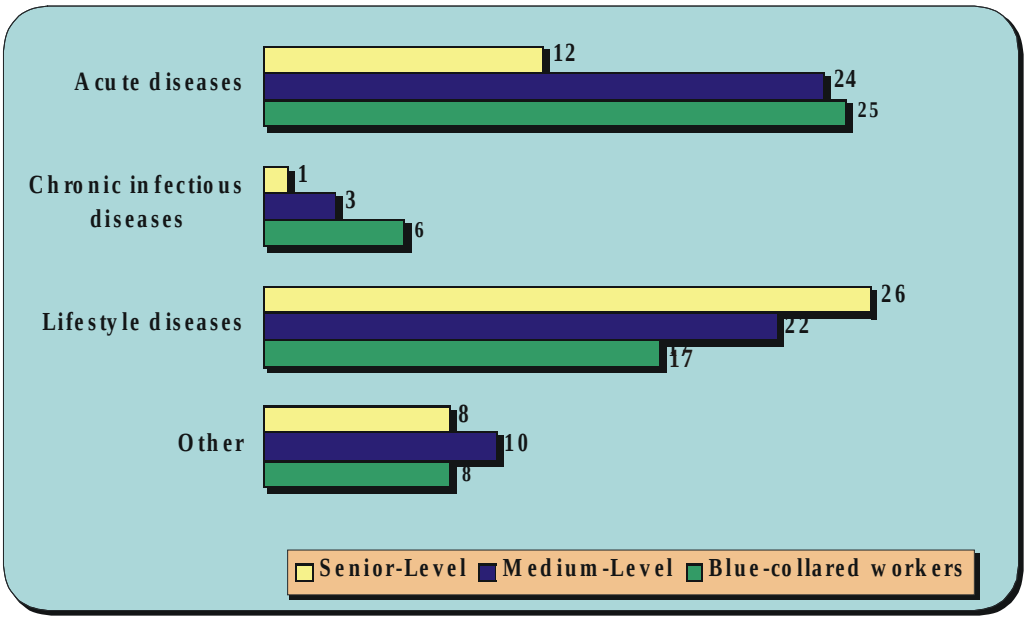
Figure 4: Major Disease Afflictions in Past Year



India is in a peculiar situation since it is in a state of transition and diseases afflicting both the rich and the poor can be found simultaneously in the country. The low-income groups are usually affected by infectious diseases while the high-income groups are affected by chronic diseases owing to a sedentary lifestyle. As expected, a majority of the blue-collared workers with low incomes were afflicted by acute diseases like diarrhoea, influenza, dengue and malaria as well as chronic infectious diseases like tuberculosis and HIV/AIDS (Figure 5). In general, blue-collared workers are unable to afford expensive curative treatment on their own and are usually not sent for preventive health check-ups by employers, leaving them vulnerable to disease. Senior-level executives with high incomes were afflicted with lifestyle diseases like heart ailments, diabetes, stroke and emotional stress owing to lack of physical exercise and dietary control. This corroborates findings of the Health and Wellness Survey conducted by Apollo Hospitals Group in 2003. They found that more than half of the executives were prone to lifestyle diseases like cardiac risks, followed by high cholesterol, high blood pressure and

diabetes. In fact, they had found that 71 per cent of the employees and 82 per cent of the CEOs were overweight.

Figure 5: Major Afflictions According to Management Grades



Source: Health and Wellness Survey, Apollo Hospital, 2003.

Table 3 shows that there is a positive correlation between preventive health care and profits. This suggests that there may be a positive impact of preventive health care on the Indian industry. Given the data limitation of small sample size, the correlation coefficients are not very large, suggesting that there may be other factors at work and profitability is not the only measure of efficiency. Further, there is a negative correlation between profits and absenteeism and profits and mandays lost. In the sample, all large firms have facilities for preventive health care and their correlation coefficients for absenteeism and mandays lost are negative. This seems to suggest that a healthy workforce can contribute to greater profits through greater productivity and savings on medical expenditures.

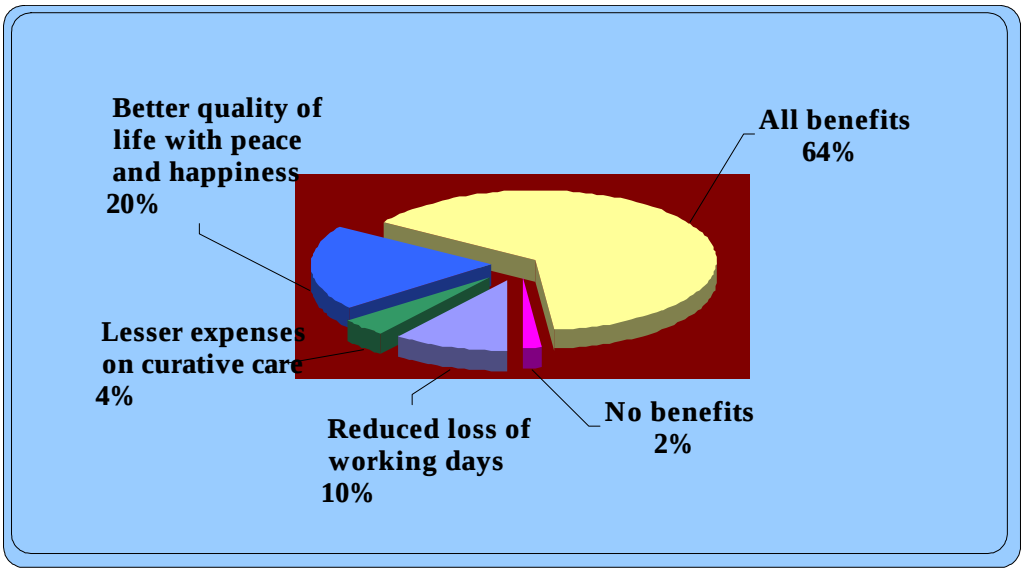
Table 3: Correlation between Preventive Health Care and Profitability of Indian Companies by Size

	Preventive health care	Absenteeism	Mandays lost
All	0.172	-0.047	-0.218
Small	0.299	-0.105	-0.079
Medium	0.28	0.057	-0.151
Large	-	-0.314	-0.368

This corroborates with the results of the survey where 82 per cent of the respondents (including many of those who do not provide preventive health care facilities at present) agreed that preventive healthcare measures increase firm productivity and profitability. Employee wellness demonstrates a real contribution to company bottom lines since promoting employee health is a means of controlling health care costs. Thus, in an era where competitiveness and profitability are determined by intellectual capital, promotion of employee health is crucial for the organization. This leads to significant policy implications regarding tax exemptions and other sops for preventive health care activities, particularly for small and medium companies.

The study also conducted an electronic survey for employees since they are the direct beneficiaries of any system of preventive health care. Nearly 58 per cent of the respondents were working in the services sector and 60 per cent were white-collared workers. Interestingly, the same percentage of responding employees were white-collared, among whom there is greater awareness and practice of preventive health care as compared to blue-collared workers. Of the total, 56 per cent of the employees surveyed had undergone some sort of preventive health check-up. When asked about the benefits accruing from such check-ups, 64 per cent stated minimum loss of working days, savings on health care expenditures and a better quality of stress-free life with peace and happiness (see Figure 6).

Figure 6: Benefits from Preventive Health Care in Employee Survey



check-up that helped the employees to take timely action, 58 of them answered in the affirmative. Thus, it is clear that preventive health care has direct benefits to employees in terms of a higher quality of life and indirect benefits to the society in terms of a more productive labour force to drive the engine of growth.

As regards the financing of preventive health check-ups, more than half of the respondents in the company survey supported the idea of vouchers as an effective delivery tool for preventive health care measures such as health check-ups and follow-ups. The rest were undecided depending on the merit of the scheme and wanted to know more details of the mechanism and concrete business proposals. Nine of the respondents showed no interest in the voucher system. This is in sharp contrast to the overwhelming support given to the voucher system in the employee survey where 262 of the 288 (over 91 per cent) respondents were in favour of such a scheme for financing preventive health check-ups. Thus, it is important that the merits of the voucher system be made clear to the companies where they will have savings in terms of costs, resources and time. This is particularly true for those companies that reported zero spending on health care since they have to be educated regarding the benefits of preventive health care for the company and the employees. Moreover, given the dismal state of public health spending and the non-existent insurance system in India, serious thought must be given by private employers and the government to the fact that the intended beneficiaries (employees) support the voucher system for financing preventive health care.

VI
International Comparisons

In developing countries, the greatest burden of disease is due to communicable diseases, malnutrition and complications of pregnancy and childbirth. In developed countries, the burden of disease is mainly from non-communicable diseases such as cardiovascular diseases, cancer and accidents. As developing countries grow, they are likely to experience an epidemiological transition from communicable to non-communicable diseases. In future, communicable diseases are expected to decline but the emergence of new infections and non-communicable diseases are new threats that have to be dealt with. According to an estimate, 388 million people worldwide are expected to succumb to death due to chronic non-communicable diseases [Abegunde and Stanciole, 2006]. Around 80 per cent of these deaths will be in low- and middle-income countries and that too in the most productive age groups. Nearly 45 per cent of deaths due to chronic diseases occur under the age of 70 with a direct impact on working age populations. Developing countries will have to deal with the ground realities of limited resources entwined with the dual burden of infectious and chronic diseases. Thus, preventing lifestyle and chronic diseases is a vital investment, particularly for developing countries like India.

Table 4 shows the health indicators for select developed and developing countries. India's per capita spending on health care at $27 is abysmally low compared to other countries. India's per capita government expenditure is even lower and highlights the importance of the private sector in health care expenditures. Around three-quarters of the total health care spending in India is accounted for by the private sector which is very high compared to other countries. Of this total private expenditure, 97 per cent is attributed to out-of-pocket spending by individuals and less than 1 per cent to prepaid insurance schemes. This leaves little room for preventive health care spending in India. This is in contrast to Brazil, Korea and Thailand which are also developing countries but have much higher per capita health expenditure. In developed countries, the government plays a significant role as a provider of quality health care with a concomitantly lower share for private health care expenditure.

Table 4: Health Indicators for Select Developed and Developing Countries, 2003

Country	Per capita total health expenditure ($)	Per capita govt health expenditure ($)	Share of private health expenditure in total health expenditure (%)	Share of out-of-pocket expenditure in private health expenditure (%)	Share of private prepaid plans in private health expenditure (%)
Brazil	212	96	54.7	64.2	35.8
China	61	22	63.8	87.6	5.8
India	27	7	75.2	97	0.9
S. Korea	705	348	50.6	82.8	4.1
Thailand	76	47	38.4	74.8	14.6
Canada	2669	1866	30.1	49.6	42.3
France	2981	2273	23.7	42.2	53.5
Japan	2662	2158	19	90.1	1.7
U.K.	2428	2081	14.3	76.7	23.3
U.S.A	5711	2548	55.4	24.3	65.9

Source: The World Health Report 2006: Working Together for Health, World Health Organization.

Notes: (i) Government health expenditure includes both recurrent and investment expenditures made during the year.

(ii) Private health expenditure is defined as the sum of (a) outlays for prepaid plans and risk-pooling arrangements for insurance and health maintenance organizations, (b) outlays by private companies for medical care other than prepaid schemes and social security payments, (c) spending by non-profit institutions, (d) household out-of-pocket spending.

The health care system of China has made significant strides since Second World War in the provision of health care services based on the emphasis on government policies to invest in human development. It has been successful in developing an extensive health care infrastructure that reaches even the remote provinces. Another developing country, Brazil, has demonstrated how other countries with low income and resources can adopt a model of preventive care. It has successfully used public-private partnerships to provide health care facilities for its populace. In Thailand, government concessions have been effective in getting private investments into the health care sector. The government exempted hospitals from corporate tax for 3-8 years, wrote off utility charges for a period of 10 years and allowed 50-100 per cent reduction on import duty for machinery. These measures resulted in the number of private hospitals being doubled during 1990-96. The government also introduced a social health insurance scheme in 1990 wherein all employees in a company employing 10 or more persons are entitled to inpatient services under a scheme equally funded by employees, employers and the government. Public spending on health in Thailand targets the poor section of the population

for rural and primary care. In fact, South Korea has succeeded in increasing the coverage of the population under social insurance from 14 per cent in the mid-1970s to 100 per cent by the beginning of the 1990s. Due to the foresight of the government, health was identified as a priority area and a key element of labour force productivity. By the beginning of 1980s, insurance coverage was made compulsory for the entire organized sector and initiated among the self-employed through voluntary community-based insurance.

The US is the largest spender on health care services, reaching $1.9 trillion or 16 per cent of GDP in 2005 as compared to an average of 9 per cent for other industrialized countries. It relies on a system of licensing to control the supply and quality of health care services and each state has its own standards. According to the Wellness Council of America, more than 80 per cent of American companies with 50 or more employees have some form of preventive health care programmes for their employees. The Dallas Chamber Report (2006) also provides evidence of the benefits of corporate investment in preventive health care such that in the past decade, the annual return on investing a dollar on employee-wellness programmes yielded a return of $6. It was found that well-designed worksite-wellness programs resulted in a 25 per cent decline in health costs, sick leave, disability pay and workers' compensation.

In industrialized countries, concerns regarding rising health care costs owing to the problem of ageing and high insurance charges, have prompted fears that an increasing number of jobs will be outsourced in the future. According to the Employment Policy Foundation in the United States, insurance premia have gone up dramatically, rising 87 per cent since 2000 and health coverage has become the most expensive benefit paid by the employers. Health care costs affect every level of the U.S. industry and particularly for multinational corporations that have to bear massive 'legacy costs' for retired employees. For instance, General Motors spent $5.6 billion on health care expenditures for its 1.1 million employees in 2006 and that led to $1,500 being added to the price tag of every automobile. Such heavy burdens of health care expenses have the potential to break the back of not just a business enterprise but the economy as a whole. Since these costs can make operations in the US prohibitive, it could lose its competitiveness regarding strategic location of businesses. In addition, countries like Australia, Japan and Singapore that are faced with rapidly ageing populations also have concerns about rising health care and lower productivity.

There is little doubt that in the years to come, it is the quality of the labour force and cost of health care that are likely to be the major determining factors for competitiveness, both for businesses and economies. In order that the 'demographic dividend' that India is currently enjoying owing to its young population, does not turn into a 'demographic cliff', it is important for the country to not only maintain its replacement rate but also to ensure that the labour force remains healthy and productive. Herein lies the importance of preventive health care, since an efficient and productive workforce is likely to be the main driving force behind competition among companies and nations alike. Any nation aspiring for world leadership has no option but to implement standards that maintain the health and productivity of its citizens.

VII
Conclusion and Policy Recommendations

It is increasingly being recognized that the healthier the population of a country, the greater its economic growth. A minimum level of physical and mental well-being is considered critical to attain high growth in the process of development. In India, the health care system is experiencing dramatic changes from what it was a few decades ago. While liberalization of the economy has expanded opportunities for employment and additional incomes, it has also brought with it urbanization and changes in lifestyles. These changes have had a profound impact on the epidemiology of diseases and health care demands of the people. The Indian health care system has the challenge to make available quality and affordable health care to a population that is growing from a billion to a billion and a quarter in a decade. It has to equip itself to deal with life-threatening diseases that affect a large section of the underprivileged along with addressing lifestyle diseases that impact a large number of the relatively well off people. While one segment of the society is making the transition and has started getting treatment from super speciality hospitals at exorbitant rates, a large section of the population still suffers in the hands of quacks and other substandard providers. Given this background, this report tries to suggest solutions for effective delivery of health care by stressing the importance of prevention through a system of vouchers issued by the employers for the benefit of employees to be used at their convenience.

With rising incomes and urbanization, modern lifestyles mean a compromise on quality time for healthy routines. It then becomes necessary that periodic health check-ups be done for early detection of risk factors and diseases. This is particularly true for "silent" diseases such as diabetes, obesity, hypertension, stress, high cholesterol and cardiovascular diseases that do not have any early symptoms and regular screening tests are the only way for early detection. All these diseases have the potential to seriously impair normal life and if left untreated, lead to complications and even death. The silver lining is that these diseases can be easily prevented and cured if detected early. Even slight modifications in lifestyles like eating responsibly, exercising, avoiding stress, and sleeping well can help in managing these diseases so that individuals can lead normal lives.

Indian companies like Infosys and Wipro have developed programmes for employee well-being. Infosys has started a programme for employee well-being in India and Australia called Health Assessment Lifestyle Enrichment (HALE) for reducing absenteeism and psychological stress. Similarly, Wipro runs a programme called Mitr (friend) to take care of the physical and emotional well-being of its employees in both the IT and the BPO businesses. Under this programme, some people were actually trained to counsel their colleagues at the workplace to counter stress in the office and at home. In fact, such initiatives have become important indicators of corporate social responsibility and this goes into building their image of a company that cares for its employees. Such wellness programmes are worthy of emulation. Based on the findings of the survey, it is recommended that the private sector should adopt the following health care measures for the employers: conduct health audit of all employees at regular intervals through preventive health check-ups depending on the job profile; follow-up with preventive check-up reports and counselling; organize preventive healthcare awareness camps; introduce schemes like vouchers that increase the purchasing power in the hands of employees, while

ensuring that they are used for intended purposes. In fact, employees can be made to bear partial cost of curative treatment so as to encourage them to adopt a more healthy and preventative lifestyle.

A majority of costly and disabling conditions can be prevented with proper intervention and many of their complications can be avoided or at least delayed. Strategies for reducing the incidence of disease include early detection, increasing physical activity and reducing tobacco and alcohol consumption. The returns from the scarce resources available for health care can be maximized by diverting these resources towards prevention in order to delay complications. Expenditures on promoting healthy habits have benefits for households as well as the overall economy by increasing labour productivity, lowering absenteeism, raising household incomes and savings, lowering school dropout levels with positive impact on future earnings and capabilities, enhancing competitiveness by reducing health care expenditures of employees and enabling alternate consumption of education, nutrition, leisure for a good quality of life.

Health concerns can hamper the prosperity of a country if timely action is not taken, and thus the need for preventive health care. This is not surprising given that more than four-fifths of the parameters in the Human Development Index relate to health care. India is home to 16 per cent of the world population and 21 per cent of the world's diseases. However, the health care facilities remain grossly inadequate with a doctor to thousand population ratio of only 0.5 and just one bed per thousand population. This is very low compared to the figures for other developing and emerging economies of a doctor to thousand population of 1.5 and 4.3 beds per thousand population. Thus, there is an urgent need to address this dismal situation of inadequate access to health care facilities.

In order to maintain a healthy citizenry, the government should adopt a two-tier approach. At one level, the government has to step in to fulfill its traditional role of supplying public goods like clean drinking water, sanitation, nutrition and environmental protection. At the other level, the government should facilitate private intervention by giving incentives to the enterprises that promote health care through preventive measures. The government could provide direct subsidies to these companies or indirect subsidies in the form of tax exemptions. Presently, Section 17 of the Income Tax Act provides exemption for medical expenses up to Rs 15,000 for employees. This figure could be amended given the rising costs of health care. For this, the government needs to recognize preventive health care as an investment expenditure rather than as consumption expenditure since a company's earnings will be critically dependent on the quality of its labour force in the years to come. While Section 80-D of the Income Tax Act provides tax exemption for health insurance and medical treatment, at present there is no provision for income tax exemption relating to preventive health care. It may be worthwhile to consider preventive health care measures including vouchers under tax exemptions for both the companies using the vouchers and the companies providing the vouchers.

Given the ageing problem faced by the industrialized countries, Indian enterprises have a competitive advantage in terms of their young, skilled and English-speaking labour force. But, in order to maintain that advantage, there has to be a public-private partnership since health matters cannot be left to the concern of health care providers alone. The highly skewed public health expenditure on curative care has meant lack of resources for preventive health care. The way

forward is to forge mutually beneficial partnerships between the private sector, the government and the health care providers. One way is to finance preventive health care expenditures through a voucher system for check-ups and health screenings. Rising expectations of a wealthier and well-informed society coupled with escalating health care demand necessitates the formulation of new mechanisms to make the health care industry a propeller of economic growth. The government can promote this voucher system by offering tax and other fiscal incentives to those employers who are willing to invest in preventive health care.

Business enterprises have an important stake in optimally using their health budget for minimizing absenteeism, reducing attrition, building team spirit and enhancing productivity. Improvements in health will not only improve the performance of the organization but will also translate into macro-economic gains through increases in income, consumption, savings and investments in the economy with feedback effects on better health outcomes and so the virtuous circle of a healthy populace will go on. Even small steps like health vouchers are as important as systemic overhaul and any change has the potential to create the foundation for success in the future.

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Appendix

Preventive health care, in this paper, is with reference to the individual and is therefore different from the term as used in government documents and hospitals, which is more in a general sense implying hygiene, sanitation, etc. Preventive Healthcare, as used here, is about preventive health check-ups and wellness programmes provided by employers to their employees. The first phase of the survey was carried out from February-May 2007. During this time, e-mails were sent out to companies using four databases including Prowess database of the Centre for Monitoring Indian Economy (CMIE) and a database for IT and ITES companies. It is possible that some companies were listed on more than one database, so that the actual number of companies contacted may be lower. The entire survey was electronic and follow-up was done through e-mails and phone calls. Till the end of June 2007, 81 respondents had replied to the questionnaire and were all private companies. A major obstacle to getting more replies was a very high delivery failure of 76.8 per cent. The probable causes for this were incorrect e-mail addresses, e-mail addresses given of people who were no longer employed with the company and e-mails blocked by the company server.

Initially, we selected companies from each industry manufacturing, banking services, financial services and services listed in Prowess. Designations/names and e-mail addresses given in the database were those of company heads, not those of the HR personnel. In some cases, these heads forwarded the e-mails to the HR, while many others did not, resulting in the questionnaire not reaching the right person(s). When the delivery failure rate was quite high from these two databases, we decided to use other databases and sent out e-mails to more companies. The problem of delivery failure persisted with the other two databases as well since, like Prowess, they also had the information on company heads, and not the HR personnel, with probably similar implications. Thus, a limitation of the study pertains to data availability and sample selection.

In the next phase of the survey, we targeted the individual employees themselves to find out about the benefits of preventive health care to them. This was also an online survey carried out during March-May 2007. There was an overwhelming response to this survey since there was little chance of delivery failure given that it was a follow-up of the earlier survey. We got 288 responses till the end of May 2007.

As regards the company survey, the list of respondents included some of the big names in the Indian industry like Amadeus, Becton, Cadila, Dickinson, Coca-Cola, E-convergence, Emami, Exide, Fidelity, Genpact, Godrej, HCL Comnet, i-flex, IL&FS, Infosys, Ingenico, Kirloskar, LogicaCMG, Magna, Medtronic, Mico BOSCH, Microland, Motorola, Nestle, PEPSICO, POSCO, Satyam, Scicom, Sun Life, Syntex, TCS, Tata Steel, TeamLease, Tetrapak and Textron. A sector-wise break-up shows that 57 per cent of the firms belonged to the manufacturing sector and 43 per cent to the services sector. The geographical distribution of the respondents in Figure A1 shows that most of the respondents were from the industrially advanced states of India like Maharashtra, Karnataka and Haryana (mainly on account of the satellite town of Gurgaon). The sample of firms ranged from small with less than 50 employees to very large firms with employees up to 75,000 (see Figure A2). A third of the firms had employees numbering from 101-500 but almost a quarter were large firms employing between 1,001 and 10,000 persons.

Of the 81 responding companies, financial data from the Prowess database was available for 37 companies. A correlation analysis of preventive health care and its impact on profits and labour productivity was carried out for these companies. The analysis was carried out for all companies as well as sub-samples according to turnover: small companies with net sales less than Rs 100 crore numbering 14, medium companies with net sales between Rs 100 crore and Rs. 1,000 crore numbering 15 and large companies with net sales more than Rs 1,000 crore numbering 8. Profitability is measured as profits before tax. Absenteeism was measured by the proportion of employees on leave and mandays lost as the number of working days lost due to sick leave. A limitation of the study is the small sample size due to which the relationship between preventive health care and profitability could not be studied by using rigorous econometric tools.

To complement the online survey for employees, we also undertook a field trip for five days in the National Capital Region of Delhi. The research team focused on offices and factories in Gurgaon, Noida, Bhikaji Cama Place and Nehru Place. It should be noted that women were very reluctant to fill in the questionnaire. On the one hand, we came across a large number of people who do not get any benefits from their employers, yet they went in for preventive health check-ups as they were generally health-conscious. On the other hand, there was another group of people who did not make use of any office vouchers for preventive health check-up until and unless it was made compulsory. For instance, as it is now becoming a norm that an employee goes through a rigorous medical examination before joining a company, young people at the beginning of their careers are being forced to go through preventive health check-ups.

Figure A1: State-wise distribution of firms

Sexual and Reproductive Health Awareness Among Adolescents

Case Study in Two Slums in Delhi

Chittaranjan Mishra*

Abstract: *Awareness of sexual and reproductive health issues is abysmal among adolescents in India. Neither government nor non-governmental programmes sufficiently address these issues among adolescents. This study explores key sexual and reproductive health issues among adolescents in two slums in Delhi. Apart from making an attempt to critically examine awareness of various issues relating to SRH among adolescents, the findings also underscored the socioeconomic underpinnings of the slums as a causative factor.*
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This research note explores adolescents' awareness and knowledge on sexual and reproductive health (SRH) issues especially on HIV and STD in two slums of Delhi. The centerpiece of the research note is an in-depth investigation of adolescents' awareness and knowledge on HIV and STD, modes of transmission, and preventive steps.

Adolescents are among the key stakeholders in the sexual and reproductive health interventions. Because of the unique position they occupy in the stages of psychosocial development and their easy vulnerability to the outside environment, the understanding of the adolescents SRH needs form an important ingredient for a successful SRH intervention.

The World Health Organization (WHO) recognises the importance of adolescents health for the future health and development of countries. At the Forty Second World Health Assembly in 1989, the importance of youth as a critical element for the health of future generations and that the health of youth depends on their own actions, choices and behavior was recognized. [WHO1989]. The assembly passed a resolution to highlight adolescent issues and asked member states to develop socially and culturally acceptable programmes to meet adolescent health needs. The WHO definition of adolescence as the period of life between 10-19 years was adopted at the South Asia Conference on adolescents in 1998.

Awareness of sexual and reproductive health issues is abysmal among adolescents in India. Neither government nor non-governmental programmes sufficiently address these issues among adolescents. Most adolescents do not have the privilege of making decisions about their own health as other family members control such decisions. Due to familial and social dynamics adolescents feel less empowered to make any choice in the realm of SRH. The low level of awareness on SRH issues is more evident in urban slums where the lack of access to appropriate information on SRH issues compounded with problems of socio-economic deprivation has led to the general insensitivity of the youth towards SRH.

This study explores key sexual and reproductive health issues among adolescents in two slums in Delhi. Apart from making an attempt to critically examine awareness of various issues relating to

SRH among adolescents, the findings also underscored the socioeconomic underpinnings of the slums as a causative factor.

I
Background

The study was conducted in two slums of Delhi, i.e. Badarpur and Sangam Vihar. Badarpur is a blend of urban and rural settlement, situated in the southern part of Delhi and adjacent to the state of Haryana. Spread over 200 acres it houses a two-lakh population mainly migrants belonging from Rajasthan, UP, Bihar and M.P. People largely depended on irregular employment such as daily wageworkers, cart pullers, hawkers, vendors and helpers. Sangam Vihar is an urban slum situated in the south of Delhi. This urban settlement is spread over 150 acres of encroached agricultural land and designated as an 'unauthorized settlement' and has a population of over 100,000 residing in more than 20,000 dwelling units.

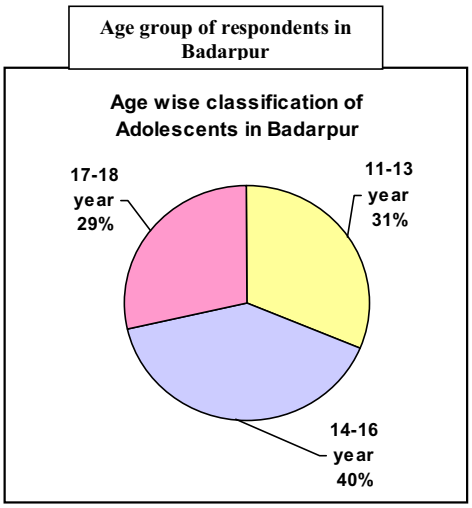
Respondent Profile

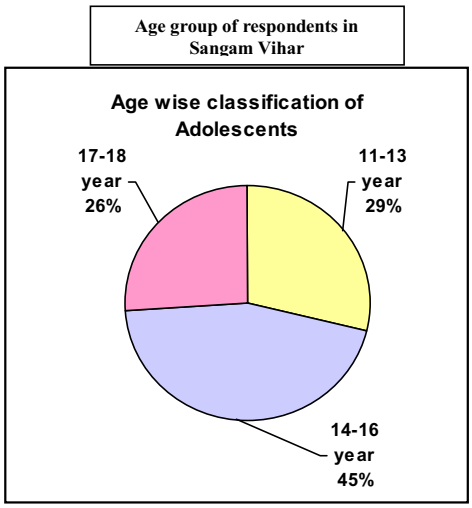
In Badarpur, 140 adolescents (both male and female) were interviewed and for that purpose 140 households were visited on the basis of stratified random sampling from the 20 locations selected for evaluation. Applying the same method in Sangam Vihar 200 households were selected from the identified 20 locations and 200 male and female respondents were interviewed for the study. A semi-structured interview schedule was administered to the sample adolescents to garner information on their awareness and knowledge on SRH issues especially on HIV and STD.

Age Composition: In Badarpur as well as Sangam Vihar all the respondents belonged to the age group of 11-18 years. The data in Graph I shows that a majority 40 per cent of the total respondents in Badarpur belonged to the 14-16 year age group. While 31 per cent respondents were in the age group of 11-13 years, 29 per cent of the adolescents surveyed belonged to the 17-18 year age group. In Sangam Vihar a majority 45 per cent of the total respondents belonged to the age group of 14-16 years. While 29 per cent respondents were in the age group of 11-13 years, 26 per cent of the adolescents surveyed belonged to the 17-18 year age group.

Graph I: Age wise classification of Adolescents

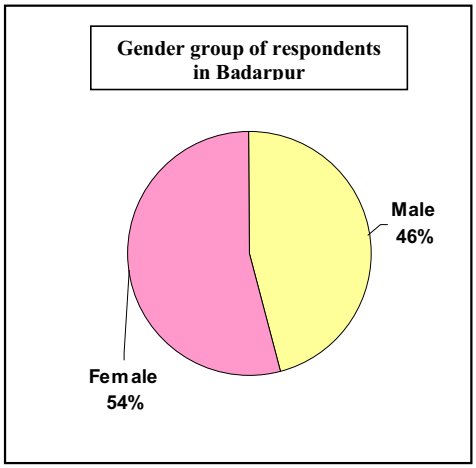
The data in Graph 1 shows that a majority 40 per cent of the total respondents in Badarpur belonged to the 14-16 year age group. While 31 per cent respondents were in the age group of 11-13 years, 29 per cent of the adolescents surveyed belonged to the 17-18 year age group. In Sangam Vihar a majority 45 per cent of the total respondents belonged to the age group of 14-16 years. While 29 per cent respondents were in the age group of 11-13 years, 26 per cent of the adolescents surveyed belonged to the 17-18 year age group.

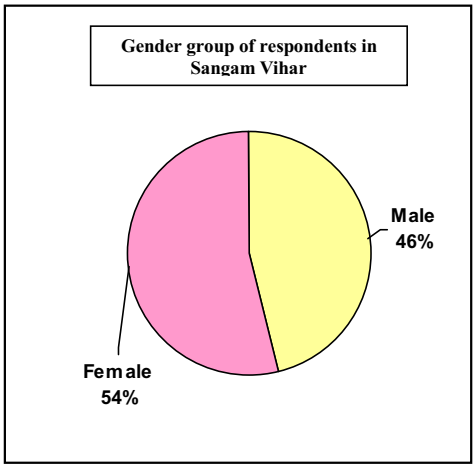




Gender composition of adolescents: Graph II shows that in Badarpur as well as in Sangam Vihar 54 per cent of the surveyed adolescents were girls.

Graph 2: Gender wise classification of Adolescents

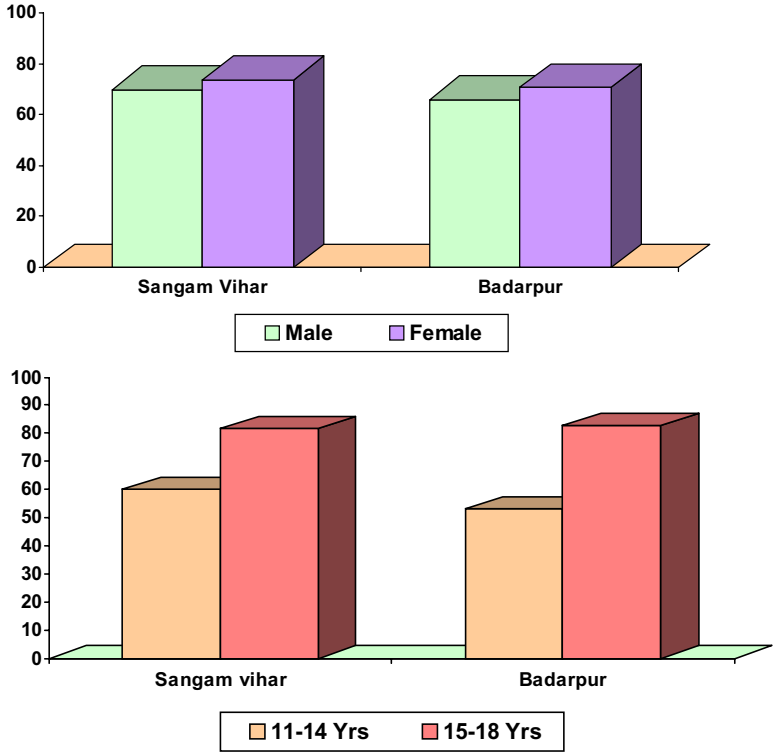




Graph 3: Awareness about HIV/AIDS

In Sangam Vihar 72 per cent of the surveyed adolescents found to be aware of HIV/AIDS where as 69 per cent of the adolescents were aware of HIV/AIDS in Badarpur. Chi square test is applied to test whether awareness of HIV/AIDS is independent of the sex of the adolescents. The test showed that both in Sangam Vihar and Badarpur awareness of HIV/AIDS is independent of the sex of the adolescents (Table value of Chi square at 5 per cent for one degree of freedom= 3.84 where the test value in Sangam Vihar= 0.18 and in Badarpur= 0.25). Contrary to the common perception, the findings underscored the fact that gender is not a barrier in the acquisition of information

on HIV/AIDS. This necessitates the equal involvement of adolescent boys and girls in any future awareness strategy on HIV/AIDS.

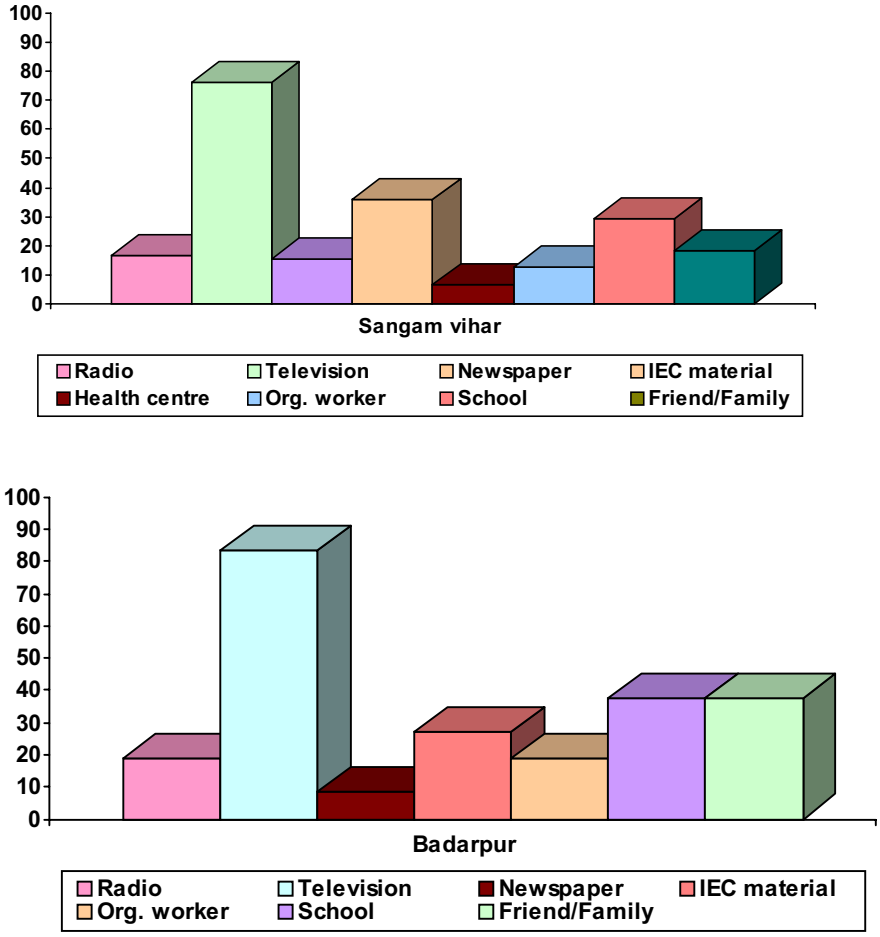


The study tried to find out the interrelationship between the age group and awareness of HIV/ AIDS. Chi square test is applied to test whether awareness of HIV/AIDS is independent of the age of the adolescents. The test showed that both in Sangam Vihar and Badarpur awareness of HIV/ AIDS is not independent of the age of the adolescents (Table value of Chi square at 5 per cent for one degree of freedom= 3.84 where the test value in Sangam Vihar= 4.98 and in Badarpur= 6.62). This indicates that in both the slums an interlinkage exists between the age group and awareness of HIV/AIDS. The findings revealed that in both the slums respondents belong to the 15-18 year age group are more in numbers than the 11-14 yrs age group in regard to the awareness of HIV/AIDS.

Graph 4: Source of Information on HIV/AIDS

The survey findings show that in both the slums television is the most potential source of information. Considering the socio-economic condition of the slums the findings seems to be unusual but the information solicited from some of the program implementers revealed that in both the slums specific programmes on HIV/AIDS were beamed through the local cable operators to sensitize the community members on HIV/AIDS. In Sangam Vihar 36 per cent and in Badarpur 27 per cent of the respondents identified IEC materials as a source of information on the awareness of HIV/AIDS. In both the slums school came to the third place as a source of information. The over all picture

reveals that IEC materials do not contribute significantly for awareness generation of HIV/AIDS in the both the slums. Considering the vulnerability of the adolescents in slums towards the disease, IEC materials should play an effective role in complementing the other sources of awareness generation activities.

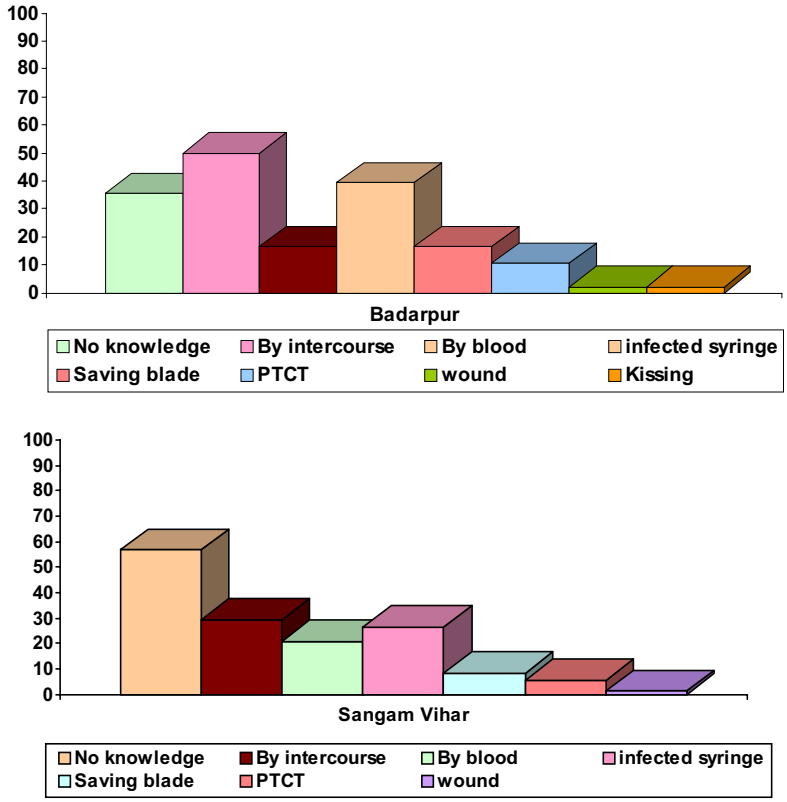


Graph 5: How HIV/AIDS spreads

The study made an attempt gauge the knowledge of adolescents on how HIV/AIDS spreads. Getting the right information on the transmission of HIV/AIDS is very important as any incomplete or wrong information can lead to the decision making of inappropriate sexual behavior for the adolescents.

While in Sangam Vihar 43 per cent of the respondents opined that they knew about how HIV/AIDS spreads, in Badarpur 65 per cent of the respondents had the knowledge about the mediums of transmission. In Sangam Vihar and Badarpur sexual intercourse was emerged as the prominent reason of transmission of HIV/AIDS with 29 per cent and 50 per cent of the respondents men-

tioned about it respectively. Sharing of infected syringe as a reason came to the second place in both the slums and transfusion of infected blood as a reason was placed at third position. Since all the respondents were unmarried, very few of them mentioned about the Parents to Child Transmission (PTCT).

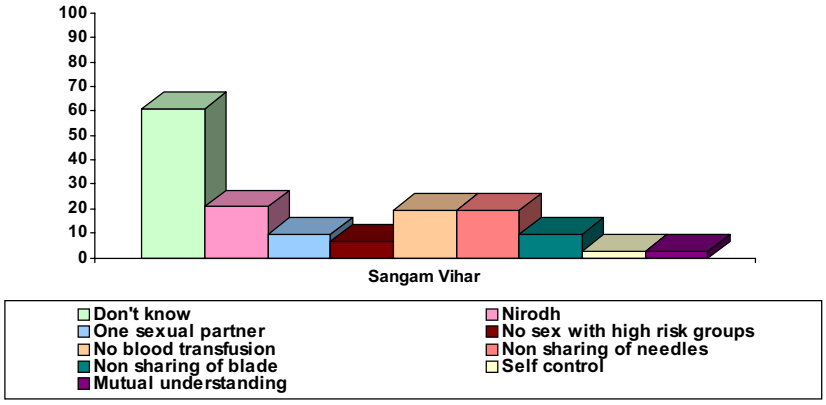


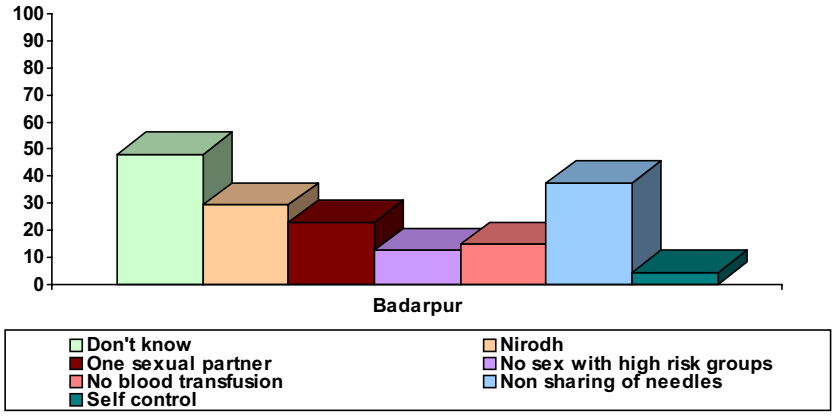
Graph 6: Prevention from HIV/AIDS

The survey solicited information from the respondents to know the knowledge regarding the prevention from HIV/AIDS. Getting right information on the prevention of HIV/AIDS is the key for any HIV/AIDS prevention strategies. The findings are presented in Graph 6.

About 61per cent respondents in Sangam Vihar reported their ignorance about the preventive measures against HIV/AIDS. Those who had the knowledge about the preventive measures, about 21per cent of them mentioned the use of condoms while 19 per cent of them pointed out non-sharing of needles and avoidance of blood transfusion as the preventive steps against the disease.

In Badarpur 48 per cent of the respondents did not know the preventive steps against the disease. Those who were aware about it 38 per cent of them mentioned non-sharing of needles while 29 per cent respondents reported the use of condoms as the preventive steps. One sexual partner was mentioned as a preventive step by 23 per cent of the respondents.

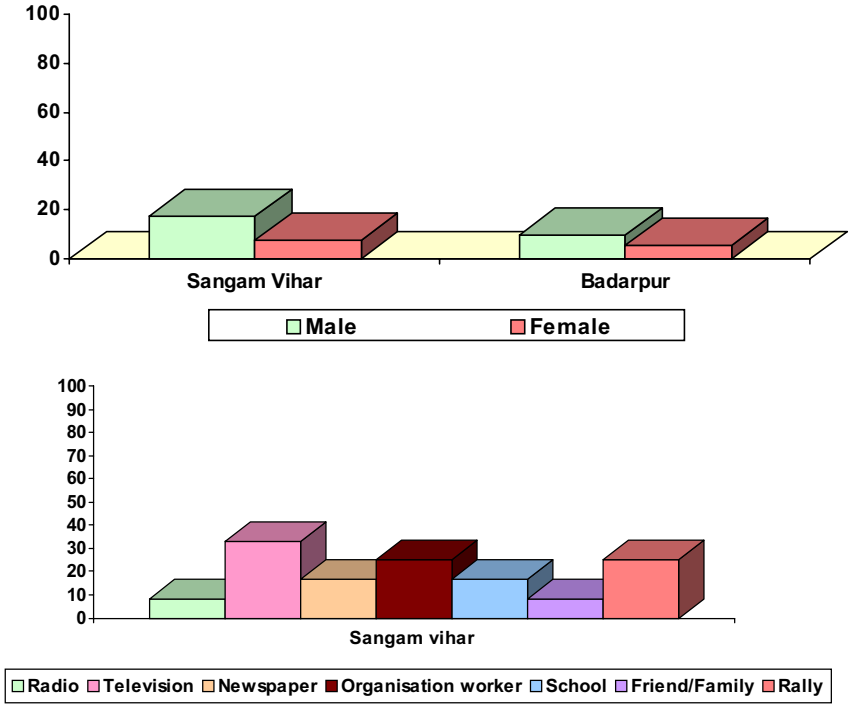




While Abstinence, Be faithful and Condom (ABC) are considered as important preventive steps against the disease it appeared in the survey findings in both the slums that except Condom the other two preventive steps is hardly mentioned by the sample adolescents. Another important thing noticed in both the slums that despite the claims of having aware about HIV/ AIDS half of them had hardly any knowledge about the preventive steps against the disease. The policy planners as well as the programme implementers should take a serious note of this fact as insufficient information on the disease can lead to inappropriate decision making among the adolescents.

Graph 7: Awareness about STD

Knowledge on Sexually Transmitted Disease (STD) is equally important in understanding the larger issue of SRH among the adolescents. Considering the importance of STD in any SRH intervention, the study tried to examine the awareness about STD among the same respondents.



The findings indicate that in both the slums the awareness on STD is abysmally low among the respondents. In Sangam Vihar 12per cent respondents were aware about it while in Badarpur 7 per cent of them had the awareness about STD. The different factors can be attributed to this low level of awareness in these slums. In the slums a culture of secrecy persists in the community, so any discussion about the issue is still perceived as a taboo. Because of illiteracy and the social exclusion the adolescents in the slums are less open to talk about the issue of STD. Considering the sensitivity and seriousness of the issue it is not easy to solicit the information on the awareness about STD among the adolescents. According to some girls interviewed during the survey "since STD is gupta rog I cannot disclose about it". Despite these constraints the percentage of awareness on STD is much lower than the percentage of awareness on HIV/AIDS.

Graph 8: Source of information on STD

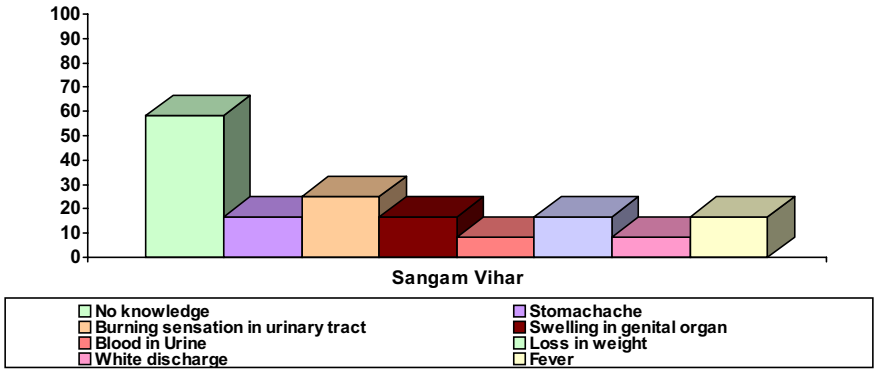
In Sangam Vihar the study findings show that television programmes are the main source of information about STD followed by organization workers working in the survey area and rally organized within the slums. There is hardly any mention of IEC materials in the awareness about STD.

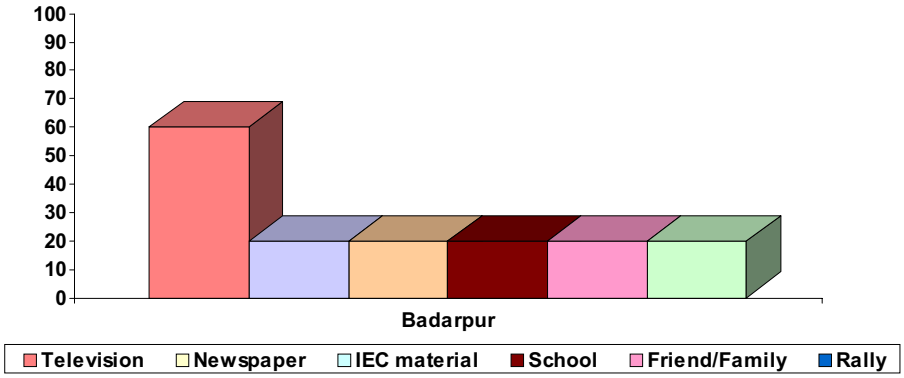
In Badarpur, television was found to be the main source of information with 60 per cent of the respondents mentioned about it. About 20 per cent of them pointed out the sources such as newspaper, school, friend/family, rally including the IEC material. The respondents did not

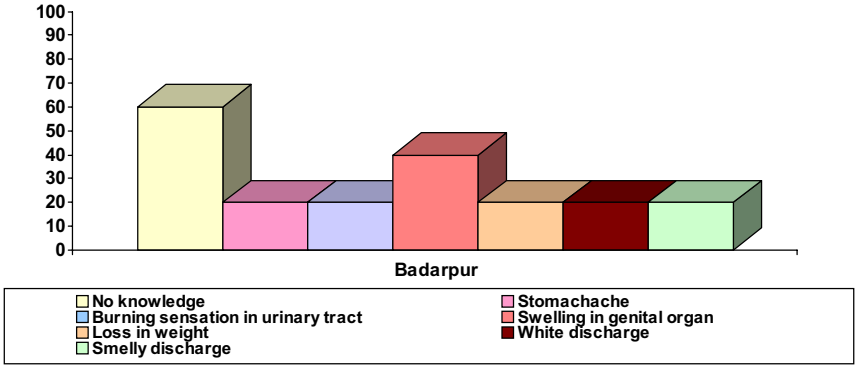
mention any specific strategy adopted on behalf of any organization in the area to sensitise the adolescents on STD. The overall picture in both the slums reflects apathy from the government as well as the community-based organizations (CBOs) in implementing any specific strategy to sensitize the adolescents regarding STD.

Graph 9: Symptoms of STD

Since most of the respondents practice some secrecy about STD, it is very important to gauge the knowledge regarding the symptoms on STD of the adolescents.





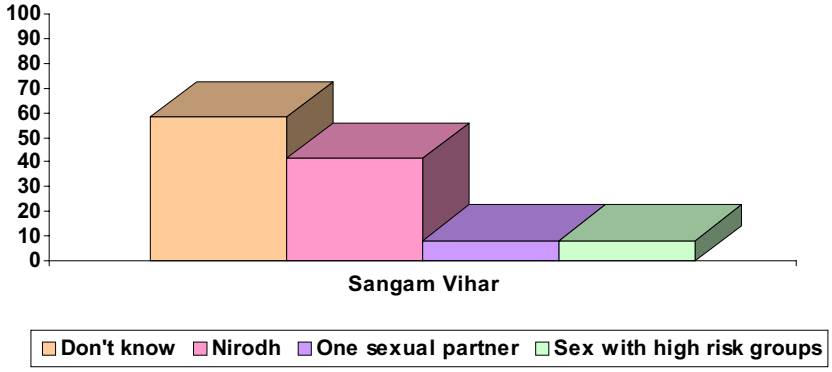


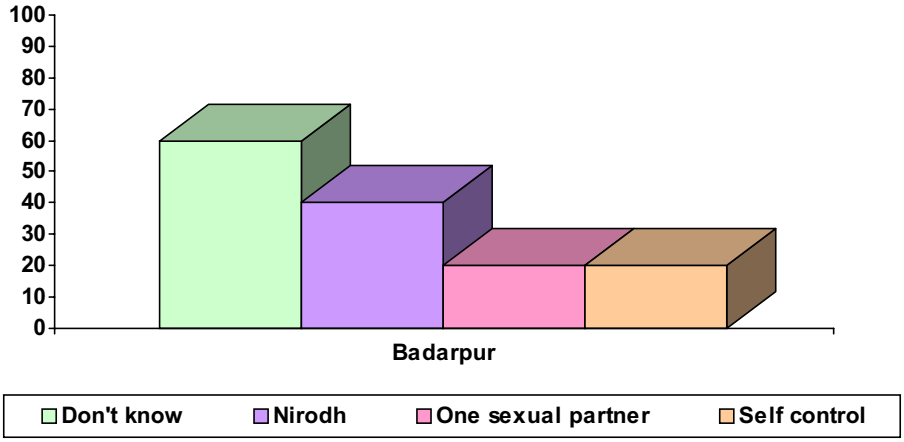
The findings in Sangam Vihar show that 42 per cent of the respondents were aware about the symptoms of STD. About one-fourth of those aware of the symptoms mentioned burning sensation in urinary tract as a symptom while 17 per cent of each named symptoms such as stomachache, swelling in genital organ, loss of weight and fever. A few respondents also mentioned blood in urine and white discharge as symptoms of STD.

In Badarpur 60 per cent of the respondents had no knowledge of the symptoms of STD. Of those who were aware, 40 per cent of them pointed out swelling in genital organ as one of the symptoms of STD. One-fifth of the respondents each mentioned symptoms such as stomachache, burning sensation in urinary tract, loss in weight, white discharge and smelly discharge.

Graph 10: Prevention of STD

Appropriate knowledge about the preventive steps against STD is vital for the slum community especially for the adolescents, as the knowledge will empower the adolescents in the informed decision making of using precautionary measures against it.





In Sangam Vihar the study findings reveal that 42 per cent of the respondents were aware about the preventive steps of STD. Those who were aware about the preventive steps, 42 per cent of them mentioned use of condoms while 8 per cent each of them named keeping one sexual partner and avoiding sex with high risk groups as the steps for prevention.

The study findings in Badarpur show that 40 per cent of the respondents were aware of the preventive steps of STD. Of those who were aware, using condoms as a preventive step was mentioned by 40 per cent of the respondents while 20 per cent each named keeping one sexual partner and self control as the preventive steps of STD.

Summing Up

A number of striking findings emerged from interviews with adolescents that warrant further attention. Although, there exists a general awareness about HIV/AIDS among adolescents in these two slums, they lack specific knowledge regarding the modes of transmission of HIV and methods of prevention. This points to the need of rigorous and continuous efforts to create awareness among adolescents on specific issues related to HIV/AIDS such as right information on modes of transmission and correct ways of prevention.

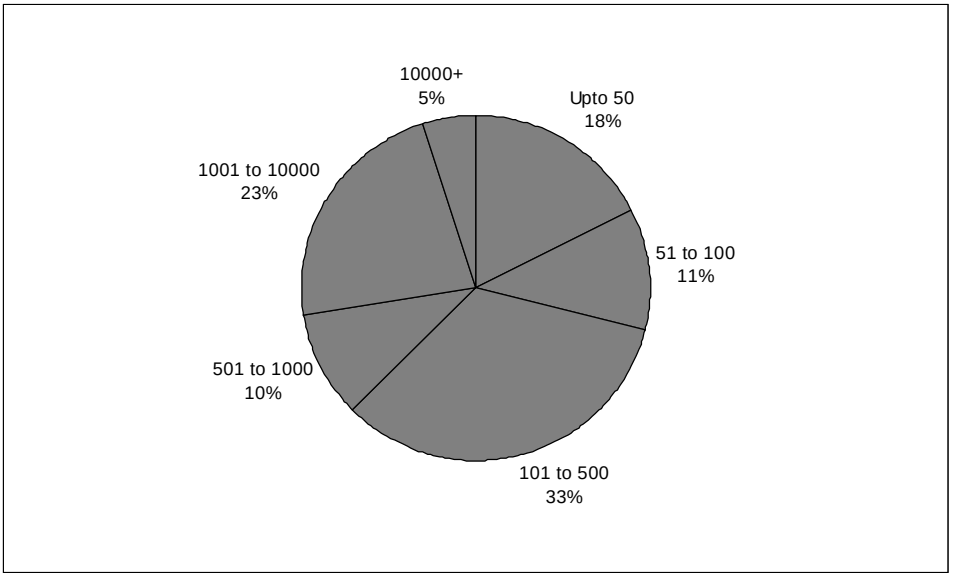
The Chi-square test showed that both in Sangam Vihar and Badarpur awareness of HIV/AIDS is independent of the sex of the adolescents while awareness of HIV/AIDS is not independent of the age of the adolescents. This necessitates the implementation of IEC strategies taking into account the high level of ignorance on SRH issues found in the early years of adolescence.

Contrary to the trend observed in the case of general awareness towards HIV/AIDS, surprisingly few adolescents had any knowledge of STD among the respondents in both the slums. Among those who were aware of STD, understanding of the symptoms of STD and ways of prevention was very poor. The findings reveal a high level of ignorance towards STD among adolescents in Badarpur as well as Sangam Vihar. This raises concerns in the context of awareness on prevention and control of STD is essential for any successful sensitisation programme on awareness building of HIV/AIDS among the adolescents in the slum community.

References:

WHO (1989): Reports of Expert Committees and Study Groups on 'Health of Young People.**GRAPHS**

Figure A2: Size distribution of sample firms



Book News

Health, Medicine and Empire

Biswamoy Pati, Mark Harrison

Orient Longman, Rs.300.00
https://www.orientlongman.com

Biswamoy Pati, is Reader at the Department of History, Sri Venkateswara College, Delhi University. Mark Harrison, is Senior Research fellow and Assistant Director of the Wellcome Unit for the History of Medicine, University of Oxford.

This collection of essays weaves together several themes related to the social history of health and medicine in colonial India. Its focus ranges from analysing Europe's relationship with India's indigenous medical systems, to case studies of two mental asylums(in Madras and Lucknow), the location of the leprosy asylum, the technological aspects and social implications of the colonial vaccination policy, and to colonial interventions related specifically to cholera and plague in the pilgrimage centres of puri and pandharpur. It also examine indigenous initiatives associated with the Indian drug industry and the Unani medical system and their interactions with the colonial health establishment and modern medicine.

Besides charting out hitherto unexplored areas in the history and historiography of colonial medicine and its articulation with indigenous systems, this book demonstrates the rich possibilities of inter-disciplinary research. Of particular interest to the specialist reader, it is also useful to those working on modern India history, cultural studies and sociology.

Sexual and Reproductive Health Awareness Among Adolescents

Case Study in Two Slums in Delhi

Chittaranjan Mishra*

Abstract: *Awareness of sexual and reproductive health issues is abysmal among adolescents in India. Neither government nor non-governmental programmes sufficiently address these issues among adolescents. This study explores key sexual and reproductive health issues among adolescents in two slums in Delhi. Apart from making an attempt to critically examine awareness of various issues relating to SRH among adolescents, the findings also underscored the socioeconomic underpinnings of the slums as a causative factor.*
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This research note explores adolescents' awareness and knowledge on sexual and reproductive health (SRH) issues especially on HIV and STD in two slums of Delhi. The centerpiece of the research note is an in-depth investigation of adolescents' awareness and knowledge on HIV and STD, modes of transmission, and preventive steps.

Adolescents are among the key stakeholders in the sexual and reproductive health interventions. Because of the unique position they occupy in the stages of psychosocial development and their easy vulnerability to the outside environment, the understanding of the adolescents SRH needs form an important ingredient for a successful SRH intervention.

The World Health Organization (WHO) recognises the importance of adolescents health for the future health and development of countries. At the Forty Second World Health Assembly in 1989, the importance of youth as a critical element for the health of future generations and that the health of youth depends on their own actions, choices and behavior was recognized. [WHO1989]. The assembly passed a resolution to highlight adolescent issues and asked member states to develop socially and culturally acceptable programmes to meet adolescent health needs. The WHO definition of adolescence as the period of life between 10-19 years was adopted at the South Asia Conference on adolescents in 1998.

Awareness of sexual and reproductive health issues is abysmal among adolescents in India. Neither government nor non-governmental programmes sufficiently address these issues among adolescents. Most adolescents do not have the privilege of making decisions about their own health as other family members control such decisions. Due to familial and social dynamics adolescents feel less empowered to make any choice in the realm of SRH. The low level of awareness on SRH issues is more evident in urban slums where the lack of access to appropriate information on SRH issues compounded with problems of socio-economic deprivation has led to the general insensitivity of the youth towards SRH.

This study explores key sexual and reproductive health issues among adolescents in two slums in Delhi. Apart from making an attempt to critically examine awareness of various issues relating to

SRH among adolescents, the findings also underscored the socioeconomic underpinnings of the slums as a causative factor.

I
Background

The study was conducted in two slums of Delhi, i.e. Badarpur and Sangam Vihar. Badarpur is a blend of urban and rural settlement, situated in the southern part of Delhi and adjacent to the state of Haryana. Spread over 200 acres it houses a two-lakh population mainly migrants belonging from Rajasthan, UP, Bihar and M.P. People largely depended on irregular employment such as daily wageworkers, cart pullers, hawkers, vendors and helpers. Sangam Vihar is an urban slum situated in the south of Delhi. This urban settlement is spread over 150 acres of encroached agricultural land and designated as an 'unauthorized settlement' and has a population of over 100,000 residing in more than 20,000 dwelling units.

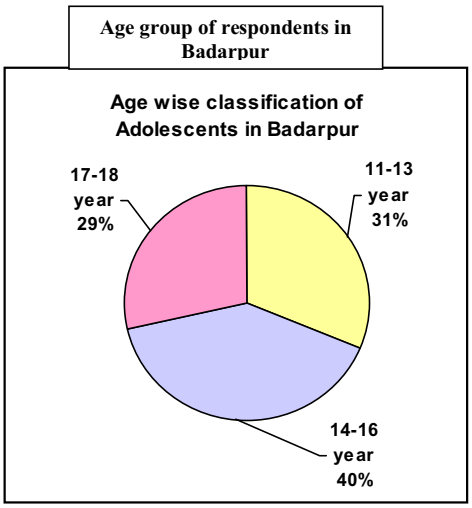
Respondent Profile

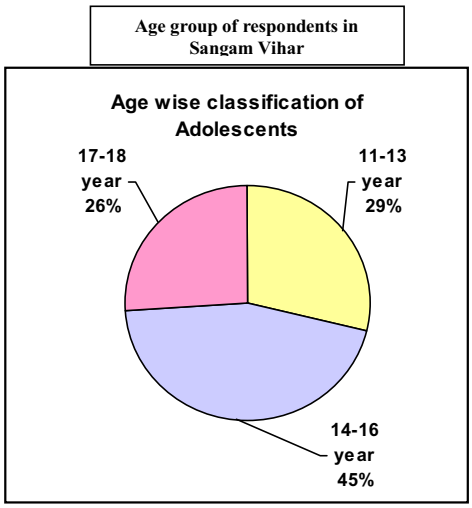
In Badarpur, 140 adolescents (both male and female) were interviewed and for that purpose 140 households were visited on the basis of stratified random sampling from the 20 locations selected for evaluation. Applying the same method in Sangam Vihar 200 households were selected from the identified 20 locations and 200 male and female respondents were interviewed for the study. A semi-structured interview schedule was administered to the sample adolescents to garner information on their awareness and knowledge on SRH issues especially on HIV and STD.

Age Composition: In Badarpur as well as Sangam Vihar all the respondents belonged to the age group of 11-18 years. The data in Graph I shows that a majority 40 per cent of the total respondents in Badarpur belonged to the 14-16 year age group. While 31 per cent respondents were in the age group of 11-13 years, 29 per cent of the adolescents surveyed belonged to the 17-18 year age group. In Sangam Vihar a majority 45 per cent of the total respondents belonged to the age group of 14-16 years. While 29 per cent respondents were in the age group of 11-13 years, 26 per cent of the adolescents surveyed belonged to the 17-18 year age group.

Graph I: Age wise classification of Adolescents

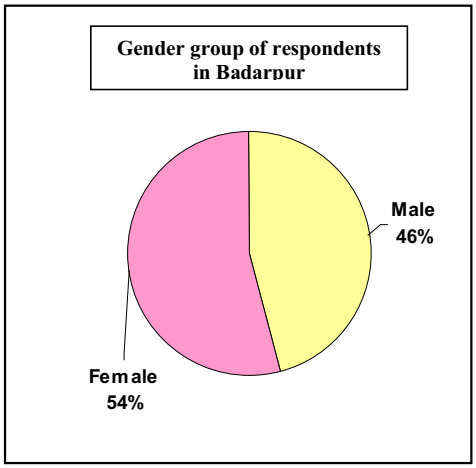
The data in Graph 1 shows that a majority 40 per cent of the total respondents in Badarpur belonged to the 14-16 year age group. While 31 per cent respondents were in the age group of 11-13 years, 29 per cent of the adolescents surveyed belonged to the 17-18 year age group. In Sangam Vihar a majority 45 per cent of the total respondents belonged to the age group of 14-16 years. While 29 per cent respondents were in the age group of 11-13 years, 26 per cent of the adolescents surveyed belonged to the 17-18 year age group.

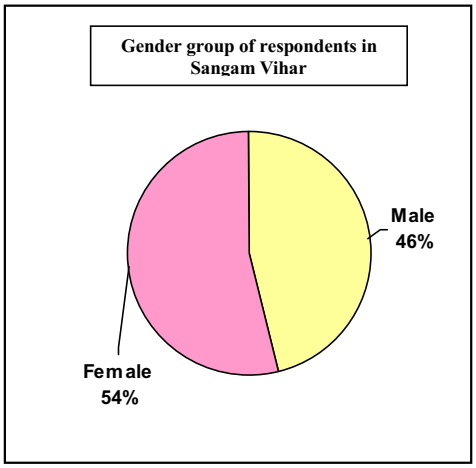




Gender composition of adolescents: Graph II shows that in Badarpur as well as in Sangam Vihar 54 per cent of the surveyed adolescents were girls.

Graph 2: Gender wise classification of Adolescents

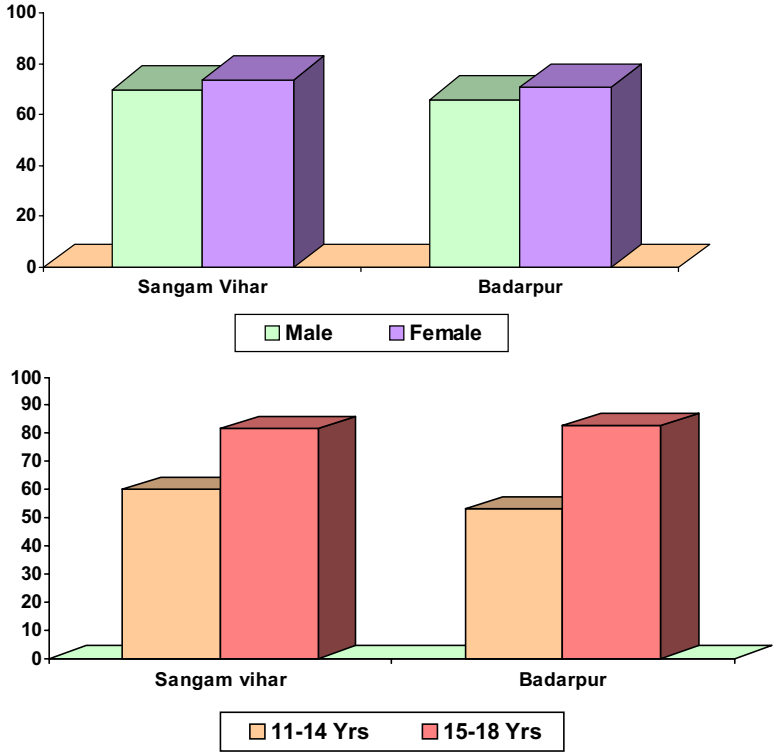




Graph 3: Awareness about HIV/AIDS

In Sangam Vihar 72 per cent of the surveyed adolescents found to be aware of HIV/AIDS where as 69 per cent of the adolescents were aware of HIV/AIDS in Badarpur. Chi square test is applied to test whether awareness of HIV/AIDS is independent of the sex of the adolescents. The test showed that both in Sangam Vihar and Badarpur awareness of HIV/AIDS is independent of the sex of the adolescents (Table value of Chi square at 5 per cent for one degree of freedom= 3.84 where the test value in Sangam Vihar= 0.18 and in Badarpur= 0.25). Contrary to the common perception, the findings underscored the fact that gender is not a barrier in the acquisition of information

on HIV/AIDS. This necessitates the equal involvement of adolescent boys and girls in any future awareness strategy on HIV/AIDS.

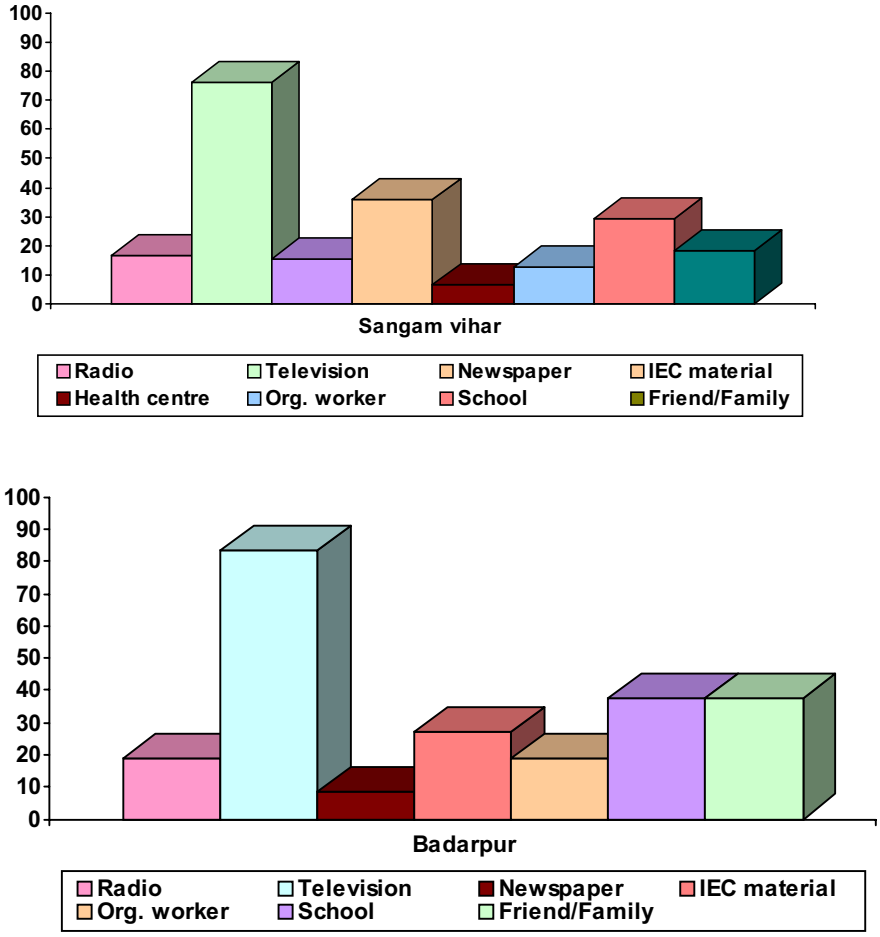


The study tried to find out the interrelationship between the age group and awareness of HIV/ AIDS. Chi square test is applied to test whether awareness of HIV/AIDS is independent of the age of the adolescents. The test showed that both in Sangam Vihar and Badarpur awareness of HIV/ AIDS is not independent of the age of the adolescents (Table value of Chi square at 5 per cent for one degree of freedom= 3.84 where the test value in Sangam Vihar= 4.98 and in Badarpur= 6.62). This indicates that in both the slums an interlinkage exists between the age group and awareness of HIV/AIDS. The findings revealed that in both the slums respondents belong to the 15-18 year age group are more in numbers than the 11-14 yrs age group in regard to the awareness of HIV/AIDS.

Graph 4: Source of Information on HIV/AIDS

The survey findings show that in both the slums television is the most potential source of information. Considering the socio-economic condition of the slums the findings seems to be unusual but the information solicited from some of the program implementers revealed that in both the slums specific programmes on HIV/AIDS were beamed through the local cable operators to sensitize the community members on HIV/AIDS. In Sangam Vihar 36 per cent and in Badarpur 27 per cent of the respondents identified IEC materials as a source of information on the awareness of HIV/AIDS. In both the slums school came to the third place as a source of information. The over all picture

reveals that IEC materials do not contribute significantly for awareness generation of HIV/AIDS in the both the slums. Considering the vulnerability of the adolescents in slums towards the disease, IEC materials should play an effective role in complementing the other sources of awareness generation activities.

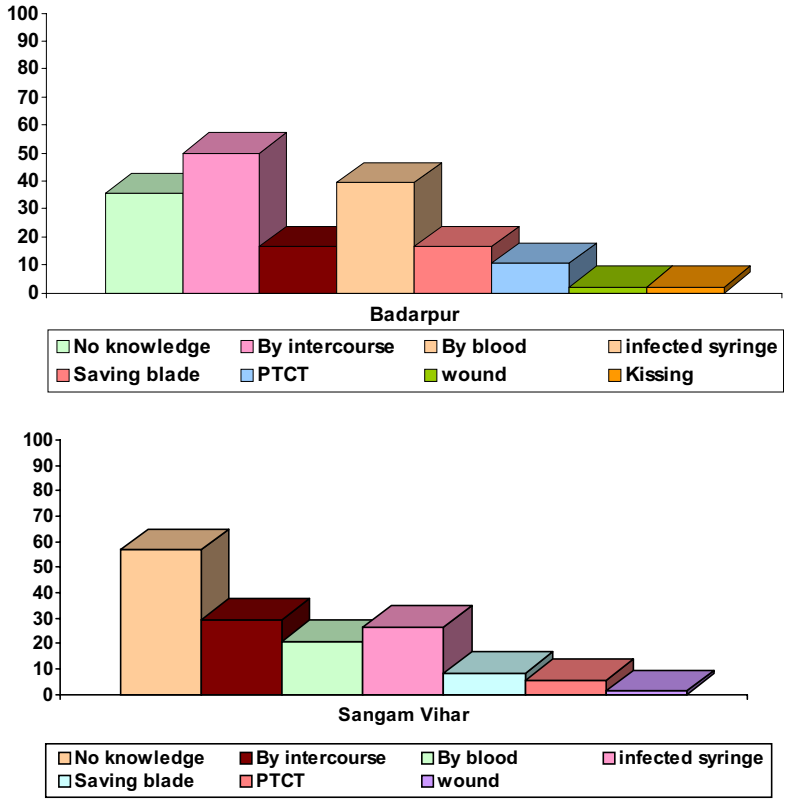


Graph 5: How HIV/AIDS spreads

The study made an attempt gauge the knowledge of adolescents on how HIV/AIDS spreads. Getting the right information on the transmission of HIV/AIDS is very important as any incomplete or wrong information can lead to the decision making of inappropriate sexual behavior for the adolescents.

While in Sangam Vihar 43 per cent of the respondents opined that they knew about how HIV/AIDS spreads, in Badarpur 65 per cent of the respondents had the knowledge about the mediums of transmission. In Sangam Vihar and Badarpur sexual intercourse was emerged as the prominent reason of transmission of HIV/AIDS with 29 per cent and 50 per cent of the respondents men-

tioned about it respectively. Sharing of infected syringe as a reason came to the second place in both the slums and transfusion of infected blood as a reason was placed at third position. Since all the respondents were unmarried, very few of them mentioned about the Parents to Child Transmission (PTCT).

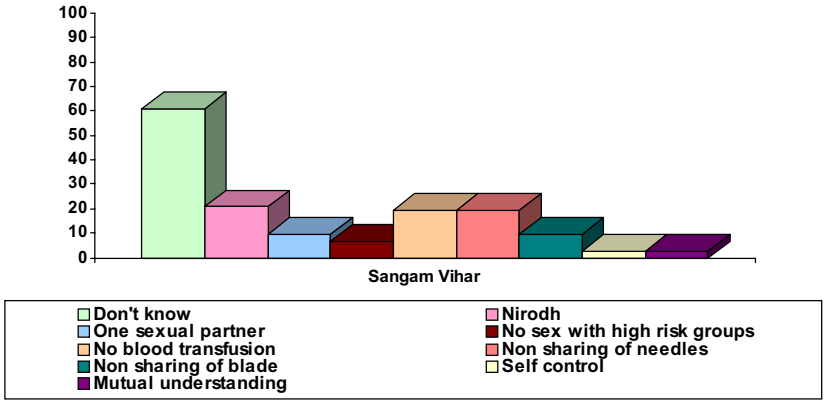


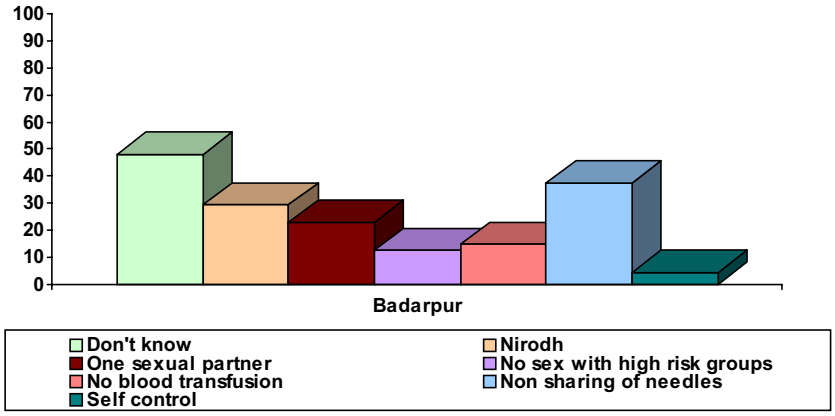
Graph 6: Prevention from HIV/AIDS

The survey solicited information from the respondents to know the knowledge regarding the prevention from HIV/AIDS. Getting right information on the prevention of HIV/AIDS is the key for any HIV/AIDS prevention strategies. The findings are presented in Graph 6.

About 61per cent respondents in Sangam Vihar reported their ignorance about the preventive measures against HIV/AIDS. Those who had the knowledge about the preventive measures, about 21per cent of them mentioned the use of condoms while 19 per cent of them pointed out non-sharing of needles and avoidance of blood transfusion as the preventive steps against the disease.

In Badarpur 48 per cent of the respondents did not know the preventive steps against the disease. Those who were aware about it 38 per cent of them mentioned non-sharing of needles while 29 per cent respondents reported the use of condoms as the preventive steps. One sexual partner was mentioned as a preventive step by 23 per cent of the respondents.

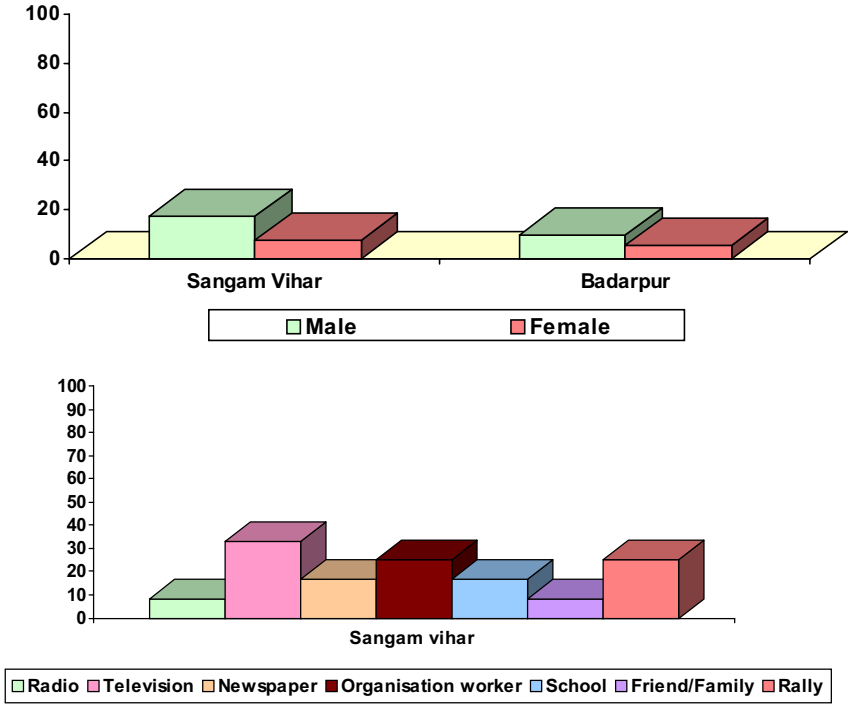




While Abstinence, Be faithful and Condom (ABC) are considered as important preventive steps against the disease it appeared in the survey findings in both the slums that except Condom the other two preventive steps is hardly mentioned by the sample adolescents. Another important thing noticed in both the slums that despite the claims of having aware about HIV/ AIDS half of them had hardly any knowledge about the preventive steps against the disease. The policy planners as well as the programme implementers should take a serious note of this fact as insufficient information on the disease can lead to inappropriate decision making among the adolescents.

Graph 7: Awareness about STD

Knowledge on Sexually Transmitted Disease (STD) is equally important in understanding the larger issue of SRH among the adolescents. Considering the importance of STD in any SRH intervention, the study tried to examine the awareness about STD among the same respondents.



The findings indicate that in both the slums the awareness on STD is abysmally low among the respondents. In Sangam Vihar 12per cent respondents were aware about it while in Badarpur 7 per cent of them had the awareness about STD. The different factors can be attributed to this low level of awareness in these slums. In the slums a culture of secrecy persists in the community, so any discussion about the issue is still perceived as a taboo. Because of illiteracy and the social exclusion the adolescents in the slums are less open to talk about the issue of STD. Considering the sensitivity and seriousness of the issue it is not easy to solicit the information on the awareness about STD among the adolescents. According to some girls interviewed during the survey "since STD is gupta rog I cannot disclose about it". Despite these constraints the percentage of awareness on STD is much lower than the percentage of awareness on HIV/AIDS.

Graph 8: Source of information on STD

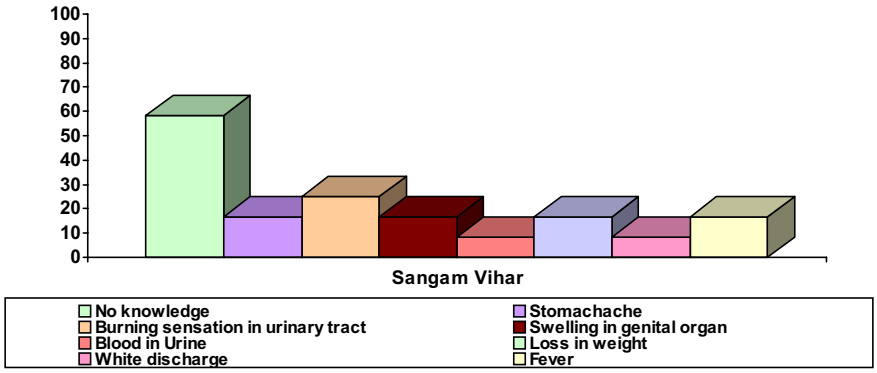
In Sangam Vihar the study findings show that television programmes are the main source of information about STD followed by organization workers working in the survey area and rally organized within the slums. There is hardly any mention of IEC materials in the awareness about STD.

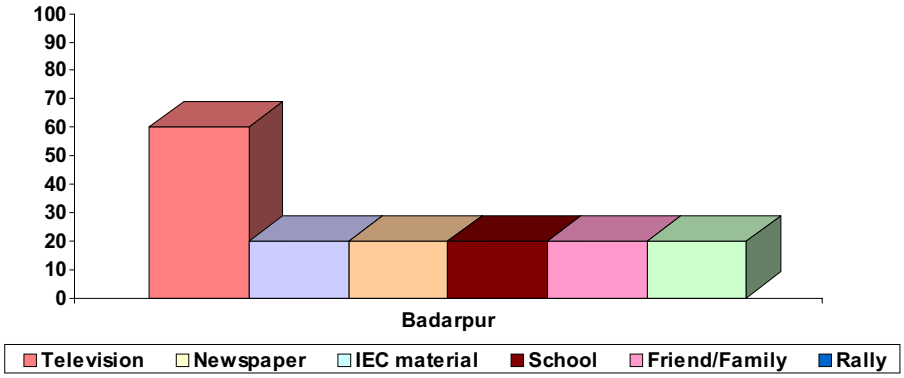
In Badarpur, television was found to be the main source of information with 60 per cent of the respondents mentioned about it. About 20 per cent of them pointed out the sources such as newspaper, school, friend/family, rally including the IEC material. The respondents did not

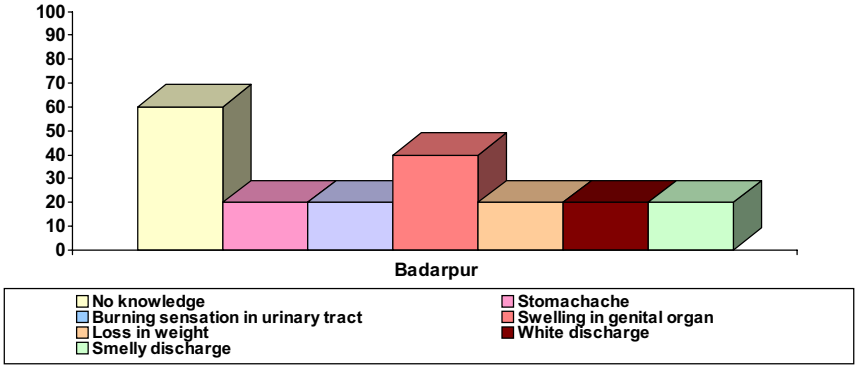
mention any specific strategy adopted on behalf of any organization in the area to sensitise the adolescents on STD. The overall picture in both the slums reflects apathy from the government as well as the community-based organizations (CBOs) in implementing any specific strategy to sensitize the adolescents regarding STD.

Graph 9: Symptoms of STD

Since most of the respondents practice some secrecy about STD, it is very important to gauge the knowledge regarding the symptoms on STD of the adolescents.





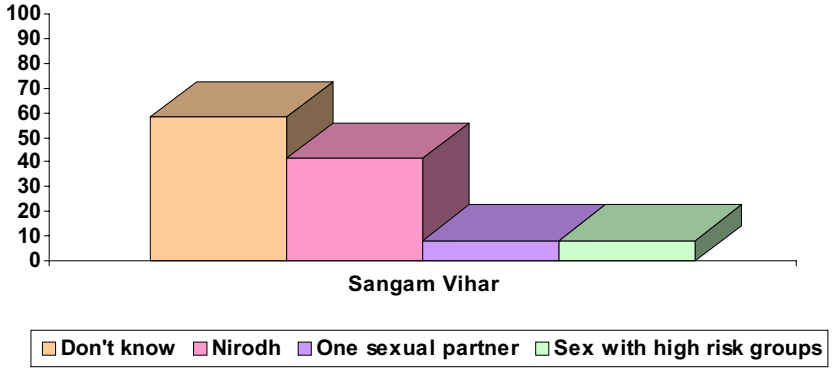


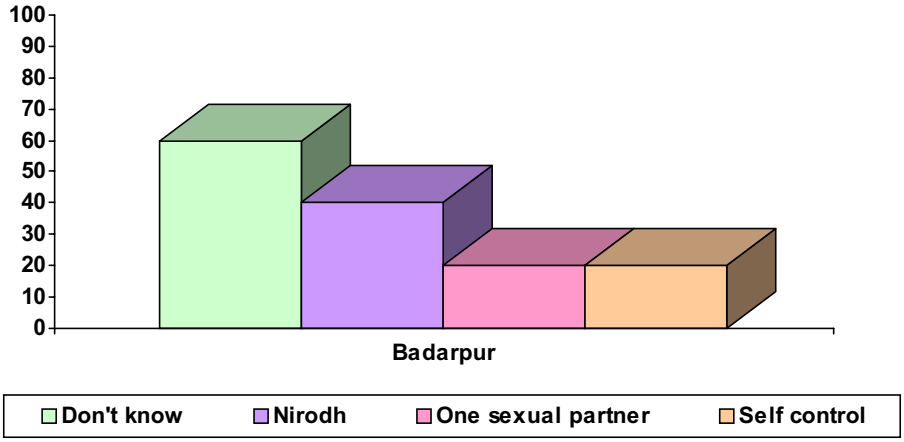
The findings in Sangam Vihar show that 42 per cent of the respondents were aware about the symptoms of STD. About one-fourth of those aware of the symptoms mentioned burning sensation in urinary tract as a symptom while 17 per cent of each named symptoms such as stomachache, swelling in genital organ, loss of weight and fever. A few respondents also mentioned blood in urine and white discharge as symptoms of STD.

In Badarpur 60 per cent of the respondents had no knowledge of the symptoms of STD. Of those who were aware, 40 per cent of them pointed out swelling in genital organ as one of the symptoms of STD. One-fifth of the respondents each mentioned symptoms such as stomachache, burning sensation in urinary tract, loss in weight, white discharge and smelly discharge.

Graph 10: Prevention of STD

Appropriate knowledge about the preventive steps against STD is vital for the slum community especially for the adolescents, as the knowledge will empower the adolescents in the informed decision making of using precautionary measures against it.





In Sangam Vihar the study findings reveal that 42 per cent of the respondents were aware about the preventive steps of STD. Those who were aware about the preventive steps, 42 per cent of them mentioned use of condoms while 8 per cent each of them named keeping one sexual partner and avoiding sex with high risk groups as the steps for prevention.

The study findings in Badarpur show that 40 per cent of the respondents were aware of the preventive steps of STD. Of those who were aware, using condoms as a preventive step was mentioned by 40 per cent of the respondents while 20 per cent each named keeping one sexual partner and self control as the preventive steps of STD.

Summing Up

A number of striking findings emerged from interviews with adolescents that warrant further attention. Although, there exists a general awareness about HIV/AIDS among adolescents in these two slums, they lack specific knowledge regarding the modes of transmission of HIV and methods of prevention. This points to the need of rigorous and continuous efforts to create awareness among adolescents on specific issues related to HIV/AIDS such as right information on modes of transmission and correct ways of prevention.

The Chi-square test showed that both in Sangam Vihar and Badarpur awareness of HIV/AIDS is independent of the sex of the adolescents while awareness of HIV/AIDS is not independent of the age of the adolescents. This necessitates the implementation of IEC strategies taking into account the high level of ignorance on SRH issues found in the early years of adolescence.

Contrary to the trend observed in the case of general awareness towards HIV/AIDS, surprisingly few adolescents had any knowledge of STD among the respondents in both the slums. Among those who were aware of STD, understanding of the symptoms of STD and ways of prevention was very poor. The findings reveal a high level of ignorance towards STD among adolescents in Badarpur as well as Sangam Vihar. This raises concerns in the context of awareness on prevention and control of STD is essential for any successful sensitisation programme on awareness building of HIV/AIDS among the adolescents in the slum community.

References:

WHO (1989): Reports of Expert Committees and Study Groups on 'Health of Young People.**GRAPHS**

Utilisation, Expenditure and Financing of Obstetric Services

Denny John*

Institute of Public Health, Bangalore

***Abstract**: There is plenty of evidence that maternal health and obstetric services are inaccessible to a large majority of people. With lack of social health security mechanisms, private health insurance too expensive to be accessed, and increased and inevitable usage of private health services for obstetric services it becomes imperative for the government to look into alternative financing strategies for improving financial access for obstetric services in the country.*

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As per the Census 2001, women account for 495.7 million representing 48.3 per cent of India's total population. Women are productive workers contributing to the economy as well. There are around 106 million women (NSS 55th Round, July-June 1999-2000) in the workforce, out of which around 40-45 per cent are in the reproductive age group.

Maternal morbidity and mortality are major public health problems in the whole of south-east Asia, signifying not only the poor status of women in the region but also the often appalling standards in basic healthcare. About 40 per cent of all maternal deaths in the world occur in the south-east Asia region [WHO 1998] with India alone accounting for half of all such deaths. The UNFPA estimated the number of maternal deaths in the country is at 112,000 per year in 2000. It is estimated that maternal deaths account for a tenth of all female deaths in the reproductive age group in the country [CBHI 2003]. The survey of causes of death estimates bleeding during pregnancy and childbirth, and anaemia to be the leading specific causes of maternal mortality [reported in CBHI 2003]. Further, UNFPA unsafe abortions were a 'leading cause of maternal mortality and contribute significantly to the maternal morbidity' in the country in 2000. Glaring shortcomings in the healthcare services, like poor coverage and quality of antenatal care, unsafe deliveries, lack of emergency obstetric care and poor referral services also contribute to high rates of maternal deaths [WHO 1998]. The NFHS-2 estimates the maternal mortality ratio in the country to be 540 per 100,000 live births with the urban estimates to be 267 per 100,000 live births [IIPS and ORC Macro 2000]. Further, the UNFPA estimated that, for every maternal death, there are 30 other women who suffer from 'chronic, debilitating conditions, which seriously affect the quality of life' [UNFPA 2000]. Bhatia and Cleland (1996) report from their study of 3,600 women near Bangalore in Karnataka that about 40 per cent of all women suffered from at least one morbid condition during their antenatal, delivery or post natal period. About 18 per cent of the women reported one morbid condition during their antenatal period, 8 per cent experienced a problem (especially prolonged labour) during delivery and (quite notably), 23 per cent had a problem during their post natal period.

The same study [Bhatia and Cleland 1996] also found, quite significantly, that degraded living environment, as in a slum, has deleterious effects on people's health and that the morbidity rates were highest for those adult women with children who were living in slums and were engaged in paid

work. The multiple burdens of 'production and reproduction' borne from a position of disadvantage has telling consequences on women's well being.

In India, the maternal mortality ratio varies according to the region, higher in rural and underserved areas as compared to urban areas. One of the main reasons for this is that only 35 per cent of an estimated 30 million deliveries in India take place in an appropriately equipped health facility. While there are cultural reasons why some women prefer to deliver at home, the main reason for home delivery is the lack of accessible, affordable and acceptable health services. Most public health institutions are poorly equipped and poorly staffed. A study from Gujarat shows that 65 per cent of all community health centres do not have a gynaecologist. In the others, blood-banking facilities are absent and nurses trained in assisted delivery do not exist. On the other hand there are private obstetric facilities, but they are very costly and most poor families (37 per cent of the population) cannot afford it.

Table 1: Maternal Mortality and Deliveries

Indicator	Value
Total Population in India	1.080 billion*
Maternal Mortality Ratio in India	407/100,000 live births**
Infant Mortality Rate	58/1000 live births***
Proportion of institutional deliveries in India	30%****
Proportion of deliveries in the private sector	41%

Source: * Census 2001; **SRS Bulletin April 2000
*** SRS Bulletin April 2006
**** NFHS-2, 1998

Utilization of Institutional Obstetric Services

Although India has made significant strides in reducing maternal and child mortality, a lot more needs to be done. India is still one of the few countries with the highest maternal and child mortality [National Family Health Survey [NFHS 2000]. Similarly, a lot more needs to be done with respect to variation between and within states in India. For example, significant variation is observed between states with respect to antenatal care (ANC) coverage i.e., there are districts with full ANC coverage below 5 per cent (districts of Bihar, Uttar Pradesh, Madhya Pradesh and Assam) to others with more than 80 per cent (districts of Kerala, Tamil Nadu, Karnataka). Although the infant mortality rate (IMR) in India is 64 per 1,000 live births, Kerala has IMR of 10 per 1,000 live births whereas Orissa, Madhya Pradesh and Uttar Pradesh have more than 80 per 1,000 live births [SRS 2003]. The same holds true for other indicators including the maternal mortality rate. Such variation is also observed between urban and rural areas; and between scheduled tribes and the scheduled caste population compared to other groups. Using the example of institutional deliveries, it is observed that among the richest 20

per cent of the population in India, 65 per cent of deliveries take place in institutions, while among the poorest 20 per cent, only less than 10 per cent are institutional deliveries [Mahal et al 2001]. Over the last decade there has been a steep increase in the share of private institutions in childbirth, both in urban and rural areas (See Table 2).

Table 2: Childbirth by Place of Deliver, 2004 and 1995-96 *(*per 1000)

Place of delivery	Rural			Urban		
	2004 (60th)	1995-96 (52nd)	1986-87 (42nd)	2004 (60th)	1995-96 (52nd)	1986-87 (42nd)
Govt. Hospital						
Private Hospital	183					
166	-					
-	89					
46	310					
429	-					
-	290					
192						
Hospital	359	179	135	739	594	482
Home*	651	787	805	261	384	468
All#	1000	1000	1000	1000	1000	1000

* include 'other places', other than 'hospital' for NSS 52nd round
# include 'not recorded' cases in NSS 52nd and 42nd rounds
Source: NSSO 60th round

Expenditure on Institutional Obstetric Services in India

With only 10 per cent of the total population in the country covered with some form of health insurance [Nandraj and Vadiar 2000], most of the population have to relies on out-of-pocket expenses for their healthcare expenses, even for availing obstetric services.

a) Expenditure on childbirth - An average of Rs. 1,521 was spent per childbirth during January-June, 2004. There was a perceptible difference in the expenditure incurred for childbirth between the rural and urban areas (see Table 2). For childbirth, this amount was Rs. 1,169 and Rs. 2,806 in the rural and urban, respectively. Again, the cost of a child delivery in private hospital was as high as Rs. 4,692 as compared to Rs. 1,111 in a government hospital. On the other hand, the average cost for delivery of a child at home was only Rs. 428 – the expenditure being Rs. 414 in the rural areas and Rs. 552 in the urban areas. It may be noted that the average expenditure per childbirth was higher in the rural govt. hospital (Rs. 1,165) than their urban counterpart (Rs. 994).

Table 2: Average expenditure per childbirth by place of delivery (In Rs.)				
Sector	*Average expenditure on childbirth*			
	Govt. hospital	**Private Hospital**	**Home**	**All**
Rural	1165	4137	414	1169
Urban	994	5480	552	2806
Rural + Urban	1111	4692	428	1519

Source: NSSO 60th round

Note: The expenditure on childbirth includes expenditure incurred on treatment of any complication arising at the time of childbirth, expenditure on transport, boarding and lodge etc.

b) Expenditure incurred for availing maternity care: Expenditure involved in the case of availing of antenatal care services was more than that of the post–natal care services, irrespective of whether the women resided in the rural or urban area (See Table 3). For a woman, average expenditure on antenatal and postnatal care was, respectively, Rs. 499 and Rs. 404 in the rural areas. The corresponding values in the urban areas were Rs. 906 and Rs. 596. As expected, the antenatal and post-natal care services were found to be much more expensive in the private sources as compared to the government sources. This differential is sharper in the case of antenatal care in the urban areas.

Table 3: Average Expenditure on ANC and PNC by Women by Source of Service for Each Broad Age Group (In Rs.)						
Sector	**Average expenditure on ANC from sources**			**Average expenditure on PNC from sources**		
Rural	230	918	499	232	541	402
Urban	356	1377	905	367	762	595

Source: NSSO 60th round

The usage of private facilities added to the aspect of lack of health security mechanisms has forced most families to resort to out-of-pocket mechanisms to pay for their delivery expenses. Some members have chosen not to seek care due to financial reasons [ICMR 2003]. A pilot study conducted by ICMR [ICMR 2003] covering around 3,71,480 households in four states [Uttar Pradesh, Uttranchal, Maharashtra, Karnataka, and Delhi (slum)] presented that 11.1 per cent of the population size cited lack of money for not seeking treatment (See Table 4).

Table 4: Obstetric Services Care	
Variable	**Percentage**
How far is the health facility	
< 5 km	45.5
> 5 km	54.5
Type of transport available	
Rickshaw	26.7
Van	20.0
No Transport	13.3
Any other	40.0
Reasons for not taking treatment	
Due to inadequate transport	55.6
No male member was available	33.3
No money	11.1

Source: ICMR, 1993

The 3 Delays model [UNICEF 1999] specifies the three types of delay that contribute to the likelihood of maternal death:

1. Delay in deciding to seek care (Individual and family)
   - Lack of understanding of complications
   - Gender issues, Low status of women
   - Socio-cultural barriers to seeking care
   - Poor economic conditions of the family

2. Delay in reaching care (Community and System)
   - Lack or underutilization of transport funds
   - Non availability of referral transport in remote places
   - Lack of communication network

3. Delay in receiving care (System)
   - Poor facilities, personnel and Supplies
   - Poorly trained personnel with indifferent attitude

The Global Burden of Disease estimates for South Asia also suggest that the major causes in order are: haemorrhage (31 per cent), sepsis (14 per cent), hypertension (14 per cent), abortion (14 per cent) and obstruction (10 per cent). The higher haemorrhage per centage is also consistent with the high background rates of anaemia reported among Indian women. The leading causes of maternal death have been, haemorrhage (38 per cent), sepsis (11 per cent), and abortion (8 per cent) [SRS 2006].

Apart from the delays in accessing obstetric service in the country, a cause of concern is the higher caesarean rates in developing countries, including India. A study in Jaipur, India that the CS rates in a leading private hospital rose from 5 per cent in 1972 to 10 per cent in the late 70s to 9.7 per cent between 1980-85. The CS rates were as high as 23 per cent in 1989 [Kabra, et. al.1994]. In Chennai City, India, the CS rate was reported to be 45 per cent, a level that is considered unjustifiable [Pai et.al. 1999]. A rising trend in CS rates, from 11.9 per cent in 1987 to 21.4 per cent in 1996 has also been reported from Kerala, the state with the best demographic characteristics and access to health care within India [Thankappan 1999]. Another study on c-section delivery rates in Kerala,

India has indicated that they are more likely to occur in private health institutions (Padmadas, et. al., 2000). A paper by Mishra and Ramanathan (2001) using NFHS, 1992-93 data states that analysis of the correlates of the occurrence of C-section indicates a strong association with private sector institutions. With increasing usage of private institutions for obstetric services over the last decade this becomes a cause of concern (see Table 2).

In this context, a major policy concern is the need to develop financing mechanisms, which are able to target the scarce resources to those who cannot afford to pay apart from establishing clinical protocols for obstetric services. The challenge is to explore innovative ways by which government subsidies could be better targeted at those who cannot afford to pay, improve equity and efficiency of services, provide choice of providers and improve responsiveness and quality of care. These results are possible if the approach promotes competition, is able to involve the private sector, is in line with government thinking and the preferences of patients, and moves away from input-based funding towards output/performance based funding [Bhatia et al 2004].

Initiatives for Financing Obstetric Services

The Janati Suraksha Yojana is a centrally-sponsored scheme with the centre providing 100 per cent of the funds. Some states e.g Andhra Pradesh make their own contribution thereby increasing the amount of cash assistance for institutional deliveries. Tamil Nadu has introduced a separate scheme, the Dr Muthulakshmi Reddy Memorial Maternity Assistance Scheme, for providing mothers with Rs.1000 per month for six months i.e. three months prior to the delivery and three months after, other states such as Jharkhand have created voucher-based payments by distributing the money in the form of vouchers at each point of service such as Rs 700 at the end of third trimester and Rs 300/- after 10 weeks of delivery date on initiation of immunization process of the child. 100/- f Out of the funds provided for JSY for 2006-07, about 71.2 per cent of the funds allocated have been utilized in the year 2006-07 (See Annexure).Tthe state-wise break-up shows that states like Delhi, Nagaland and Arunachal Pradesh, and union territories of Chandigarh and Daman & Diu have not at utilized all the funds allocated to them for the purpose of JSY. Among other states, Manipur, Jharkhand and Haryana utilized less than 20 per cent of the funds released. Only 10 states spent more than 70 per cent of the funds allocated to them under JSY. This poor utilization could be attributed to a myriad of factors, such as poor social marketing of the scheme, long procedural processes, lack of understanding of scheme at health facility level, and difficulty among certain community members of availability of suitable identity cards such as BPL, caste certificate, birth certificate etc (author's findings).

Community health financing mechanisms such as voucher payments, and community health insurance schemes have been shown as effective strategies for reaching out to communities who otherwise would have been excluded in the health security systems implemented by government and private insurance agencies. Bhatia et al (2006) proposes a demand-side financing of through usage of competitive voucher schemes as a demand-side financing strategy for certain RCH services in India. Along these lines, the government of Gujarat has initiated Chiranjeevi Scheme to increase the proportion of institutional delivery in districts of the state by involving the private care providers and creating a demand-side mechanism through distribution of pre-paid vouchers to eligible women in the districts. On the other hand, organisations such as SEWA have utilized community insurance schemes (i.e VimoSEWA) for providing maternity benefits (along with other benefits) to the poor communities in Gujarat state (See Table 5)

Table 5: Description of Packages Offered under VimoSEWA (with effect from 01/01/ 2003)

Risk Covered	Package I	Package II	Package III
Member's Insurance Premium (Rs)			
Annual Premium	85	200	400
Fixed deposit	1,000	1,400	4,800
Member's Insurance Benefits (Rs)			
Hospitalization	2,000	5,500	10,000
House & Assets Insurance	5,000	10,000	20,000
Natural Death	3,000	20,000	20,000
Accidental Death of Member	40,000	65,000	65,000
Accidental Death of Husband	15,000	15,000	15,000
Husband's Insurance Premium (Rs.)			
Annual Premium	55	150	325
Fixed Deposit	650	1,800	4,000
Husband's Insurance Benefits (Rs.)			
Hospitalization	2,000	5,500	10,000
Nautral Death	3,000	20,000	20,000
Accidental Death	25,000	50,000	50,000
Joint Insurance Premium (Rs.)			
Annual Premium	140	350	725
Fixed Deposit	650	4,200	8,800
ADDITIONAL BENEFITS FOR FIXED DEPOSIT MEMBERS			
(1) Money benefit 300/-	(2) Denture : 600/-	(3) Hearing old : 1000/-	

Other NGOs such as Seva Mandir, an NGO in Udaipur district in Rajasthan, has started Emergency Obstetric Care Insurance in nine remote villages on the Gujarat–Rajasthan border. Under this programme, women can avail of care in three full-service, private maternity hospitals in Gujarat in

response to any complication during pregnancy or delivery. For a premium of Rs.350, women have access to a *dai* (traditional midwife) trained by Seva Mandir on safe delivery and pre-natal care. The dai will provide basic antenatal and postnatal care including tetanus toxoid (TT) vaccinations and iron and calcium tablets. If there are no complications during pregnancy and delivery, this *dai* will also be able to provide in-house services for a normal delivery. In the case of any complication, the dai will provide support in visiting a hospital and even accompany the woman to the institution. In-hospital care is offered for both prenatal and delivery care, in the case of an emergency or a complication. For prenatal care, women cover their own cost of transportation to the clinic but Seva Mandir will cover the entire cost of care, including the cost of one ultrasound per pregnancy, if required. Antenatal care (ANC) visits are limited to two per pregnancy and medicines are limited to curative care. In the case of delivery care, Seva Mandir will bear 75 per cent of hospital costs in addition to Rs.800 to help cover the cost of transportation.

Conclusion

With lack of social health security mechanisms, availability of expensive private health insurance, and increased usage of private health services for obstetric services; it becomes imperative for the government to look into alternative financing strategies for improving financial access for obstetric services in the country. Demand side financing strategies such as community health insurance, voucher payments and obstetric insurance may be one option for policymakers in India to counter the limitations of the current supply-side financed RCH programme. However, with all the many advantages demand-side ommunity financing mechanisms have its set of drawbacks. (See Box)

Box : Advantages and Disadvantages of Demand Side Financing

Advantages	Disadvantages
Potential to target subsidies	May have high administrative costs
Payment linked with performance	Complex to set up
Stimulates provider competition	Difficulties in targetting
Greater Choice to users	Leakages / abuse
Consumer empowerment	Opportunity for collusive behaviour
Encourage innovation	Moral hazard and cream-skimming
Promotes public private partnerships	Weakening the public sector
Users surplus capcity in the private sector	Issues around capacities, skills and systems.
Improves equity, efficiency, choice, responsiveness and quality of services.	

Source: Bhatia M R, et al, 2002

In recent times attempts have been made by the government in bringing out social security mechanisms such as the Social Security Bill for Unorganised Sector, 2005 and the health insurance for BPL populations such as the Rastriya Swashtya Bima Yojana, yet the reach of commu-

nity health financing mechanisms such as community health insurance and voucher payments to reach out to vulnerable populations cannot be ruled out. A system needs to be created to identify the needy populations in terms of socio-economic status and linking them to quality health services for their obstetric needs. In a country with one of the highest out-of-pocket expenditures on health there need to measures to protect the poor. Apart from gathering field evidence on how various community obstetric financing mechanisms could support the poor there is a need to link the access to availability of quality obstetric services. A regulatory mechanism through standard treatment guidelines and clinical protocols for obstetric care linked to a pro-poor community financing mechanism could go a long way in improving poor people's access to various obstetric services in the country.

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Annexure Table: Utilization of Funds allocated by JSY

State/UT	Funds realeased in 2006-07	Expenditure reported by State	% Utilization

Andaman Nicobar Island	10.00	1.99	19.9
Andhra Pradesh	4073.20	4550.00	111.7
Arunachal Pradesh	26.2	0.31	1.2
Assam	1300.00	1331.32	102.4
Bihar	610.00	190.00	31.1
Chandigarh	5.23	0.00	0.00
Chattisgarh	513.00	516.55	100.7
D & N Haveli	9.17	0.73	8.0
Daman & Diu	5.23	0.00	0.0
Delhi	65.49	0.20	0.3
Goa	7.86	3.38	43.0
Gujarat	851.85	185.56	21.8
Haryana	350.00	39.11	11.2
Himachal Pradesh	100.00	20.66	20.7
J & K	138.33	123.84	89.5
Jharkhand	392.89	64.67	16.5
Karnataka	916.00	594.02	
Kerala	511.94	284.45	55.6
Lakshdweep	4.83	0.31	7.1
Madhya Pradesh	4261.00	2482.00	58.2
Maharashtra	785.79	209.07	26.6
Manipur	78.57	13.45	17.1
Meghalaya	39.29	42.75	108.8
Mizorum	78.57	37.27	47.4
Nagaland	65.49	0.00	0.00
Orissa	1600.00	1571.31	98.2
Pondichery	19.64	6.10	31.1
Punjab	145.37	56.84	39.1
Rajasthan	4085.00	3056.35	74.8
Sikkim	13.1	7.46	56.9
Tami Nadu	1827.00	1441.00	78.9
Tripura	117.86	43.70	37.1
Uttar Pradesh	1375.00	436.80	31.8

Uttaranchal	79.56	56.06	70.5
West Bengal	1678.99	1233.67	73.5
Total	26141.00	18600.93	71.2

Book News

DEMOCRACY IN THE FAMILY

Insights from India

Edited by JOY DESHMUKH-RANADIVE
Indian School of Microfinance for Women, Ahmedabad

Sage Publications, India
February 2008, Rs 595.
http://www.sagepub.in

The book is unique in the way it employs diverse research methods to address the issue of justice in the family under the common theme of examining whether the ethos of democracy is relevant to it. The interface between principles of democracy inside and outside the home is explored through the sub-themes of 'Experiencing the Family', 'Expressing the Family', 'Seeking Justice' and 'Including the Excluded'. The topics covered range from examinations of the institution of the family, the site of the household, practices of householding and relationships between members, the impact of non-democratic norms and attempts to seek justice in the face of domestic strife and violence, to the advocacy of inclusive strategies that involve men and entire communities in democratising the family.

MANAGING A MODERN HOSPITAL

A V SRINIVASAN
Indian Network, Hyderabad

Sage Publications, India
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Health care has become one of India's fastest growing sectors in the past decade. A multitude of private players have entered this market, combining to offer high-quality health care and service in world-class hospitals and nursing homes all over India. It has been recognised that a professional approach to hospital administration and better resource allocation will go a long way to ensure both quality and cost-effectiveness in health care in India.

The second edition of this successful book contains a well-planned collection of writings on modern hospital management. Revised and updated, it also contains two new chapters that discuss and highlight new developments in this field.

Making a Case for Cultural Competence

Arab-Bedouin Women in Inter-Cultural Encounters with Pre-natal Services

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Abstract: *This paper reveals an Arab-Bedouin perception of ownership of the female body and of future children at the stage of pregnancy, discussing the possible influences on decision-making in the arena of use or refuse of prenatal medical care. The paper then concentrates on how medical professionals should take into account these different ways of viewing ownership of the female body and of approaching the implementation of decision-making rights. The question emergent is what kind of cultural awareness and competence medical professionals should develop when treating Arab-Bedouin women who are the largest non-western community in South Israel.*

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Data was collected from a preliminary short-term survey conducted at the Soroka University Medical Centre (hospital) in Israel, as part of the activity for reducing infant mortality among Arab-Bedouin population. About 30 Arab-Bedouin women who were in birth-hospitalisation were interviewed about their knowledge and understanding of amniocentesis tests. The women were then asked whether they would agree to utilise such tests if they were medically recommended to them. Many of the women responded that in such instances the decision would not be theirs but of their husbands and extended families. These results were triangulated with data collected through participant observation and conversations with Bedouin mothers of children born with congenital malformations at the neonatal unit of the hospital. Conversations with medical personnel in the hospital indicate that the dominant medical discourse presupposes that all women are the ultimate controllers of their bodies, and therefore able to make independent decisions about using or avoiding the use of various medical services with strong implications over the future of both mothers and (future) children. This assumption leads to a praxis in which pregnant women are usually the first to be approached and informed by medical staff about possible problems in pregnancy, while husbands are often considered of secondary importance concerning decision-making on the future of their wives pregnancies.

This brief case-example illustrates how western-biased perceptions of the human body as the sole ownership of (female) individuals may lead to inter-cultural miscommunication due to misunderstanding of the reason for women's possible resistance to medical care, that may ultimately lead to misjudgement of women's responses to medical recommendations.

In terms of moral values this case-example raises a dilemma between a cultural relativistic approach supporting the legacy of respecting 'otherness' versus a universal approach to human rights emphasizing gender equality and women's rights.

This paper suggests that obtaining optimal intercultural communication and establishment of mutual trust between medical professionals and Bedouin users of prenatal services requires maintenance of a delicate balance between a respect to others' perceptions of body and children ownership, and between supporting the rights of women in making independent decisions and obtaining control over their bodies and their future.

I
Introduction

The concept of universal human rights is well embedded in the discourse of western-oriented helping-professions. It underlines equal treatment by acknowledging the right for basic or minimal rights to all human beings, regardless of their cultural or regional origin [Zechenter 1997]. Ideologies of social justice, coherent with the same principle, advocate the commitment of the welfare state in providing health and social security to the poor and to weak and disenfranchised populations [Shalev 2003]. In the discourse of helping professions, the medical profession among them, these principles are implied through the morals and laws of eligibility to equal treatment for all citizens. Since 1994 a national health insurance was established, covering medical care to all Israeli citizens – Arabs and Jewish with no discrimination. The law opened the possibility for using a wide range of prenatal services to the poor and weak populations, which previously did not have enough resources for the arrangement of health insurance. However, as Michel de-Certeau had already noted, equality can only be achieved if policy makers will sensitize their services by looking at the local significance of such services from the point of view of the users (1988, 1997). Anthropology has well established the claim that in order to accomplish the ideology of human rights, at least in the case of the most basic rights which, we believe, should be accessible to all human beings we need to look at local contexts and understand the implications of the new possibilities offered by the modern world, and how to offer them in ways that could be accepted and enjoyed by people who belong to non-western oriented groups. This concept known as cultural competence combines values of human rights with a pragmatic approach aimed at achieving efficacy in cross-cultural communication, and it applies very well to a wide range of human services, including medicine.

To exemplify and further explain this argument I rely on a research conducted at the Soroka hospital (formally known as the Soroka University Medical Centre) as well as on my previous fieldwork over the last seven years among welfare services provided to Bedouin families. Most of my data is collected by participant observation and audio-recorded in-depth interview. The current data will be analysed by examining cultural assumptions embedded in the discourse of texts and subtexts collected in the various sites. A small scale and short term survey made by the project for decreasing infant mortality serves as a supplemental indicator of the women's responses to a rather focused questionnaire.

The main site of research is presently the Soroka hospital. It is the central regional hospital, which provides services to most of the population of the South of Israel. The Bedouin population consists approximately 25 per cent of the southern population. The Bedouins are the larger indigenous population, of approximately 160.000 people, in the south. In the past it was a nomad and pastoralist society, now sedentarised by the modern state, a society experiencing a drastic transition to a rather modern way of life [Abu-Rabia 1994]. As many other indigenous groups the Bedouins were disenfranchised by the modern state of Israel and are now suffering very high rates of unemployment, poor residence conditions, high rate of dropout from school systems, and derived health problems [Saad et Al 2000]. Infant mortality as an indicator for the populations' health condition is significantly high with a rate of relative risk of 3.6 [Amitai 2004]. Being such a large population with a high birth rate (5.3 per cent) justifies a careful look at this population's cultural attributes, especially those, which are relevant to the behavioural patterns on the use of prenatal medical care.

Let me explain the Bedouin local context commonly encountered at the prenatal services with a case-story. Aysha was a young, unmarried woman when I first met her, a few years ago when I did fieldwork among social workers working with the Arab-Bedouins of the Negev. The people from her village hosted me in their village. Their village is one of the many unrecognised settlements of Arab-Bedouins in the Negev area, in the southern region of Israel. Claiming custody on the land where most Bedouins reside, Israel is refusing to legally acknowledge these unplanned settlements and to provide running water, electricity as well as other infrastructures normally provided to other Israeli citizens and townships. As many other young Arab-Bedouin women of today, Aysha grew up in the village. She was fortunate to have 12 years of education but was not allowed to continue her studies. She was expected to marry and stay at home and raise as many children as she could bear. Albeit some personal dreams of self-fulfilment she had developed after meeting with Jewish women and some Arab-Bedouin row-model women, she was willing to resign her dreams but still hoped to marry someone out of love and not out of tribal interests. Aysha's great concern in those early days was finding a future husband but that process turned to be quite difficult. As a young unmarried woman she was allowed to go out only accompanied by one of her brothers. In the uncommon events when she went out, she was expected to avoid talking to any stranger, so her chances to encounter potential husbands and fall in love were limited and restricted. Even when she met someone she liked and who would express an interest in her there was the restriction of the custom of endogamy [see Kressel 1977, 1988]—that the young and handsome man, although he was an honourable, educated and a working person did not belong to her tribe or coalition of tribes, and therefore the family rejected the marriage.

Another component that contributed to the strain on the young woman was the fact that her two patrilineal first cousins, who as all Bedouin males were allowed much more freedom to move around and married Arab (non-Bedouin) women from the north. This situation creates a significant surplus of competing unmarried Bedouin women concentrated in the south, and a related shortage of eligible husbands. Young women like Aysha face all these restrictions and obstacles in choosing husbands for life before even mentioning personal attributes that ensure a desired future quality of life and respect of Bedouin brides. These restricted possibilities often defer consideration that ensures the future husband will treat future wives with respect and care for their families, or even ensure their ability to be good providers who will satisfy material needs and affection. Traditionally,

marriages arranged between families do not put any importance on personal attraction in the negotiations. Money, however, is another substantial obstacle, for Bedouin brides require a large sum of money to be paid by the groom's family as bride price, an expense avoided when the bride comes from abroad—again, a factor which encourages men to marry someone from the outside, making for more Bedouin women compete for a smaller number of desirable men for marriage.

II
Circumstances of Marriage and Decision-Making

Under these circumstances, and after several unsuccessful negotiations, Aysha and her family began to get greatly concerned for her future in marriage. Several offers made by her brothers were refused by Aysha: Once, she was offered marriage as a second wife, another time the offer was to marry an elder, an honourable man who was 40 years older than her. Eventually Aysha became quite anxious and decided to accept an offer for an exchange, a process called badel, when two men exchange and marry each other's sister. Such an arrangement creates a mutual dependence on each other's success, for if one of the couples don't get alone and decide to divorce the other couple is forced do the same. Time was running out and Aysha's brother, who by this time had a personal interest in the success of the negotiations, became impatient with Aysha. Aysha herself became worried and even despaired, when eventually, perhaps out of exhaustion, she agreed to marry someone she had never met before. After the marriage was consummated as the patrilocal Bedouin tradition instruct, she was taken far away from her family, into a stranger's house with a strange family who soon became hostile towards her, denying her even the most essential necessities such as food supply or freedom to move around and socialize with her peer Bedouin women in the immediate neighbourhood.

Aysha got pregnant soon after the marriage, fulfilling her in-law family expectation by conceiving a son. But despite the fact she was carrying a son "for their family" her husband's family continued to show hostility towards her. They even denied her allowance to approach the prenatal clinic where she intended to have prenatal tests and care. Eventually, in her desperation, she tried to commit a suicide and luckily, she was unsuccessful and ended in the hospital where I met her again and listened to her unfortunate and distressful story. Knowing her stressful social situation, the head of the prenatal unit hospitalised her for as long as he could. At that point she felt depressed enough to think about divorce, even though she knew that according to the local Bedouin custom, by seeking divorce she risked her right to custody of the baby she was carrying. Aysha explained her thoughts to me: "I am glad it is a boy, if it was a girl I could not be sure how they (her husband's family) would take care of her. A boy will be hopefully well-attended for as they care for boys and not for girls".

Her willingness to separate from the baby she was carrying even before giving birth bothered me. What could possibly lead her to consider separation from her unborn child at this early stage. It really upset me to think how easily she was willing in her distress, to forgo raising her child and think of going back to her mothers' home. Of course, this is not the story of Aysha alone. During my six years listening to Bedouin women I heard many cases and stories where abused Bedouin women had resigned their motherhood and gave away their rights to raise children they have borne,

sometimes even at a very young age to escape severe personal abuse. In another instance, Aysha complained: "They want children (especially boys) but they do not want to take care of the children's mothers".

Aysha's words describe the Bedouin local concept of ownership of the female body as separated from her affinity family (the family she had formed with her husband and their children). The most important social role of being a mother is well established and unquestioned among most Bedouin women. Women are totally invested in the task of bearing and caring for 'their children' — the children of the male's lineage. This is perhaps the greatest contradiction in which Bedouin women are trapped. The children, according to the Bedouin tradition, belong to their father's lineage, to which the mothers do not belong. Under such circumstances it is not surprising that families would prefer their daughters to marry someone from the closest circle of relatives possible. In that way they remain attached to their consanguineous system for the grooms belong to the same family of the bride.

Understanding the social mechanism of marriage among Arab-Bedouins and the related concept of ownership of (future) children by male descent has important implications for medical care, especially at the prenatal stage. The difference made by this other perception of ownership of the female body is seen in situations where pregnant women are requested by medical staff to make independent decisions concerning their pregnancies. Decisions such as providing a formal consent for amniocentesis testing, and obviously derived decisions to abort malformed fetuses identified through medical procedures as with congenital (sometimes hereditary) malformations, are much more complicated issues here than among secular Jewish women. These decisions often involve not only the father's consent but also some other representatives of the male lineage and extended families. What complicates such situations even more is that the women are often blamed for the fetuses' malformations, putting at risk the reputation and justification achieved through motherhood. A common fear women have reported in interviews is the fear of being abandoned by their husbands who may look to marry another woman and cease to provide for them and their children. During fieldwork I met many abandoned women in that sad situation. In my conversations with women they often related their husbands' abandonment to giving birth to too many girls, to the birth of children with congenital malformations or to having problems in bearing more children. The fear of abandonment pushed women to bear as many children as they could, often risking their own health. Cases of Caesarean surgery are among the situations where cooperation with the medical staff is influenced by this other perception of ownership of the body, and of future children. While physicians understand such medical procedures as requesting consent for saving the lives of both the pregnant mother and/or the new born child, the extended family and the women themselves are concerned with putting in danger their reputation as multiparous women who will be able to deliver and raise large families in the future. Sometimes such considerations may lead to a refusal to sign consent for Caesarean surgery, putting at risk the health of the present child and possibly the future. The medical staff often misunderstands the Bedouin women's different responses to medical recommendation. Sometimes the women are criticised for ignorance and at other times they are accused of subjecting themselves to the men's domination and desires. Certainly, such feelings among the medical staff permeate the discourse used at the time of offering treatment to Bedouin women creating mutual mistrust and frustration.

The social recognition of the mutual commitment between two familial entities as the only proper mean to create human life is accepted by social scientists as a universal feature. It implies a mutual dependence of males on females from different groups for creating and raising children, and for fulfilling female and male's central goals in life, particularly for the Bedouin woman and man. All over the world this is the way families are formatted and the basic cells for human society function. However, the case example of this article shows that despite the mutual dependence between men and women for procreation, lives of children created by mothers who do not belong to the same lineage put women in vulnerable situations and the health and welfare of these children come under question as well. Medical professionals, influenced by dominant western-oriented views, are often unaware of the possibility of the existence of such different views of ownership of the female body and of the implication of the Bedouin view of ownership on children's health and well-being. Putting aside for a moment the issue of human rights, for women in such vulnerable and entrapping situations the question that emerges is of a functional virtue of the social mechanism that may put at risk the commitment of the Bedouin mothers and fathers to their children and to each other and for the women themselves.

From the medical and social welfare services point of view, this article suggests that more awareness and attention should be invested in understanding how medical recommendations affect such dynamics between men and women for the purpose of increasing the commitment of men for the welfare of their pregnant wives and future children. Physicians and other medical staff involved should understand the potential risks when explaining to future parents about fetuses' congenital malformations [on congenital malformations among Bedouins of the Negev see Carmi et al. 1998]. By understanding the possible consequences that women may be blamed for and later abandoned, physicians should take the responsibility in clarifying these malformations that are not the women's fault. The same sensitivity is required for pregnant women who are to be subjected to Caesarean surgery and are afraid of loosing their reputation as multiparous. It sounds banal and trivial to explain to husbands what common knowledge everywhere is: The vital importance of the connection between mothers and their children, especially at the early stages of childhood. However, after witnessing many cases of forced separations of mothers from their children for the reason of belonging to different lineages, I find this intervention necessary and of direct influence on the children's health and the mother's welfare. Despite being a permeating (perhaps patronizing or dominating) factor in another's culture and society, putting a priority on the health of these children seems to justify an intervention from the outside world of medicine and social welfare services.

Fortunately for their children, the vast majority of Bedouin mothers are very attached and committed to their children. Even Aysha herself, who had declared an intent to separate from her son and leave him in his father's family care, soon after birth created a very strong bonds with much love and affection for her son. Despite knowing this would demand from her a personal sacrifice of living in a family who ostracised her she decided to raise her son. Aysha has decided to make the effort in her husband's family knowing that in the long term it will be better to rely on building her own nuclear family and acquire a social position as a mother bearing children that would grant her a relative stability. I even dare to say, that children in the Bedouin society are concerned their mothers' *raison de'etre.* In the words of the women: it's a case of *'uladi hayuni'* or, 'my children are my life'.

III
Towards Cultural Competence

Getting back to the ideology of the universality of human rights, which asserts that all human beings must have at least a minimum of human rights necessary for human functioning [Nussbaum 1993], it seems worthwhile to notice that this position should not negate the ability of awareness to the existence of a variety of cultural perceptions which include norms, beliefs and values that for some non-western populations have a particular prevalence, although in the west they would be considered unacceptable violations of basic human rights. Recognising others' views of the ownership of the body raises a problematic position for the medical services. It may expose medical professionals to what looks from their viewpoint to be an acceptance of severe violation of the rights of women as individuals and even as members of their society. However, recognising the existence of such others' perceptions should not imply necessary acceptance of the internal inequality that stands in a strong contradiction to equal (or universal) human rights. On the other hand, by ignoring or refusing to address these norms or cultural ideas social injustices are not being prevented, or avoided.

My argument here is that there is no point in pretending to blur the differences through a continuous universalistic discourse which intends to provide similar attention to women users of prenatal services from any origin or cultural background. We are all equals as human beings but the different circumstances and cultural contexts in our lives demand differential ways to attend different situations in life. Particular attention to cultural differences is instrumental for the recognition of such other ways of knowing and understanding. It does not imply accepting or justifying them. Further, we must remember that some of such 'strange' others' perceptions sometimes resemble more commitment to human beings than the western concepts of universalism could ever promote. To do some justice to the Bedouin culture, which I have quite severely criticised in this paper, I will mention the great collective commitment of its members to each other and the great investment made in the caring of many Bedouin husbands for their wives and children.

In conclusion, through the long-standing debate between the ideologies of universal human rights versus cultural relativism, a prominent idea emerges and claims that adopting one approach undermines the other [see for example Nagengast 1997; Messer 1993, 1997; Turner 1997; Zechentner 1997; Handwerker 1997]. My suggestion here is that this situation is not necessarily real and that a delicate middle way which asserts a universalistic support to health and welfare rights for all human beings can be combined with a non-judgmental recognition of the different perceptions of ownership of female bodies and of future children. After all, we all mean to consolidate health and not to undermine social and cultural norms and values.

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Books

Sex-Selective Abortion in India — Gender, Society, and New Reproductive Technologies

Edited by Tulsi Patel;

Sage Publications, New Delhi; 2007

pp. 432; Rs. 495.

Reviewers

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The essays in this book are the outcome of a workshop conducted by the Department of Sociology, Delhi University in October 2003. The papers attempt to provide an overview of the variety of approaches to the issue of missing girls in India. The book shifts the controversial question of 'why millions of women do not survive in India' to 'why millions of girls fail to take birth and are not wanted in India'. The chapters are based on fieldwork, survey data, archival records supported with fresh analysis of Census and NSS data. The essays are based on a comparative exploration of northern region of India.

'Missing Girls'

The issue of 'missing girls' and NRT is discussed in chapters 2 to 4. In the second chapter, Leela Visaria has made an attempt to estimate the magnitude of deficit of girls in India as a whole and in some of the female disadvantaged states and have compared the situation in them with that in Kerala, which is considered a female advantaged state. Based on primary data collected from one district each of Gujarat and Haryana, the paper discusses some indirect evidence of female selective abortion.

The analysis points out that son preference is so strongly entrenched in Indian society especially in the north-western region and the well-being and status of girls is so precarious once they are married, that couples avoid having girls at all costs. The linking of legal abortion services with the finding and revealing the sex of the foetus provides an opportunity to abort the child of an unwanted sex. Women in the study areas in Gujarat and Haryana are well aware of the ban on sex determination tests but felt that the ban should be removed and couples should have the choice to decide the sex composition of their children. Interestingly, with the practice of getting rid of daughters being prevalent in these regions for generations, certain social groups in both Gujarat and Haryana have started feeling the deficit of brides for their sons.

Ashish Bose's paper looks at the issue two levels: Through a detailed district level analysis of the 2001 census data, and through intensive fieldwork in the state of Punjab, Haryana and Himachal Pradesh. The study reveals that men and women accept the idea of a two- child family and are also aware of the technology of pre-birth sex determination tests. As in most

parts of India, two sons constitute the cut-off point for accepting sterilization. People seem to be quite puzzled about the government's stress on a small family norm when it opposes the conduct of these tests and subsequent abortions. They argue that since every family wants at least one son, if not two, the best way to ensure a small family is to go for the test and act according to the results. Although the states like Punjab, Haryana and Himachal Pradesh are economically prosperous, the attitude towards the girl child is alarmingly unprogressive.

The fieldwork leads to the conclusion that there are at least three pre-conditions for the spread of female foeticide: easy access to medical facilities, in particular, ultrasound and abortion facilities; ability to pay the doctor and abortionist for the test and abortion; and, a good network of roads to cut down the cost of travel and the time taken to travel. These conditions are fulfilled in the study areas, which has the lowest child sex ratio in India. But with higher levels of economic growth and better transportation networks will all states in India follow in the footsteps of Punjab and Haryana?

The study contends that there are numerous causes for the spread of female foeticide and it would be unscientific to believe that dowry alone is the cause, as is the general perception. Families that are well-off and do not have to depend on dowry to augment their income are also opting for female foeticide. Female foeticide is a symptom of increasing crime against women. It would be manifestly wrong if we conclude that female foeticide is a matter of medical technology alone.

The chapter by Rainuka Dagar empirically investigate the dependence of female foeticide on socio-economic development vis-a vis the parameter of Gender Equity Index. The paper explores the trend of child sex ratios in empirically developed and underdeveloped states including, practice of female foeticide among groups with different income and education levels across rural-urban populations and the practice of female foeticide in socio-economic advantageously placed groups, that is, NRIs / ethnic groups in western developed countries.

The chapter by Tulsi Patel has two parts. The first part begins with a section providing a context of the use of new reproductive technologies in their place of birth and their use in India. The second part of the paper discusses how daughters in everyday life come to be considered a burden for parents, their families including both sets of grandparents. It discusses how the birth of grandchildren brings together the affinal relatives and consaguineal kin's common view about sex of children born. Female foeticide, it points out is not seen as an act committed for the welfare of the family, which includes gendered structures with the male in authority. The sex of the foetus is assumed to be created biologically but technologically detectable, and thus considered terminable. It is an odd fact that the upwardly mobile and those with better economic resources adopt sonography in favour of sons to avoid having more than one daughter. It is supported by two issues: the demographic composition of households, around marriage and gift-giving practices that make daughters seem as sexual, social and economic burdens. Cultural politics has surrounded the occurrence or non-occurrence of biological events, such as conception, pregnancy, miscarriage, induced abortion and child birth, operation routinely at the micro political level in the household and the family. The ability or inability to reproduce has cultural meanings. Sonography enables to achieve or at least have the potential for desirable biological outcomes having culturally coloured meanings and they have a potential to reduce the separation between 'desirable' and 'actual' outcomes. And, especially during ruptures of time-honoured social arrangements people get secretive among themselves too.

The chapter by Alpana Sagar reveals that female elimination is not merely due to economic compulsions but is pervasive across class and region. It is rooted in our very cultural and social, economic and political processes. Legislation alone is not sufficient to prevent female elimination. Nor can it be a substitute for cultural changes and consciousness rising at a countrywide level.

Reema Bhatia discussed the health policy and role of health worker in altering the sex ratio. The doctors and the entire health hierarchy share an understanding that family planning and control of fertility is not possible till a couple has the desired number of sons. The health workers are meant to be agents of positive change but they end up propagating wrong practices. In order to meet targets the entire health hierarchy is pushing people towards attaining the desired family composition at the fastest possible rate. The disastrous consequences are reflected in the low sex ratio at the national level.

Rashmi Kapoor explores the ironical situation of coexistence of female infanticide and female foeticide and that of adoption, predominantly of girls, in the same socio-cultural milieu. The prevailing principle is that neither social conformity, nor traditional nor secular values guide individuals to adopt a child; rather the individual's needs and desires drive childless couples to adopt. The practice of adoption in India isan institution, which is paradoxical in itself. On the one hand, there are parents who because of several reasons abort fetuses, kill baby girls or abandon children. On the other hand, there are childless couples who need children to complete their families. These childless couples adopt the abandoned children and form a family. Abandoning children is a milder form of aggression and prejudice against girls as compared to female infanticide and female foeticide, which are fatal. But, abandoning children is an extreme case of neglect and an indifferent attitude of parents towards their welfare, which can again be fatal. By adoption of girls, adoptive parents are consciously demolishing the preconceived idea of male superiority and trying to re-establish the worth of the girl child.

Representation, Articulation, and State

Vishwanath's paper argues that the efforts of the colonial state to suppress female infanticide are a reminder of the complex relations between state and society. The records provide information on the lower castes being influenced by the higher, on the issue of female infanticide. The perception of female infanticide during colonial rule is in terms of its caste specificity, hypergamy, hierarchy, status maintenance, dowry avoidance and so on.

Vibhuti Patel discusses the political economy of missing girls in India. The philosophical and medical details of New Reproductive Technologies (NRTs) need a public debate as these technologies are primarily concerned about efficiency of the techniques to avert birth rather than safety of women.

The later essay by Tulsi Patel explores the manner and the processes of the relationship between the technology and the culture of reproduction, mediated by the practice of the Indian state focussing largely on North India, especially the upper class, middle class, and those groups with lower incomes, who cherish middle class aspirations, who are struggling to come out of the shadow of prosperity. The paper gives the contemporary historical context of NRTs and deals with reproduction as a social and political issue.

The book is a commendable piece of work highlighting the problem of sex ratio and sex selective abortion in India. It clearly addresses the nexus among culture, society and new reproductive technologies and opens up enormous possibilities for fresh theorization on sex ratio within the fertility family, planning, society and new reproductive technologies framework.

[Abridged from eSocialSciences
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Reproductive Health in India: History, Politics, Controversies Health

Edited by Sarah Hodges

Orient Longman**,** Rs.620.00

https://www.orientlongman.com

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Within the scholarly fields of demography, development studies, medical anthropology and public policy, the history of reproduction has been dominated by preconceived and often a-historical ideas about India's supposed long-term trend towards "over-population." When these scholarly fields have invoked histories of fertility and contraception, these histories have largely been made to serve as the "pre-modern" antithesis to a fully "modern" future. In contrast, this volume brings together historians to tackle the complex questions of reproduction in modern India. Taken together, these essays map out and ask questions of the institutions, discourses and practices by which women's reproductive health came to hold meaning and play strategic roles.

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