Health e-Letter

Vol 2, Issue 1, February 2008

Anniversary Special

Letter from the Editor

We've completed a year

By Kalpana Jain

The Health e-Letter, a small but ambitious journalistic effort to track India's healthcare, is a year young. In the past year it has acquired its distinctive features, a character and a voice. It was born out of our belief that there is no real and consistent coverage of India's many public health issues.

A three-tier system of health care delivery with primary health centres, district health centres and tertiary care hospitals was envisaged as the best mechanism for delivering healthcare to a young India when it attained Independence. However, the system could not cope with ever increasing challenges, a growing population and political apathy. The gap was filled in by private health centres, which were allowed to function without stringent regulations.

Today 85 to 90 per cent of doctors are engaged in private practice. The wide disparity in income is attracting the best into the private sector. For this and several other reasons, public health institutions are rapidly deteriorating. Much of the private sector growth is taking place in big cities where they can get maximum profits. As a result of this concentration many are resorting to unethical practices to increase profits. To make matters worse, adequate regulations are missing. In short, the common man has difficulty finding good, affordable healthcare.

Only 17 per cent of all health expenditure in the country is borne by the state. The major chunk -- 83 per cent -- comes as out-of-pocket payments from people. The poor are at a severe disadvantage. In the absence of any savings they slip deeper into debt. Healthcare costs remain the main reason for 35 per cent of poor sliding down the poverty line.

Some other vulnerable groups such as the elderly find they have little choice in their growing years when faced with expensive healthcare costs. Doctors admit they find many elderly patients, especially women, stopping treatment once they learn that the cost of treatment would be way beyond them. Doctors suspect many of these elderly just choose to die. It may well be so, as people over 60 would also find it difficult to get a good insurance cover.

WHO IS READING US AND WHY

I have valued reading the newsletter and its articles. I have appreciated the choice of stories and the sensitivity with which they are written. The issues covered reflect contemporary concerns. They are informative and written in a reader friendly manner.

Dr Mira Shiva,
Coordinator, Initiative for Health, Equity & Society, Chairperson, Health Action International Asia Pacific, Member Central Council for Health. New Delhi

The newsletter gives me an insight into what is going on in the health sector. It keeps me updated on issues. I am looking forward to seeing it continue.

Dr L.M. Nath,
Epidemiolgist and Former Director, All India Institute of Medical Sciences, New Delhi

There is a clear gap in credible and balanced health reporting in India. Your effort in bringing out a newsletter is out of the ordinary. It fills this gap in the most convincing manner. I would like to see this newsletter grow, span out across India and become a tool for young health reporters to learn how world class health reporting is done.

Anoop Misra,
Director and Head, Department of Diabetes and Metabolic Diseases Fortis Hospitals, New Delhi and NOIDA

Most of us would not know where to head if an emergency arises and who to trust. A telling case is of a doctor who works on public health issues. He was diagnosed as suffering from gallstones following a sharp pain in his abdomen. He was advised immediate surgery. He found to his utter shock that his insurance firm refused to pay saying gallstones was a preexisting condition. Not able to find reliable and affordable hospitals in Delhi, he decided to go to a hospital run by a Trust in another city.

So, the least we can do is become more aware. Through the past one year we have zealously tried to explain public health shortfalls to you. We have tried to tell you what increasing commercialisation means for your health. We have tried to bring you stories on impact of privatisation on public health facilities. A series of such stories were much appreciated by our readers. We have tracked numerous other issues -- emerging epidemics, HIV/AIDS, pulse polio campaign to name a few. At the same time we have celebrated success, we have brought to you stories of people who care and we have profiled those who have shown that there is way to bring about change.

We do not function on a great deal of resources, but on our own commitment and motivation. I must add that launching this was a bold initiative as this had not been attempted earlier. When we started off we didn't know if we will get any readers, any reactions, any stories or even any contributors.

But we were rewarded by the rich comments and encouragement from our readers. Some of them urged us to brighten it up by adding more graphics, some said we should explain medical terminologies in a separate box, some encouraged us by telling us it was great concept and we should continue. Gradually, we evolved. It gives us great joy to see a few readers added every month or to get e-mails from people who received the Health e-Letter through a friend. Our readership, although small, is steadily growing.

Our contributors work mostly for prominent language newspapers. We translate their writings into English, as we could then connect with readers across the country. I would like to take this opportunity to applaud this small team of highly committed contributors who worked for free for most part of last year. Shekhar Deshmukh, Toufiq Rashid, Sudhir Mishra, Dipti Raut, Manish Srivastava, Manoj Pratap, Kumar Jitendra Jyoti, Shivani Parihast Das and Manoj Ojha have come with me on this journey. For most of them, not working in English is their biggest strength. They speak the language of the ordinary man and therefore connect better with him.

Having made a beginning we hope to expand and build. We hope to improve our coverage and get you many more stories. For some of you who have expressed difficulty in reading an online magazine we hope to come up with printed copies. And finally, we will rely on your feedback and to tell us how you would like us to grow.

In this issue we decided to bring you the best of Health e-Letter stories. These are stories that stand out for reflecting new trends, serious concerns as also appreciate some remarkable contributions of rare individuals. So we have stories that highlight handing over government hospitals to private players, impact of commercialization on public health facilities, update on most neglected but deadly kalazar, unique contribution of unknown faces such as Vittal Prabhu, health trends from Kashmir as also assault on the freedom of health journalists in Bihar.

Your encouragement makes us stay. Do continue to provide us your feedback at healtheletter@gmail.com.

WHO IS READING US AND WHY

I really appreciate the subjects covered in the newsletter. The stories are objective and provide a deep insight into issues.

Ratan Jalan,
CEO, Apollo Health and Lifestyle Ltd, Jubilee Hills, Hyderabad

The simple, elegant design of the Health e-Letter makes for a very comfortable reading. Kalpana has started a very strong initiative that has pioneered the concept of health journalism in India, which, like developmental journalism, has become redundant in our newspapers and magazines. I would like to see the Health e-Letter linking up with some of the premier internet health sites around the world so that international experts can access this professional, well-researched Indian view on health issues.

Neelima Mathur,
Trustee & Trainer, Formedia
Executive producer, Spotfilms

I find the Health e-Letter extremely valuable as it gives readers a different perspective that is objective and truly pro-people and consumer oriented. We need views that reflect what consumers of health delivery systems actually feel about the present health system in as dispassionate a way as possible. Health e-Letter offers all that in the most simple and concise manner. It's a good start. But tough times lie ahead. Sustaining it and making it socially valuable would be quite a challenge.

Ashok Row Kavi,
UNAIDS Consultant on MSM/TG issues

UP health mess: Now plastic surgeons to run heart department

By Sudhir Mishra

PRIVATISATION FALLOUT

Lucknow: BSS Bhatnagar has recently been diagnosed with a heart problem. He urgently needs an open heart surgery. In the private hospitals in the city it would cost him over Rs 1.5 lakh. Only at the government-funded King George Medical University could the surgery be done at a subsidized cost of Rs 30,000 and by the finest surgeons.

The only problem is this: Bhatnagar cannot afford to go to a provide hospital and at the King George Medical University's Cardio Vascular Thoracic Surgery (CVTS) department there is no surgeon. Almost all have left the KGMU for lucrative jobs in the private sector. The one remaining surgeon, who is also the head of a depleted department, is proceeding on his annual vacation. Between June 9 and June 16, the department will be in the care of plastic surgeons.

For quite sometime now the CVTS centre has been functioning with only one doctor - Professor Shekhar Tandon. The waiting list is long for the few surgeries that do get performed in the department. Only five surgeries are performed by this department every month. When Professor Tandon goes on vacation next month, even those few surgeries will come to a halt. Patients like Mr. Bhatnagar may have no choice but to spend a whopping out-of-pocket amount at a private heart care centre.

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Two months ago, an assistant professor at KGMU, SK Singh, went on leave. But he did not come back. Initially, he went to Australia; then for a few days he joined the Sanjay Gandhi Post Graduate Institute, Lucknow, and finally he joined a private hospital.

When Professor Tandon goes on his vacation not only do the surgeries stop but services at the out patient department get suspended, as well. The OPD too will be temporarily taken over by the plastic surgery department.

Some time back this department enjoyed a prestigious reputation as it had the finest surgeons on its rolls. In fact, surgeons trained here command immense respect at several centres across the country. The first team to perform open heart surgeries was from this centre during the early seventies. Under the leadership of a well-known heart surgeon, Professor KN Sinha, the team took on various challenges.

KGMU's former dean, Professor Mahendra Bhandari, is upset over the state of the department. He feels sooner or later it will have to close down. No competent cardiac surgeon would work for the paltry pay package and the near-absent infrastructure that the hospital provides. Most doctors are willing to forego good salaries and perks if they are valued and get satisfaction from what they are doing. Neither seems to be there. However, at Apollo or Escorts Hospitals, cardiac surgeons from hospitals like KGMU are valued for their vast and varied experience.

This crisis seems to be hitting a nasty patch in several public health institutions across the country. A rapid rise of the private health system combined with a complete neglect of the public health system is fuelling this trend. Competent doctors who suffered oppressive environments, lack of research facilities and low pay packets are now leaving in huge numbers for swanky private centres. Despite there being few insurance options, people are being pushed into dipping into their hard-earned savings to seek treatment at these expensive private hospitals.

Various other departments at KGMU also experience a similar crisis during summer months. There are 223 professors in the 32 departments of KGMU. During the months of May and June the administration ensures that half of the doctors can avail leave from May 1 to June 7 and the other half can make use of it from June 9 to July 15. Even so, four departments would be left with one professor each. Fifteen other departments will have four or fewer professors. This not only affects the OPD services and operations, but also the teaching arrangement.

No teachers for medical colleges

By Manish Srivastava

PRIVATISATION FALLOUT

Lucknow: Uttar Pradesh's Chattrapati Sahuji Maharaj Medical University (CSMMU) had a strange experience few months back. An advertisement was published for recruitment of seven teachers for this college's cardiology department but only four turned up for the job interview. Out of these four, two were selected. Only one joined the college. Another teacher, who was appointed in nephrology department, has not joined till date. In the dental college, 23 posts have been lying vacant for a long time.

The reason for this is quite clear. Government medical colleges, which were most sought after place for medical teachers, are no more an attractive place to work. Thirty doctors from this college alone and 31 from Sanjay Gandhi Postgraduate Medical Institute have left.

THE VACANCIES

	Allopathic Medical Colleges		Ayurvedic Dept	
	Positions	Vacant	Positions	Vacant
Professors	137	26	35	20
Readers	194	50	55	45
Lecturers	325	267	130	37

The condition has deteriorated so much that out of the six government medical colleges in the state, five are being run without permanent principals. There is no permanent vice chancellor for the Chattrapati Sahuji Maharaj Medical University. Even homeopathic, ayurvedic and unani medical colleges are granting degrees to medical graduates without having a principal.

In fact, a fear of cancellation of recognition has been hovering over some colleges for last few months due to lack of teachers. In allopathic medical colleges, 177 seats out of 334 are being filled up without getting the recognition. Radiology and microbiology departments at the CSMMU too have not been recognised by the Medical Council of India.

There seems to be no solution to the problem arising out of the shortage of teachers. First let's have a look at allopathic colleges. The position of principal at Agra Medical College continues to be vacant since Dr D N Sharma's quitting to move to Delhi. The Principal of Jhansi Medical College, Dr Kamal Sahani, is practising at the Kanpur Cancer Institute. The post in Jhansi is being looked after by a stand-in principal, while at Gorakhpur Medical College, Dr Lalit Mohan has been appointed as a temporary principal after Dr Saudan Singh left for Delhi.

Meerut Medical college is being run under a provisional principal following the retirement of Dr Usha Sharma. Allahabad Medical College is now under the Central Government, but yet it has no regular head, while Dr S K Katiyar, Principal of the Kanpur Medical College is scheduled to retire next year. Of all these, only Dr Kamal Sahani was selected through Public Service Commission. Even the state's only medical university has a temporary chancellor in DR S K Aggarwal.

The condition is no different in Unani, homeopathic and ayurvedic medical colleges. Out of seven homeopathic colleges only two have regular principal, while just one ayurvedic college out of eight has permanent principals. UP has two unani medical colleges and both of them are being run by stand-in heads.

If we put some light on the shortage of teachers, we will find that at allopathic medical colleges, out of the required 137 positions, only 111 have been filled. There are 194 positions for Reader, of which, 50 are lying vacant, while out of 325 positions for lecturer, mere 58 seats have been filled. In ayurvedic department, there are 35 positions for professor, of which 20 are lying vacant. Only 10 readers are there as against the requirement of 55, while there are 93 lecturers, whereas the requirement is of 130 lecturers.

Experts feel that if this shortage is not taken care of soon, then the recognition of these colleges may be

withdrawn.

The director general of medical education, Dr M C Sharma, says that all medical colleges are suffering from the dearth of teachers, adding that efforts are on to fill the vacancies at allopathic medical colleges. For this, he says, the required position will be advertised through the Commission. He further says that the selection of medical university chancellor will be done by the Governor.

Commenting on the diminishing interest of medical teachers towards government colleges, Dr S C Tiwari, a senior doctor at the CSMMU, says that the prime reason for this has been the handsome package being offered by the corporate colleges and the government medical colleges of other states. A good doctor at a corporate hospital can easily earn about one to two lakh rupees per month. Recently, the Garhwal Medical College in Uttarkhand issued an advertisement in which a professor's pay scale was fixed at Rs 75,000, while a medical college in Karnataka pays Rs.65, 000 to a professor. In contrast, teachers at the medical university and colleges in Uttar Pradesh are paid between Rs.35, 000 and 40,000.

In such a scenario, why would a medial teacher want to teach in Uttar Pradesh?

Peoples' health goes into private hands

By Kalpana Jain

PRIVATISATION FALLOUT

Ahmedabad: An increasing number of public health facilities are being contracted to private trusts or corporate houses as state governments find they are unable to manage them. The Gujarat government has recently signed an agreement with Wockhardt Hospitals Group (WHG), a leading supplier of hospital pharmaceutical products, to manage the 275-bed Palanpur Civil General Hospital in the state.

Some believe that this public-private partnership will benefit people by improving health services while several others are of the view that this is an "insidious way of privatizing a government facility." "It would eventually increase costs and make treatment that much more inaccessible for the poor," they say.

Gujarat and Bihar have the fewest people using the public health services. Only 25 per cent people in Gujarat use the public health facilities. Few doctors are available in these facilities. Government data shows that 65 per cent of the posts for gynecologists are vacant in community health centres in Gujarat. In district hospitals, 30 per cent of the posts need to be filled up. There is an acute shortage of pediatricians as well in the state district hospitals. Some 67 per cent of those posts are vacant.

Health experts in Gujarat are concerned that the government is no longer interested in filling up posts or improving public health facilities. Increasingly, it is finding that bringing in private players is a better option. In December 2005, it launched the Chiranjeevi scheme involving private practitioners for safe child birth.

With this new agreement, the charitable Palanpur Civil General Hospital may no longer provide free treatment to most people. A statement by Wockhardt promises to run it "efficiently within the allocated annual budget, besides providing to patients medical treatment and facilities at tariffs fixed by the Government of Gujarat." The government has said that 'Rogi Kalyan Samiti', or Patient welfare committees, will be set up to oversee the functioning of the hospital. The committee will have three nominees from the state government.

Non government organizations in Ahmedabad are apprehensive about the move. "The person paying the highest donation usually becomes the patron of the committee. Eventually expensive technology starts coming in and costs go up. Diagnostic tests and services become expensive," says Sejal Dand at NGO, Anandi.

Health experts at the Indian Institute of Management are asking for transparency. "The government should circulate the contract with Wockhardt. These projects should also be independently monitored," says Professor Dileep Mavalankar at IIM. The agreement with Wockhardt is for ten years. After the completion of ten years, it will be reviewed again for extension.

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public health facilities. Increasingly, it is finding that bringing in private players is a better option. In December 2005, it launched the Chiranjeevi scheme involving private practitioners for safe child birth.

The government worked out a detailed arrangement for paying these private practitioners. It empanelled private doctors, who were reimbursed at a fixed rate for each delivery carried out by them. The payments were made for a batch of 100 deliveries and each enrolled private doctor was given a fixed sum as deposit in advance to conduct the deliveries and meet expenses. The health workers in these districts identified families living below the poverty line and advised them where they could go for a delivery without having to pay any fee. In fact, the government provided them free medicines and transport facilities, explains Professor Ramesh Bhatt at the Indian Institute of Management, who has studied the scheme in detail.

Each doctor received Rs 179,000 for these 100 deliveries. The government fixed Rs 800 for normal deliveries and Rs 5,000 for caesareans. It assumed that 15 per cent of deliveries would be complicated. Charges for pre-delivery consultation, sonography, transport and a traditional birth attendant were also included. From this amount doctors were asked to reimburse Rs 200 as transport cost and Rs 50 to the attendant.

The scheme started functioning in December 2005. Going by official statistics it has been a success. It enrolled 73 per cent of total specialists in the five pilot districts. Around 34 per cent of child births for women living below the poverty line took place in the scheme. No maternal deaths were reported in the five pilot districts.

However, no one is quite sure whether it is sustainable in the long run. Moreover, says Sejal Dand, these women are not receiving any ante-natal care. Transport too continues to be a problem for the women. And there have been cases where gynecologists have referred complicated cases to hospitals run by Trusts.

Professor Bhatt too agrees that the scheme has some flaws. It "lacks quality control," he says. People have to travel long distances and they continue to go to local quacks and traditional birth attendants despite these services. Professor Bhatt says the other challenge is upscaling it as conditions are not the same all over.

Whether this will be sustainable in the long run or if it short-term building of a political constituency is an answer few are willing to give. But yes, gradually the government is finding the easier option of entrusting public health to corporate houses, private trusts and non government organizations.

HEALTH MESS IN GUJARAT

- **Declining sex ratio for the 0 to 6 age group from 928 in 1991 to 878 in 2001**
- **Percentage of severely stunted children is the highest in the country**
- **46.3 per cent women suffer from anemia and more than one-third of the women are undernourished**
- **Allocation of resources to health has declined from 4.81 per cent to 2.87 per cent of the state health budget**
- **Unregulated growth of the private sector**
- **Growing Rural-Urban divide in services**
- **Only 25 per cent of the population uses public health services - women use much lesser than men due to the problem of accessibility and affordability**
- **50 per cent vacancies in community health centres**
- **Only 30 per cent of the population is aware of HIV/AIDS.**

Nineteenth century hospital conditions in a 21st century city

STATE OF HOSPITALS

Gurgaon may popularly be known as the Singapore of India thanks to its glitzy malls and hip younsters flaunting the latest fashion labels. But when it comes to the public health system, the city could take a few lessons from the island nation. Our reporter ***Manoj Ojha*** *spent time looking at the Gurgaon Civil Hospital, which gets a patient load of about 800 to 900 every day. The hospital was recently in news following allegations of turning away a pregnant woman who was in labour. The woman had to deliver her baby in the parking lot of the hospital. The new born was unable to survive the ordeal and subsequently died. Here is what our reporter saw:*

Away from the glitz of the malls and five-star-like private hospitals, modernity has not even begun to touch any part of this Civil Hospital. Absenteeism, rude behaviour, malfunctioning equipment, referring patients to private

laboratories and chaos characterize this hospital as much as any other public hospital across the country. Top officials are evasive and the next man proficient in shifting responsibility.

I started off by trying to meet the chief medical officer S S Dalal. He asked me to meet the medical superintendent, Dr D S Dhankar. However, the medical superintendent was not in his office. He finally turned up for work at 11 a.m. but did not meet me. I searched for the Information Officer, who is also responsible for taking RTI (Right to Information) applications. But he too was not available in his office.

As I waited, I noticed a man with a fractured right leg and hand trying to get a receipt so that he could get his X-ray taken. The hospital ward boy who was carrying his receipt was not traceable. I overstepped my journalistic role and reached across to help him. When the ward boy did not turn up for about an hour, we approached the head nurse of the ward where the man was admitted. She paid no heed to our complaint until she learnt that I was from the media.

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When we did reach the X-ray lab, the technician said a snag had developed and nothing could be done about it. The patient was rudely told to go to a private lab. “If you are in a hurry, you can go to a private lab.” Eventually, the patient had to do so.

I returned the next day again to meet Dr. Dhankar. I reached his office at 10:30 in the morning, but was told that he was not there. I sauntered off to the pathological laboratory of the hospital. Chaos reigned here. The lab assistant, Vandana, who was to reach office at 9 am, had not arrived until 10:40 a.m. “She always does that,” said a staff member tersely.

Finally I was able to meet Dr Dhankar. He refused to comment on the incident of a pregnant women being turned away. “I was on leave at that point of time, so I won't be able to comment on it.” When asked why the X-ray machine was not functioning, Dr Dhankar said there was no problem at all. On hearing that patients were being referred to private centres, he said, “There was some problem with power supply, but it has been rectified.”

As I conversed with Dr. Dhankar, two young women came into his chamber. One among them was sobbing and wanted to lodge a complaint against an ENT OPD doctor. “The doctor in the OPD was rude,” she said. “My ear started paining when the doctor put something in it. When I complained , he said if I could not bear the pain why did I visit the hospital.” Quite clearly, he was not interested in hearing them out. Instead of taking more humiliation the two women walked off saying “all government officials behave rudely.”

I also prodded Dr Dhankar on absenteeism in the hospital. For instance, I enquired why lab assistant Vandana was not in her office. I was asked to talk to Dr Rajora, in-charge of path lab. I decided to test this out as well. But Dr Rajora too was not in his office. A staff member said, “He will reach by 1:00 p.m.” When I asked whether Vandana has come, he replied, “She came and took leave for today.”

I finally decided to leave with no real answers coming to my queries and patients struggling to find medical care in one of the fastest developing cities. As I was coming out of the hospital I witnessed chaos outside the ultrasound lab. Women who had queued up outside the lab were complaining that they had been waiting over an hour but the technician had gone off after locking up the ultrasound lab. There was no one around who could listen to them and offer an explanation.

As for taking an action on a complaint, it seemed next to impossible.

User charges force poor out of public health system

By Manoj Pratap

STATE OF HOSPITALS

Bihar: Bihar chief minister Nitish Kumar's ambitious plans of revamping the public health system seem to have achieved results only in official files. While infrastructure remains as decrepit as ever, the woes of the poor have only increased as they need to furbish a certificate

proving that they live below the poverty line or pay to access the threadbare services.

Bihar government claims that there has been such remarkable improvement in services rendered at the primary health centres that the number of people coming for treatment has gone up by 30 per cent. Non government organizations call these numbers misleading.

Forty two per cent of the population in the state lives below poverty line, says Dr. Shakeel-ur-Rahman, acting director of Centre for Human Action Research and Management (CHARM), a non government organization in Patna which works on improving health conditions of marginalised communities. This large percentage of the population can barely manage to get two meals a day. How can they afford any medical treatment?

The Bihar government introduced the concept of public-private partnership in the state in July last year. Under this, government health facilities ceased to provide free services. The government partnered with private laboratories for medical investigations such as x-ray and pathological tests. It also brought in private providers for hospital maintenance, providing power back-up and ambulance services.

The government argued that the treatment remained highly subsidized as the fee for all the procedures was only half of that of prevailing market rates. In the last six months, district hospitals and primary health centres too have been included in this public-private partnership concept.

The state government did make services free for people living below poverty line. A patient welfare committee set up by the health centre was to provide financial assistance to the poor. However, Dr Rahman says, a number of hospitals have yet to institute such a committee.

A look at patient profiles from Phulbarisharif, a block adjoining Patna city, is enough to explain the impact of new policies on the underprivileged masses. At the primary health centre in this block not a single person certified as living below poverty line had come for treatment to this centre in eighteen months.

Rahman explained that conditions had not changed much all over the state. At the subcentres - over 9000 across the state-curative services are not available. There are no medicines, doctors or even paramedical staff at these sub centres. In the Indian public health systems, sub centres constitute the first rung of health care, where minor ailments could be easily addressed.

SUB CENTRES

- **It is the lowest rung of a three-tier set up consisting of the Sub-centre established for every 3,000-5,000 population with referral linkage to the Primary Health Centre (PHC) and the Community Health Centre (CHC).**
- **A Sub centre is expected to provide all the primary health care services such as immunization, antenatal, natal and postnatal care, prevention of malnutrition and common childhood diseases, family planning services and counseling.**
- **A Sub-centre should have a female health worker commonly known as auxiliary nurse midwife (ANM), one male health worker commonly known as Multi Purpose Worker (Male).**

COMMUNITY HEALTH CENTRES

- **A Community Health Centres (CHCs) is the secondary level of health care that essentially includes First Referral Units (FRUs) and the district hospitals. 4 PHCs are included under 1 CHC. It was intended to cater to a population of 80,000 in tribal/hilly areas and 120,000 in plain areas .**
- **This was designed to provide referral as well as specialist health care to the rural population like routine and emergency care in Surgery, Medicine, Obstetrics and Gynaecology and Paediatrics in addition to all the National Health programmes.**
- **A CHC should have an anaesthetist, a public health programme manager, a surgeon, obstetrician and gynaecologist, a paediatrician, a public health nurse and an auxiliary nurse midwife (ANM).**

PRIMARY HEALTH CENTRES

- **PHCs act as referral centers for the Community Health Centres. Each primary health center covers a population of 20,000 - 30,000.**
- **Primary Health Centres provides primary health care services which include basic medical care, mother and child health care, safe water supply, basic sanitation, prevention and control of local diseases.**
- **This cornerstone of rural healthcare should have a medical officer, block extension educator, one female health assistant, a compounder, a driver and a lab technician.**

The state government did make services free for people living below poverty line when it introduced user chargers. A patient welfare committee set up by the health centre was to provide financial assistance to the poor. However, Dr Rahman says a number of hospitals have yet to constitute such a committee.

Due to unavailability of services, people move to the primary health centres for treatment, which then comes up in government records as increase in registered cases. There is overcrowding even at the primary health care centres. Instead of 30,000, one single PHC is catering to a population of two lakh people. A sub centre too is looking after a population of 9,000 instead of the stipulated 5,000. Added to this is the fact that posts of doctors and nurses remain vacant.

Finally, in a number of districts there are no hospitals. Only 23 of 38 districts in Bihar have district level hospitals. At the tertiary level, of the 101 referral hospitals, only 70 are equipped for treatment.

If public health is a mess, gag the Press

By Kumar Jitendra Jyoti

STATE OF HOSPITALS

Patna: Can't improve the public health system? Just blindfold the media. At least this is what the Nitish Kumar government in Bihar believes would help put a lid on reports on irregularities in the health system appearing in the media. The state's premier medical institution, the Patna Medical College Hospital (PMCH), recently issued an edict which disallows the entry of the Press into its disarrayed premises.

"Journalists not allowed," says a board placed prominently in the main hall of the PMCH. To ensure that this order is not defied by the Press, the PMCH has even trained its security guards on how to "identify" journalists. Security guards here have been given details on what a journalist could look like and what possible equipment he could be carrying.

Questions to the state health minister Chandrabhushan Rai on this order have drawn a blank. However, hospital president OP Chaudhary says the presence of journalists in the premises creates problems, adding that at times reporters enter operation theatres, which could harm a patient's health. Dr Chaudhary may be right. But this is not the real reason for the present ban on entry of journalists. It is clearly to cover unpalatable facts of the hospital.

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Insiders say the main fear within PMCH with media reporting is that people would learn about doctors missing from duty; resident doctors going off to sleep while on emergency duty; no nurse being present in the ward when critical patient care was required; patients being asked to buy medicines from outside even though the hospital's medical store had enough stocks; no doctor being present to attend to a serious accident victim and medical agents being allowed to move freely in the emergency ward.

These insiders point out that the list of irregularities is endless: complex surgical procedures are carried out without the presence of senior doctors; relatives of critical patients need to plead with doctors to attend to them; junior doctors get aggressive with hapless relatives; doctors strike work at the slightest pretext and when cases of gross negligence are reported by the media, they get vindictive.

The guards here are now very alert to the presence of a snooping journalist. The first question that a doctor asks on seeing a media person is "who allowed you in?" The guards have to face the ire of these doctors if a journalist

has managed to give them a slip.

On the one hand, the Bihar government is talking about transparency at every level of governance and educating people on right to Information Act. On the other, it has taken upon itself to gag the fourth estate of the democracy.

There is no dearth of good doctors at the PMCH. Patients who come here have complete faith in the ability of the doctors. However, people here have not been able to understand this new step taken by the hospital to cover the mess within. In the world's largest democracy lowering the boom on journalists can never be justified.

Sex at 72: Meet Vitthal Prabhu

By Shekhar Deshmukh

CIVIL SOCIETY ROLE MODEL

Mumbai: If political parties do bury their ideological differences it's more often than not on issues of national importance. But on March 30 both ruling and opposition party MLAs in Maharashtra banded together to form a moral brigade. They pushed for a ban on sex education in the State Assembly, saying it was ostensibly corrupting young minds.

They tore sex education books and demanded the subject be banned in schools. The moral brigade was joined by party workers and other political leaders who showed their support through public statements. Understandably, not many in civil society could oppose the decision, even if they supported sex education.

But one man decided to oppose the decision. Meet the fiery septuagenarian Dr. Vitthal Prabhu. At 72, when most people are content to lead a retired life, Dr. Prabhu has decided to battle on as a one-man army against the ban. He has decided to educate people so that an environment for change can be created. He has been spreading awareness about sex education through community meetings, informed speeches and guest lectures.

Dr. Prabhu is reviving memories of the fire-brand Raghunath Dhondo Karve, who started work on sex education way back in 1936, when only the feisty could have taken up the issue in civil society. Karve started a magazine called 'Samajswasthya' (Social Health) on issues related to sex education from Pune. He also worked toward spreading awareness on family planning.

Dr. Prabhu did not wait for the younger generation to take up the challenge. Instead, he decided to be the guiding light. Within a fortnight, Dr. Prabhu succeeded in bringing the masses around to talking about sex-related issues in schools. However, he has not been able to convince government officials. "I am trying to sell mirrors to those who are blind," he says. Irrespective of which party is in power, given a chance, every leader likes to do moral policing. The

FOR THE RECORD

March 30, 2007: "Sex education will tarnish young minds; Indian culture is under threat." This was the pretext under which MLAs of both ruling and opposition party tore apart books on sex education at the assembly session.

March 30, 2007: State Education Minister Hasan Mushrif announces a ban on sex education in the assembly.

Teacher's training programme for sex education is cancelled.

March 31, 2007: All MLAs welcome this decision wholeheartedly. "Instead of giving health related information this was a plan to bring in immorality. If such a step is taken again then Shiv Sena will handle it in a way known to them" *(Maharashtra Times)*

March 31, 2007: "The decision is a victory for those who are trying to create a virtuous and evil free society." - Feroz Patel, Students Islamic Organisation of India *(Hindustan Times)*

March 31, 2007: "This is nothing but an effort to create sex gurus in school" - Nawab Mallik, MLA, National Congress Party *(Hindustan Times)*

April 8, 2007: "Instead of educating students of Standard IX and X and trying to clear their misconceptions, it is better to train the girls in martial arts that would help them in self-protection." - Dr. Shobha Bachchav, MLA, Congress *(Maharashtra Times)*

April 6, 2007: On April 5, 2007 the controversy took a U-turn, when education minister Professor Vasant Purke suggested in the assembly the decision related to sex education be reconsidered. He said that sex education should be a part of curriculum in schools. Opinions of social scientists, educationists and NGOs would also be sought. (Professor Purke was not present in the assembly on March 30, 2007) *(Times of India)*

same has happened this time around."

"Leaders are misguiding the young generation of today by taking the 'popular' decision," says Dr. Prabhu. Banning sex education by the Maharashtra government is wrong, he says. As someone who has been working in the field of sex education for the past 30 years, he believes the leaders are naïve. He does not agree that the government has pandered to popular sentiment. "The government is being presumptuous. Whenever I have addressed a gathering on the issue of sex education it has been well received," he says.

Dr. Prabhu did not wait for the younger generation to take up the challenge. Instead, he decided to be the guiding light. Within a fortnight, Dr. Prabhu succeeded in bringing the masses around to talking about sex-related issues in schools.

MLAs opposed to sex education say they do not have anything against sex education as such. They have a problem only with the content. Dr. Prabhu agrees with the criticism. "The syllabus on sex education should be drafted keeping our needs in mind," he says.

Dr. Prabhu agrees. He has worked on a syllabus that is sensitive to the needs of the younger generation and the Indian culture. He recently presented a book with his syllabus on sex education to the Education Minister Prof. Vasant Purke. However, there has been no response from the government. And this has led him to question the government's intentions.

Buried in government's own files is a report by an expert committee that details how sex education should be imparted. In 1996 the State Commission for Women formed a committee headed by a former Vice Chancellor of Mumbai University, Professor Ram Joshi, to come up with a workable plan. The committee had given a report based on suggestions from educators, social scientists and teachers.

The report addresses the issue in a people-friendly manner. It says sex education should be renamed 'Kutumb Jeevan Shiksha' (Family Life Education). This education should be given step-by-step to students from Standard V to X. This subject should be optional. The report recommended separate classes for boys and girls. It said only teachers who were comfortable teaching the subject should be given this training. It also suggested covering subjects such as social and cultural development and responsible parenthood. It suggested that the subject be divided into the following sub-headings: physical growth and development, sexual behavior, inter-personal skills, relationships, sexual health, society and culture.

Unfortunately, the report was not even discussed in the Assembly. Dr. Prabhu, who was also part of this committee, says the state government did not show any initiative. The State Commission for Women did not bring it up either. When Dr. Prabhu called up the office of Women's Commission and inquired about the report, the man at the other end of the phone had a shocking yet revealing answer - "the file is lost."

Despite the absence of political support, Dr. Prabhu is not ready to give up his mission as he believes that sex education is the very basis of a healthy and happy society.

THE STORY OF KALA-AZAR: Few care for a disease that mostly affects the poor

By Mammen Mathew

POLITICAL APATHY

Patna: During Operation Desert Storm against Iraqi dictator Saddam Hussein, a paratrooper commando contingent came down with high fever and splenomegally (enlargement of the spleen). Initially, the best doctors failed to give it a name.

Eventually, it was found to be a variant of kala-azar. French scientists are now studying this strain. Even so, kala-azar remains a third world disease largely "irrelevant" to the rest of the world. Ninety per cent of cases are found in Jharkhand, Bihar, in small banana Republics in Latin America and remote interiors of Africa.

Sadly, kala-azar has not just been neglected by the rest of the world, but also by the rest of India and even the government of Bihar. Like HIV, it weakens immunity and makes a person vulnerable to a host of other diseases. It targets mainly the under nourished, the poor and children. Therefore, mortality is high.

The lack of seriousness with which it is treated by the political leadership in Bihar was aptly summed up when the former chief minister, Laloo Prasad Yadav, while speaking at a conference organized by the Association of Physicians of India said, "I fail to understand how a sand fly which can fly no more higher than six feet could travel over the Ganga to Patna and afflict us." As a preventive measure, he recommended a measure that often leads to its spread -- use of

cow dung.

It seems the former chief minister was not aware of a study conducted by the Calcutta School of Tropical Medicine which found that kala-azar cases were more common where khatals - or cow pens - were in close proximity to residential areas. Often, the poor in Bihar share sheds with the cattle. Within homes, a common practice was to resurface the walls with cow dung paste soon after DDT was sprayed in the area to kill the vector.

Former Union Minister for Health, Dr C.P. Thakur, who has considerable work to his credit on kala-azar, is now concerned about Jharkhand. He believes that Jharkhand with its high migration levels and slowdown in malaria control efforts may soon be in for "big trouble". The directorate of health services confirms that seven of the 22 districts in Jharkhand are seriously affected. Among them the Sahebganj and Dumka-Deoghar areas are the worst affected. Interestingly, in 1984, when Sahebganj was spraying DDT three times a year to control malaria it also managed to control kala-azar.

In 1992, Union Health Minister, M L Fotedar, made kala-azar a notifiable disease. However, there has been no effort by either Jharkhand or Bihar to encourage doctors to report kala-azar cases. Experts also point out that there is no reason for Jharkhand to believe that its mainly hilly and fresh forest cover, lesser waterlogged bodies than in the plains of North Bihar would save it from the menace.

The Union government directive to form committees and entrust village heads with spraying work failed to work as DDT was sprayed in economically well off localities in the village while the hamlets of the poor were given short shrift. Spraying too was irregular. DDT was either sold in the market or left to expire in government godowns. Malaria workers or casual labourers drafted for spraying were often not paid and, thus, they shirked their work.

In 1989, the Centre proposed a shared outlay of Rs 8 crore for spraying the then undivided Bihar. However, the state failed to meet its share. In 1990, the spraying cost for the same undivided area was pitched at Rs 22 crore. In 1995, the National Institute of Communicable Diseases proposed a whopping cost of Rs 125 crore for spraying and peripherals.

The Union government directive to form committees and entrust village heads with spraying work failed to work as DDT was sprayed in economically well off localities in the village while the hamlets of the poor were given short shrift. Spraying too was irregular. DDT was either sold in the market or left to expire in government godowns. Malaria workers or casual labourers drafted for spraying were not paid either. This was the main reason why they shirked work.

The failure of the kala-azar strategy as realized in a 1996 meeting hosted by Indian Council of Medical Research (ICMR) and the National Institute of Communicable Diseases (NICD in New Delhi, were mainly due to this partial implementation of the spraying calendar as also unplanned and haphazard spraying, leaving out the loci or potential sand fly populated areas, non-treatment of water logged areas and failure of the Revised Malaria Control Strategies.

In fact, the meeting pointed out that besides cerebral malaria and quinine resistant malaria, newer trends were visible where malaria of industrial areas and rural areas of Jharkhand differed. Short and uneven spraying was responsible for newer-resistant malarial strains which were coming up with a vengeance.

As a result of this neglect, the number of untreated and resistant cases continued to climb. Treatment by quacks, dilution of doses or wrong treatment contributed to this

KALA-AZAR FACTS

Researches suspect there are now several and region- specific-kala-azar variants in Bihar
-DR. C.P. Thakur, WHO Consultant

The same drug, as prescribed for the vector, Phlebotomus argentipes, may not be able to cure all variants of the disease
-Calcutta School of Tropical Medicine

Forty per cent of the deaths in Kala-azar are due to rising toxicity levels and medicines
-Dr T. K. Jha

Kala-azar parasitic indicators identified in cerebro-spinal fluid (CSF)
-British Medical Journal: Dr Sandeep Sen

Kala-azar in combination with TB & AIDS is potentially the biggest threat facing people in Bihar and Jharkhand this century
-National Institute of Communicable Diseases Data

Kala-azar targets the poorest socio-economic groups and children
-ICMR

There is a co-relation between cow pens and the presence of sandflies
-Calcutta School of Tropical Medicine

THE ITALIAN LINK

It might have been Leishman Donovani, an Italian who isolated the Ph. Argentipes and after whom the deadly disease Lieshmania Donovani got its doll like name in the West. But then pharmaceuticals, driven by the business of profit, have not been able to come up with an answer to the disease which never affected Europe or the Americas.

Popularly known in the 19th century as "Burdwan fever", Kala- Zar (Black Fever) claimed over two lakh lives in the 1880's in Assam, Bengal and Purnia. Around 1974, 25,000 people succumbed in undivided Bihar, with Sahebganj, now in Jharkhand a victim too.

increase. Dermal leishmaniasis or skin kala-azar reservoirs have never been estimated or identified wherein a person could have the kala-azar vector lodged in his skin and could spread it while remaining immune himself.

As it remained confined to the third world, no multinational pharmaceutical company invested in research on effective drugs. Drugs came up largely through efforts of local medical scientists. Urea Stibamine is believed to have saved a lot of lives during the fifties and sixties. But the medicine died with the death of its inventor Dr U.N Brahmachari. In the seventies, sodium stiba gluconate (SSG) came to be prescribed.

But this too is proving to be ineffective as well as highly toxic. Renal failure (liver failure), myocarditis, (heart attacks), loss of hair and impairment of vision are among some of the toxic effects. Dr T.K. Jha, an expert at Muzaffarpur, after a ten-year study pointed out that over 40 per cent of patients were dying due to side effects of the drugs.

Few realize that migrant workers from Bihar have taken the disease as far as Chennai, Pune, J &K, UP Terai, Ghaziabad, Mirzapur and Varanasi in UP, Bengal, Rajasthan and New Delhi, where hundreds of cases have been reported. The Jharkhand Government could do well to learn from the mistakes of Bihar and implement the strategies correctly and on time.

Malnutrition deaths not reported as issue acquires political tones

By Dipti Raut

POLITICAL APATHY

Nashik: Maharashtra's Human Development Report 2002 published by the state Planning Commission says that malnutrition and childhood deaths are the biggest obstacles in the industrial and economic growth of Maharashtra. While saying so, the Congress-NCP government has accepted that malnutrition amongst children is a major problem.

When the same alliance was in opposition, it had severely criticized the Shiv Sena - BJP alliance for child deaths in Mokhada and Chikhali village. Does it make the ruling party more sensitive to the issues and change anything at ground level? The answer sadly is no. The problem of malnutrition is as severe as ever.

The issue generally crops up every monsoon season. Diarrhea, cholera and pneumonia strike rapidly in poverty-infested areas of Maharashtra. As child deaths increase, they start occupying headlines and provide an issue for opposition parties to discuss. For some days the issue causes pandemonium and adjournments in the Assembly. The government then promises an inquiry committee and treatment for children and the matter is put away until the next monsoon season.

Not surprisingly, it does result in some media attention on the issue. But that generally translates into victimization of a few and desperate attempts to hide the figures. This came to light after a committee appointed by the government following a Mumbai high court directive went to some affected areas. Headed

MALNUTRITION

Year	Govt figures	NGO figures Loksangharsha Samitee, Nandurbar district, Maharashtra
2004	43	366
2005	15	146
2006	57	514

This survey was done in 14 tehsils of Nandurbar district where government figures acknowledge rate of malnutrition to be as high as 66 per cent.

CHILD DEATHS IN MAHARASHTRA DUE TO MALNUTRITION

Year	Deaths
2004	1189
2005	1085

(Figures submitted by Govt. of Maharashtra to high court of Bombay)

by Dr. Abhay Bang from an NGO, Search, the committee found that in tribal and remote areas of Gadchiroli district, childhood deaths due to malnutrition shown in government records were only a miniscule number of the "real" figure. Health workers are not informing the government about the deaths as it only leads to their suspension order without any constructive changes in facilities provided to them.

The issue needs to be tackled at several levels: One, these deaths are not a medical problem alone. The health department needs to work in close coordination with the women and child welfare department. Doctors in the medical department and anganwadi workers in the women and child welfare department are supposed to work together to check malnutrition under the Integrated Child and Development Programme. However, none of them are willing to take up the responsibility. In fact, at the time of any crisis, both these departments are busy transferring their responsibility on to the other.

Two, under the Integrated Child Development Programme, anganwadi workers need to record the name and weight of every child under six years of age in their village. Extreme cases of malnourishment are then supposed to be sent to a primary health center for treatment. And children who are not so sick are provided nutritional food and first aid at the anganwadi centre itself. However, often anganwadi workers do not even have the scales to weigh the children.

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Three, doctors are often not available at the primary health centres. If the delay in treatment results in the death of a child, it is the anganwadi worker who gets suspension orders and not the doctor. As a result anganwadi workers fudge figures and show far fewer cases of undernourished children. Consequently, mildly undernourished children do not get any notice until they reach severe forms of malnutrition.

Four, the situation of medical officers in primary health care centres or government hospitals is not quite different. In their busy schedule of visiting two to three villages, running immunization programmes, government meetings, filing reports and others, medical officers feel overloaded with their responsibilities. Malnourished children are often brought to a hospital when they are critical. If the doctor manages to save the child, rarely gets appreciation, but in the eventuality of a death, the doctor is blamed. Therefore, doctors either do not admit children who come when they are critically ill or register them as cases of pneumonia or another disease.

Five, malnourished children are often born to malnourished mothers. Most of it is directly related to poverty and girls' education. Comprehensive planning is needed to look at the problem with its multi-faceted dimensions.

Head of the health department at the Yashvantrao Chavan Maharashtra Open University, Dr. Shyam Ashtekar, says that malnutrition is a social issue rather than health issue. In tribal and remote areas where employment is not available, there is neither food security nor money to buy food grains. The problem of malnutrition gets worse at such places where there are no roads to bring food grains or medicines and parents need to migrate to earn their livelihood.

In fact, last year, the Mumbai high court, too, observed that the "problem of malnutrition is directly connected to the buying capacity of the family and the problem is very severe in those districts where the Employment Guarantee Scheme has not been implemented properly." No action has been taken to solve this problem.

One constructive step the government took was to provide a day's wages to parents who bring their malnourished children to the hospital to compensate for the loss in earnings. However, there are some other short-sighted policies that have been implemented which do not help people in the long run. For instance, nutritional meals in hospitals are provided only to scheduled tribe children as money is available through the Schedule Tribe Development commission. But there is no provision to provide food to another poor child who may not fall into scheduled tribe category.

Another knee-jerk effort is a 'Nutritional Home' scheme. Launched as an experiment, the government plans to set up a 'Nutritional Home' in villages with a large number of malnourished children. Mother and child will be provided food, medical treatment and safe drinking water in this home until they recover. However, such a scheme will only serve to isolate people from their community and will not be sustainable in the absence of participation from the village.

Now polio reaches J&K

By Toufiq Rashid

EMERGING CONCERNS

Jammu: After remaining free from Polio for more than three years, the U.P polio strain has reached as far as Jammu and Kashmir. In what the state called a `worrying development', Jammu and Kashmir has reported its first case of polio during end of December 2006.

This was the time when about 14 cases were detected from the rest of India, taking the number of cases of children affected with the disease to 624 in 2006 - a very high number compared to the 66 reported in 2005.

According to officials, it was the first case of polio from Jammu and Kashmir, an area which was considered to be one of the low risk areas for the disease. The disease was detected in a five-year-old baby girl in Jammu. According to an official who requested that he not be named, the girl was from a very low economic background and had the history of visiting Uttar Pradesh recently.

Another reason for worry is that Jammu and Kashmir is a border state sharing border with Pakistan-which along with India, Afghanistan and Nigeria are major sources of polio in the world and the border state might see more infection.

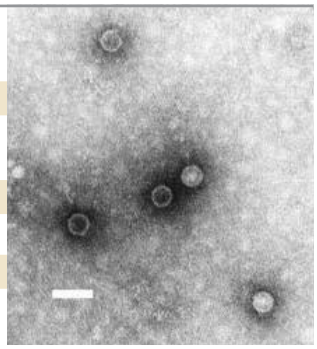
"The recent surge in the cases in north India is a cause of worry. The first case from Jammu is a clear indication that the polio strain is constantly covering new grounds," an official said. The immunization drive however has been very satisfactory in the state. According to official figures there has been more than 95 percent coverage in the state.

"Unlike Uttar Pradesh, the Muslim Majority in Kashmir is not against immunization. Even routine immunization here is very good," the official added. The immunisation drive seems to have yielded results already. As India has already recorded 21 cases across the country-with 8 in Uttar Pradesh, 9 in Bihar, 2 in Andhra Pradesh, one each in Maharastra and Haryana, Jammu Kashmir has remained safe this year.

The last case date remains December 17, 2006.

"The recent surge in the cases in north India is a cause of worry. The first case from Jammu is a clear indication that the polio strain is constantly covering new grounds."

POLIO VIRUS



- The polio virus lives in the throat and intestinal tract of infected persons.
- The virus enters the body through mouth, usually from hands contaminated with the stool of an infected person.
- Objects, such as eating utensils, can also spread the virus.
- Food and water are not thought to play a major role in the spread of polio.
- The polio virus attacks the nerve cells that control muscle movements.
- Many people infected with the virus have few or no symptoms. Others have short-term symptoms, such as headache, tiredness, fever, stiff neck and back, and muscle pain.
- More serious problems happen when the virus invades nerves in the brain and causes paralysis of the muscles used in swallowing and breathing.
- Invasion of the nerves in the spinal cord can cause paralysis of the arms, legs, or trunk.
- Symptoms usually start 7 to 14 days after exposure to the virus.
- Infected persons are most contagious from a few days before to a few days after the start of symptoms. However, persons with polio can spread the infection for as long as the virus is in their throat or stool.
- The virus can be found in the throat for about 1 week after infection and in the stool for 6 weeks or longer.

Is a new TB strain cause for concern?

By Shivani Parihast

EMERGING CONCERNS

New Delhi : A lethal new resistant strain of tuberculosis which has claimed several lives in a South African province is forcing public health experts to forewarn that a deadly new tuberculosis pandemic may be round the corner. This new strain of extensively drug-resistant tuberculosis (XDR TB) was detected in Tugela Ferry, a rural town in South African province of KwaZulu-Natal (KZN)in September last year.

Indian experts, however, do not agree with such doomsday predictions. Deputy Director, Tuberculosis Research Centre, Chennai, Dr. Soumya Swaminathan, says that India does not need to panic. ``It is unlikely," she says. The outbreak of XDR-TB KwaZulu-Natal happened in a group of people living quite closely. Former head of medicine at the All India Institute of Medical Sciences and a well-known expert on TB, Dr J.N. Pande says: "Multi-drug resistant TB(MDR TB) has been known in India for a long time," he says.

In multidrug resistant TB, the bacillus becomes resistant to the two known potent drugs - isoniazid and rifampicin. The difference between the new virulent strain and the multi-drug resistant strain is that it is resistant to the second line of drugs as well -- injectables known as fluoroquinolones. These experts add that they have seen several cases that are resistant to this last line of defense. But that has not led to any large-scale spread of the resistant strain, they say.

A lethal new TB strain is cause for concern. India already has a huge TB burden - about a third of the global cases. The Directorate general of health services estimates in its report that more than 20,000 people get infected with the tubercle bacillus each day. Of these, more than 5,000 develop the disease and more than 1,000 die from TB. In India, tuberculosis kills 14 times more people than all tropical diseases combined, 21 times more than malaria, and 400 times more than leprosy. Every year, another 20 lakh people develop tuberculosis in India, nearly one million of them highly infectious sputum positive cases - two such cases developing every minute.

TUBERCULOSIS IN INDIA

20 lakh	**people get infected every year**
10 lakh	**highly infectious sputum positive cases every year**
20,000	**people get infected everyday**
5,000	**people develop the disease everyday**
1,000	**people die from TB everyday**

Source: The Directorate general of health services estimates

''The only way to check the lethal strain from coming in is to improve adherence of multi-drug resistant TB patients," says Dr Swaminathan. Drug resistance usually happens when patients stop taking the medicine before they have been cured. For this reason, the government introduced DOTS. (Directly Observed Treatment Short Course Strategy) While this has improved compliance, it does not ensure that adherence for all. Patients drop out from the line of treatment as they are unable to go to the DOTS centre regularly. Also, the side effects are too many (nausea, vomiting and in certain cases even deafness).

Ensuring compliance for multi-drug resistant patients is even more completely. One third of these too drop out in the middle of the treatment. The medicines priced approximately at a lakh and a half rupees, need to be administered over a period of one and a half to two years, in combination with other necessary parenteral drugs; this renders the medicines out of reach for the less privileged Indian. Moreover, it is not available for free under the government programme. "These second line of drugs are more toxic having such contra indication as nausea, vomiting and gastritis" says Dr. Swaminathan.

TUBERCULOSIS KILLS...

14 times more people than all tropical diseases combined

21 times more people than malaria

400 times more people than leprosy

Source: The Directorate general of health services estimates

The good news is that XDR-TB is not more communicable than ordinary TB or MDR-TB, says Dr. Swaminathan. Also, the doctors treating these patients do not stand a higher risk of contracting the infection, unless their immune system is weak.

An outbreak of XDR-TB especially among the HIV positive people, as it happened in South Africa among the gold miners, is unlikely to occur in India, says Dr Pande. Hence XDR TB does not pose a greater risk to the HIV positive people as compared to any HIV negative person. However, the treatment for XDR-TB among the HIV positive people can be a lot more challenging.

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