Subject: **How to think about chronic diseases for the mid annual?**

What are the different ways in which to approach the chronic diseases question based on different conversations with Anand, Yogesh, Malini, Sathya and Anurag. Some discussion on these aspects would help us understand the problem in the mid annual. Please feel free to add...

1. Clinical questions -- the specificity of the disease, regional variations in presentation and disease progress, prognosis, etiology.
2. Epidemiological questions -- projections, accuracy, 'disease mongering?', how do these connect with the clinical ones, what are the links between the rural and urban in the patterns of the disease? How do we think of urbanization in relation to NCDs?
3. Public health questions -- existing PH initiatives for NCDs in India, structural questions on PH's capability to work with NCDs, what are examples and models of successful handling of PHs in the third world and the rest.
4. Patient experiences -- what do patients face with chronic diseases, how to think about the change in life experience of the patient with the progression or efforts to stall the progress of the disease, difficulties with diet, medication, life practices.

Srivats

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Shall I also add recording and reporting of chronic diseases? urban v/s rural?

Dhruv

--

Would be useful to look at how caste, gender, poverty influence experience of and access to treatment of chronic disease, especially the life style modification component.

Subha Sri

--

You have brought in the regional variation angle. Do existing manner of collecting data on chronic diseases enable us to detect variation by gender?

Padmini

--

I have a basic question-- in the description below-- chronic diseases and NCDs are used inter-changeably. Is our focus going to be on NCDs (in which case I suggest we stick to NCDs) or on chronic diseases (in which case TB, HIV etc will fall in the ambit)?

Also, important are the nutrition questions, the questions of linkage to mental health (esp depression). And appropriateness of treatment options (one sees both over-treatment and mis-treatment in NCDs-- especially a choice for more costlier options when cheaper options would suffice)

Anant (B)

--

Basic question first, Anant: I used the term chronic diseases and then didn't want to shorten it to CD because it could mean communicable diseases! That is why NCDs. When we first thought of the question, we thought of excluding TB and cancers, because each of those topics could take a full session in themselves, and TB has been discussed in the past. I would say HIV too should be excluded, not because it is unimportant but because it is a full and complex field in itself deserving a full annual discussion. But it is open to discussion to fix the ambit of the theme.

May be we want to limit the discussion to those theorized by the epidemiological transition -- heart diseases, strokes and diabetes, specifically?

Treatment options are crucial aspects of the discussion -- especially in relation to heart diseases.
Nutrition would be extremely important no doubt and would deserve a full exploration in this context, both in relation to heart diseases and diabetes and their interrelation.
Also Padmini, questions of gender are not too often probed in the Indian context, though I did see a small study in Bangalore which did comment on the problems the poor and women faced in relation to medication.
Yes Subha -- caste and gender are important dimensions.
Also Dhruv -- recording, reporting of chronic diseases, the difficulties of recording and reporting the complexities of practice, etc..
And also, please anyone who is interested in offering to be part of the organizing theme to decide content, authors, presentations, etc., please feel free to volunteer :-)
Srivats
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Sickle Cell Disease would count as a chronic disease I believe the situation of a community practitioner and of the patient is the same for any disease for which medicine is needed life long. So Diabetes and AIDS face the same problems of long term treatment, repeated testing, medicines running out In this they differ from malaria Leprosy needs medicines for less time- but still needs a long time follow up In that sense it behaves like a post operation malignant tumour from the point of view of a patient or the family practitioner.
Prabir
--
I do not know if it fits within one of these or as a separate theme but I think one could add:
Children and youth - how does it need to fit into policies/ preventive measures for the future generations (what exists and what needs to be done)
Gracy Andrew
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There are certain neglected chronic diseases that need attention:

- Leprosy , Sickle cell anaemia fall in that category and if some one takes responsibility they could be included
- Tuberculosis Policy is being revised in view of emergence of irrational treatment , emerging MDR , stock outs of medicines , gender dimension in TB malnutrition & TB addressing this would also be useful amongst others . Anurag if he can del with it , it will be great .
- Mental Health issues addressing the chronic aspects to ensure continuity of engagement of MH group and addressing of issues that need to be addressed in terms of long term care .
- I would personally like the inclusion of corporate junk food industry & their role in contributing to NCDs or chronic health problems Diabetes , Hypertension/CVDs .etc
- Dealing with Diabetes in all its dimension as Anand Zach can do will be great .
- Asthma, Chronic Obstructive Lung/Pulmonary disease doe need addressing , association with pollution , allergies , toxic polluting cooking fuels , occupational health hazards associated with silicosis pneumoconiosis (continuation of earlier meets),Parthenium ,etc Availability of affordable essential medicines and their rational use . , role of other systems of medicines .

Mira

Another interesting feature of changes in COD from infectious to chronic diseases
http://www.nejm.org/doi/full/10.1056/NEJMp1113569
The Burden of Disease and the Changing Task of Medicine David S. Jones, M.D., Ph.D., Scott H. Podolsky, M.D., and Jeremy A. Greene, M.D., Ph.D.

Thanks and regards
Dhruv
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Dhruv,
Your second article has an extremely interesting analysis, which is verging on accuracy, but flails at the attempt to provide a synthesis of what needs to be done. Perhaps this is inevitable given the complexity and intractability of modern life.
The first article link is too glib and very thankful to god that we are so much better off -- am much less impressed!

Srivats

Re gender in/ and medicine ...resource: www.gme-cehat.org
Padma
--

Not many of us would like a philosophical perspective in response to your correct comment about 'need for synthesis about what to do. Anant's response in the vaccine and its -ation debate had a strong philosophical/ideological viewpoint. Even, the analysis in NEJM's article isolates 'medical interventions or causes' without looking upon factors which lead to such causes and lifestyles. Because they are considered as given, essential or inevitable existing factors.
Dhruv
--

You must be aware of the pressure being put on editor of Lancet because of publication of UN Reports & Physicians of Human Rights on killing of children in Gaza . Please do look at the open letter in Lancet & also BMJ editorial by Dr John Yudkin about it . Pressure is being put on Editor Lancet to retract it . Gagging of Medical Journals is something we all do not support , in fact raise our concern & objection to it .
I think those who feel this needs to be responded to should do so .
Regards
Mira
--

But the first article at least admits that there is inaccuracy in CODs in death certificate in US physicians. We have been blaming our docs only.
Dhruv
--

Mira,
Two rights do not make a wrong. Yes we shld support this.
But I am annoyed with the lack of open access to papers in Lancet, BMJ and the so called Big 4 or 5. We natives go out and support them in distress. But the gates are closed for the natives to the papers and research of the Sahibs. Much of it research on natives like the Gaza children. It is a kind of IP barrier. And lack of transparency of a kind.

Even PloS I am told you have to pay to get your paper published. After the peer review process etc.
Since you know the Yudkins of the world, pl put this point across if you will and if you can.
Chinu
--

Agree with Chinu, lots of articles in Lancet, even those relevant to social equity, global health, low and middle income countries are often behind a paywall (and a hefty one at that)
I have found BMJ more responsive to appeals or recommendations to make certain article open access (if you contact the editors).
Plos always followed the author pays model for making its articles open access. Authors from LMICs can ask for a waiver or a reduced publication fees (also for Biomedcentral journals)
Chinu, There are also sahibs within natives. They would prefer publishing in the journal "abroad", hardly writing much in the journals published from India by groups in India - in fact I am told repeatedly that you cannot be a sahib for the natives; or the native sahibs will not take you seriously if you do not have foreign degrees and papers published in the biggie foreign journals.. So don't discount native's love for all foreign, including recognition there. A paper on India published in Indian journal is not supposed to make as much impact as the paper published on India in a journal abroad. So Indian journals cannot be international but the international journals can be Indian. This is what the publisher MNCs have done.
Amar
--

There is a hierarchy in Indian indexed journals too!
Dhruv
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For Mental health- can we focus on “Addressing the treatment gap”
For Tuberculosis- community health initiatives in improving access and adherence, along with the other topics already mentioned

I do not know if it fits within one of these or as a separate theme but I think one could add:

Tasneem

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I fact if MFC is discussing TB at all, it should discuss its relation with occupational hazards and/ or pneumoconiosis. We see huge numbers of pneumoconiosis patients being treated as TB patients , even if smear is negative they are put on AKT. Pneumoconiosis is NCD AND that must be included I the,list of the topics
Jagdish
--

The commonest risk factors for tb are smoking, malnutrition and diabetes.
The vulnerability factors of barriers to access to health services, poverty, delay in diagnosis and lack of airborne infection control can also be included. Satyameva jayate was a landmark advocacy in breaking the ice on the common neglected disease - TB, and we need to take the dialogue forward in our agenda.

The issue is impact of war not publication of papers . Ravi Narayan had sent communication about this . I don't believe in gagging of Medical Journals , for publishing UN Reports & Reports of Physicians for Human Rights .
I am aware of Russel Tribunal on Palestine and the various other reports UNOCHR UN Office for the Coordination of Hu John Yudkin who had worked in Tanzania & showed how majority of the Aid being given was in different ways returning to the Donor Countries . Dr Zafrullah Chowdhury where we first met Travelled to Rajshahi Medical College from Savar for taking sessions on Rational Drug Policy And Essential Drugs . I know him since then 1981 & have deep respect for him an his wife Gill for his contribution in health & human Rights .
Speaking up when it can have professional implications is not easy for everyone .. specially when being Jewish you speak up for deaths of women & children in Gaza .
You don't have to respond it is fine .
Mira
--

Yes MIra I said in the first line we shld support the cause.
Chinu
--

I suppose one has to live with it. Natives are complicit with the sahibs. You can't be conquered unless somepart of you is willing.
That is how we got ruled by koi hai and Chota and bada hazri wallahs.
Chinu
--
The positive side is reinventing the (first) wheel results in inventing the other 3 wheels.
Chinu
--

In addition to the points that are emerging, we may like to think of the following:

- The 'up-stream factors' or societal determinants of chronic diseases. For instance this would include the food industry and the marketing of high sugar/salt/fat content foods that result in obesity hypertension etc. The shift from 'agriculture' to 'agribusiness' also has a role to play. These factors are more complex such that health workers/doctors and the health system feel helpless and unable to influence them, even if the role is understood. The food industry however has no such difficulty and works with professionals and international bodies including the WHO to change recommended daily requirements, norms to diagnose hypertension, etc etc.
- A community health approach to chronic diseases wherein health promotion and life skills education play an important role to increase health literacy, followed by measures to enhance the autonomy of patients, families and communities when the disease process has commenced; and a role for inter-disciplinary teams and community health workers to support life style changes. This may sound very idealistic but is work in progress in many countries and in pockets here.

Thelma
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What is present here appears to be a nice framework which would allow to cover a lot of ground in the annual meet on NCD. I also agree with the suggestions by Thelma and Jagdish. I would like to suggest two

sub-topics for considerations – you and the group that would be coordinating the thematic content of the meet.

1. I came across a paper (see below the abstract i have pasted. i have sent the said paper to Srivats for uploading in the dropbox. Happy to send on individuals emails ids if you let me know) which speaks of adverse consequences of public health interventions and the need to respond to this issue at the intervention design level as an ethical imperative. This, to the best of my knowledge, is rather less talked about. It is a cause of concerns especially given the growing trend of using RCTs for testing various public health interventions. (Poverty Action Lab/MIT is an example). It would be relevant to include this sub-topic in the annual meet in the context of NCD. If we decide in favour of its inclusion, I would like to do a small paper on this sub-theme.

Bonell C, Jamal F, Melendez-Torres GJ, et al. J Epidemiol Community Health 2015;69:95–98.

ABSTRACT

Although it might be assumed that most public health programmes involving social or behavioural rather than clinical interventions are unlikely to be iatrogenic, it is well established that they can sometimes cause serious harms. However, the assessment of adverse effects remains a neglected topic in evaluations of public health interventions. In this paper, we first argue for the importance of evaluations of public health interventions not only aiming to examine potential harms but also the mechanisms that might underlie these harms so that they might be avoided in the future. Second, we examine empirically whether protocols for the evaluation of public health interventions do examine harmful outcomes and underlying mechanisms and, if so, how. Third, we suggest a new process by which evaluators might develop ‘dark logic models’ to guide the evaluation of potential harms and underlying mechanisms, which includes: theorisation of agency structure interactions; building comparative understanding across similar interventions via reciprocal and refutational translation; and consultation with local actors to identify how mechanisms might be derailed, leading to harmful consequences. We refer to the evaluation of a youth work intervention which unexpectedly appeared to increase the rate of teenage pregnancy it was aiming to reduce, and apply our proposed process retrospectively to see how this might have strengthened the evaluation. We conclude that the theorisation of dark logic models is critical to prevent replication of harms. It is not intended to replace but rather to inform empirical evaluation.

2. It appears health of migrants is also somewhat less studied. The ever stronger forces that push more and more workers into un-organised sector possibly also have been impacting the incidence and prevalence of NCDs. This may be covered under the framework you present. I just wanted to mention this point so that if there is work in this area it will be worthwhile for the group to learn more about it.

Sunita

--

Somewhere, we had mentioned NCD and development incl. Urbanization to be included.

Dhruv

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That's right Dhruv. The second sub-topic I mentioned might be covered under urbanization. However, this leaves out issues of workers and labour force in rural, and smaller townships. While sugarcane labour issue has been looked into extensively I am uncertain if farm labourers, labour in horticulture and allied industries have studied adequately for their health. They might have been which I am not aware of.

Sunita

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Well agriculture labourers itself is somewhat unorganized sector. Many agriculturalists themselves are labourers.

Dhruv

--

We can add brick kiln workers to the list that Sunita presents
Jagdish
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I have uploaded Sunita's paper into the MFC dropbox see link:

https://www.dropbox.com/s/85l7oiyoj53syp8/Bonell%20on%20dark%20logic%202014.pdf?dl=0

Srivats
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forwarded a mail conversation between Anurag and Srivats on the subject of chronic diseases:

Dear Srivats,
I saw your mail about the MAM and I had thought about responding in some way, but find it increasingly difficult abstracting my daily experience with people and their illnesses into words and issues for discussion. After more than 25 years as a practising doctor i can say that diseases no longer interest me primarily, although they continue to perplex me. I am more interested in people and am saddened by the constant visitation of disease on a poor population(much of which is avoidable) and the destruction that follows.Differences between acute and chronic diseases, communicable and non-communicable diseases,undernutrition/ tuberculosis/ diabetes/hypertension/mental health are in a sense specious and artificial as they are all linked in ways that we either deny or perhaps do not recognise, and which most often affect the same groups of people in terms of frequency or impact.In India acute illnesses in family members have long -lasting and devastating impact which is no less than the effect of chronic diseases, while chronic diseases like diabetes present with acute complications -thousands in India lose their limbs to diabetes or develop TB due to uncontrolled diabetes.In terms of some risk factors for diseases, should we assess the effect of smoking in terms of heart attacks(acute disease) or chronic lung disease or cancer, or the effect of alcohol on road accidents(acute effect), liver disease(chronic effect)?. We can safely say that for a large proportion of our population with the state of public health and healthcare in India, there are preventable diseases which are not prevented and treatable diseases which are not treated.
I am offering some narratives related to patients that i am seeing currently as an illustration of linkages between social conditions & diseases,some provocative comments on diabetes, and some thoughts on collective action.

- A 44 year old non-hypertensive, non-smoking, non-alcohol consuming small time property dealer who was intensely worried about repayments collapsed suddenly. Our evaluation showed a large brain hemorrhage on one side that compressed brain tissue enough to result in brain death. He was also found to have a blood sugar of 420 mg/dl for the first time in his life. No hypertension could be recorded. CT angiography did not reveal any reason for the bleeding in the brain. He leaves behind three daughters and a son.

- A 28 year old woman from the hills developed a psychotic illness after delivery. Inspite of being on psychotropic medication she did not improve and tried to hang herself. She survived but developed a stroke on one side because of possible injury to her carotid artery. Now she has both kinds of disabilities. There are 2 children under five and a devoted husband who await her recovery.

I have seen people with TB develop permanent disability of the lungs, permanent blindness as a complication of meningitis, and have 2 patients with their intestines opened onto their abdominal walls because of intestinal TB. Communicable disease leading to non-communicable sequelae of a horrific nature. Diabetes is not a disease but a syndrome. There is a diabetes of the rich and a diabetes of the poor.The latter is possibly not linked to obesity directly, but to maternal undernutrition, low weight at birth and lifelong intake of a diet which does not result in normal growth, but which can lead to abdominal adiposity with urbanisation or its equivalents.
We may discuss themes for an annual meet, and i know that MFC acts like a thought current rather than a collective for action, but the situation on the ground with a non-existent public health system and a rapacious private sector is intolerable. A very frequent event in my own experience is of people breaking down saying they have nothing left, of families taking away very sick patients home to die. Only God knows how many never approach a hospital.
I think somewhere & somehow we have to rekindle our original vision of ensuring health for all as well as relaunch a struggle for universal access to healthcare. How do we connect with people and their issues and make them politically sensitive? Jan Sunwais were tried in the past but failed possibly because they were held in the wrong location. The proper place for them would be our hospitals who are full of patients with tales of neglect & negligence, and of exploitation of misery, which are an inherent feature of our healthcare system.
Anurag
--

I am able to follow theoretically and conceptually your argument about the fluidity and un-pin-downability of disease category boundaries - which perplex you, though you are interested in people, as you say. Without offending your sense of sympathy and humanity as a doctor, let me try to raise the question of categories in two or three philosophical registers. To clarify, my questions are not intended to criticize you, but to see what can be added to what you say in whatever small way my perspective allows.
First, at the level of the disease category itself -- your observation and cutting argument is that it is very difficult to differentiate at a deep level, the difference in categories, and I quote

> Differences between acute and chronic diseases, communicable and non-communicable diseases,undernutrition/ tuberculosis/ diabetes/hypertension/mental health are in a sense specious and artificial as they are all linked in ways that we either deny or perhaps do not recognise.

While I can sense what you are saying to a degree, I have a different intellectual problem. Disease categories are ways of determining in detail differences in the pathology -- this is a part of medical science's effort to actually differentiate diseases. These differences in pathology presumably contribute to the success of modern medicine. If we refuse these differentiations or categorizations we go back to undifferentiated illnesses -- how do you propose this will be a step forward to meet our condition? What is the further differentiation that is necessary to mark out these historical problems of illness in India?
On the other hand, I understand you also saying that for the purposes of treatment or prevention, there are indications that the long term embodied historical, epigenetic, etc., determinants of disease are so similar and that therefore the curative (to a degree) and the preventive measures may actually coincide. That is though there are differences in medical categories, the long term treatment may well be very similar -- enough to ask questions whether these are actually different ailments.
On the other hand, your brilliant, because in hindsight so obvious, point about the lack of a boundary between chronic and acute diseases, manitestations, effects, iatrogenic consequences, economic catastrophes, etc. These observations and their consequences really need to be followed.
It may well be that a lay person (in 'modern' medical terms -- a believer in homeopathy, a health activist who isn't a doctor, a medical philosopher) would push to actually soften the boundaries of disease categories.

How would the category difference of being a doctor be different from being a non-medical person? In other words, what torsion or twist or dynamic are you as a doctor adding to the problem as seen by a lay person? How would your call for health for all differ from mine?
The hard question I am posing to you is, how are you going to move away from the despair of your practice to think productively about what to do?
One of the difficulties I have seen with very good doctor thinkers is that they tend to give primacy to their practice to a degree that they don't spend enough time actually thinking about their work seriously, consistently and with stamina. I am sure you don't fall in this category, because your questions have remarkable sharpness indicating a great deal of thought. However, I do see some giving in to despair, which I despair of! Also I see that you are posing a quite original crisis of categories, and then moving back, away rom it to softer solutions that may or may not be practical in the large scale in which you present them.
Srivats
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Then later on the phone this morning, Anurag repeated that it is very difficult to move back when you see absolutely intractable cases every day. He also said that he was part of so many committees which were geared to public health and targeted disease prevention, which had solutions that were piecemeal and destined to fail. So in effect, he was criticizing my somewhat "presumptuous" (my self-criticism, not his words) suggestion that he find ways to move back from despair and irresolution and think productively about the problem. I other words, he feels that there seems to be no easy solution to the complex problems of health in India.
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Thanks for your reply to my mail. Let me think about the points you raised. I realise that i have to strive for greater clarity and coherence in the points i raised. But for example, there is nothing unifying in the term non-communicable diseases into which are lumped hypertension, diabetes, mental health or cancer and injuries, or communicable diseases with different pathways of acquisition like HIV and Kala-azar. Some conditions which impact on both of these categories like undernutrition figure in neither. I feel that the categories are more like maps which create faulty boundaries. Witness the commitment to provide life long ART to the HIV positives which is considered a human right and the neglect of the rights of all other people who suffer life-threatening illnesses.
The point about primacy to your own practice is well taken, but it probably has to be so. If i encounter again and again on a daily basis, poor people driven to the edge by illnesses, a thin short woman wailing outside the operation theater about her young daughter being operated for abdominal TB(she had not eaten for 3 days, and her bills were paid by a collection), a young man of 28 with TB meningitis ready to be taken home without treatment by his father and brother whose cumulative weight might be less than my own, despair seems logical.
Anurag
--
That's a good suggestion from Anurag.
--

I can fully understand what Anurag feels because he is dealing with human beings in despair & being a sensitive person he has subconsciously internalized their pain ,suffering & sense of hopelessness .
I think we can collectively decide to modify the topic to something which is much more geared at possible action for change .. The existing situation cannot & should not be tolerated .
20% Budget cut in Health, 50% cut in ICDS , significant budget cut in Mid Day Meal . This will worsen the existing malnutrition scenario .

At the 1 year new Govt's performance Assessment the fact that in many states Ashas & AWW s have not been paid for several months was shared . This will dismantle the existing asphyxiated Health System . Shortage of doctors , nurses , medicines etc , it is really too serious . We can link this to addressing health problems Acute going on chronic spectrum with complications & sequlae .

CII ,FICCI have come up with their market friendly solutions in partnership with Pharma , Vaccine , Diagnostic Instruments & Medical Devices Industry and Corporates , with IPR issue linked to all , with the Trade Agreements in the process of being signed .

Deaths from Cold & heat which are preventable and are matter of concern
Over 500 deaths from heat , most are elderly , laborers , home less , street persons . A large number are from Telengana & AP .Most have already forgotten the prevention & treatment of Heat strokes & heat exhaustion .

There is so much more that needs urgent response from all of us , from addressing health problems to constitution violations .Each one of us tries to do the best we can , where ever we are , in spite of all the various constraints. This is not enough,, collective response is needed at critical times . The Public health crisis , the Agrarian crisis and as Prabhat Patnaik put the extremely rapidly increasing inequities , & as Jayati Gosh shared that the rural economy is suffering deeply and apparently global economy too is not great .If as a nation we can totally blind to over 300, 000 suicides of farmers, deaths obviously doesn't seem to move the powers that be .

It is definitely not a very inspiring time for most & I think a look at what is doable with all our constraints is not a bad idea .
Mira
--

Though not a correct response but in kind of disparity we is starkly facing, if it is there I would not blame either the person who responses in this way or the poets like Sahir Ludhianvi who pen such responses.

आसमां पे है ख़ुदा और ज़मीं पे हम
(God stays in the sky, we on the grounds)
आजकल वह इस तरफ़ देखता है कम
(Nowadays, he does not look at us)

इतनी दूर से अगर देखता भी हो
(Even if watches us from so far)
तेरे मेरे वास्ते क्या करेगा वो
(What would he do for you and me)
ज़िंदगी है अपने- अपने बाज़ुओं का दम
(Living is to use the power of our arms -on our side)

Dhruv
--

The hospital and community visit will be easy at Raipur or Bilaspur
Maybe try at Hyderabad too?

Prabir

If we are to do it at Hyderabad, we will need access to a hospital that is democratically oriented, with low fee or free patients from impoversihed (majority) backgrounds, and willing to have us milling around, perhaps looking in on case analyses, etc. We would also need a sympathetic medical practitioner/hospital administrator/head who will understand the questions we are trying to address and keep them on some sort of standby from his inpatient population. Others from Hyderabad must respond here, but I don't see too many candidates of this kind, with doctors of this kind.

Srivats
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Thanks
I think there is no problem about hospital visit which Srivats says is in 2016 linked with GB in Chattisgarh . Hyderabad anywhere . Objective of the visit have to be clear . I am sure between Anurag & Prabir this can be worked . .It must be in a resouce poor situation to show the links of the socio economic reality , & the disease patterns , as well as access to health care . I was thinking of Shahid Hospital , if it is possible .
I was just airing my concerns about the seriousness of the situation for many . It will get worse, land acquisition , forced migration , climate change crop failure distress sale . The day after the Rajasthan farmer had hung him self at Jantar Mantar, as Right to Food there was a rally to protest against cuts of ICDS & maternity benefits , Food etc .There were men & women farmers peasants from Jharkhand , UP Rajasthan MP Chattisgarh & the distress situation was terrible . In Uttarakhand villages have emptied out . NREGA has been stopped in some states & there is no food to eat & migration is taking place as well as Distress sale , including sale of children .Chronic hunger could be included as chronic health problem if we wanted . I recall at a public hearing about 2 decades ago feeling absolutely shocked to see so many farmers & their wives having surgical scars on their abdomen because they had had to sell their kidneys to try to get out of debt . This was in Karnataka .
People dying of heat to me reflects many things . Their are not getting free water to drink . There is a heat wave in North India .It is 45 degrees in Delhi and I believe 47-48 degrees elsewhere . Women & girls continue to struggle to get some water contaminate & inadequate of bathing & health hygiene . I remember after the Super cyclone in Orissa , some trees fell many more were chopped & taken away . The summer after the cyclone saw death of over 1000 people in Orissa
I remember an auto driver hesitatingly asking me for water after I reached home in a summer few years ago . He was elderly . I gave him cold water .What he told me still rings in my year. Earlier on people used to give water generously & in summer asked themselves on reaching their homes if we wanted water . No one gives water even on asking . Free water matkas & water coolers have been removed by the Govt Health people . Was thinking of acute thirst , chronic thirst , chronic hunger and chronic apathy . With privatization of water it will be worse . Have been seeing the full page advertisements of Suez . Remember Cochibamba & protest by the people in Bolivia against Suez wanting to control even the Rain harvested water . With Global warming it will obviously worsen .
Having been part of the Supreme Court set up 3 member commission to investigate & give recommendations the 1988 Trans Jamuna Cholera outbreak in Delhi as summer comes I worry . Having worked on Rational Diarrhea Care for decades , when I read that only 23 % of Acute Diarrheas are being treated with ORS (some one said it was only 13% , I think of all the needless diarrhea death that are going to take place this summer .
Mira
--

I was trying to imagine myself in the position Anurag was describing -- as a doctor faced with a stream of patients who come in -- each with some intractable, chronic/acute serious ailment. Each of which require, at the level of treatment or cure, extensive and expensive strategies well beyond the capacities of impoverished families. To the practitioner these diseases are clearly avoidable with measures of prevention. It would seem as if, given the constraints of having to charge money and the inability to pay, many or most of these patients could only undergo palliative care under these circumstances -- no cure, only delay, deferral of death and a degree of alleviation of suffering. What would I understand as a doctor, who was trained to differentiate diseases, categorize them, treat them effectively, efficiently and humanely? How would my training help me understand the situation? Where would all my categories and diagnoses lead? More food, less hunger, earlier access to treatment meaning more cheap, effective, early and easier to access health care. All of which seem to be unachievable, even given the fact that India is growing, shining, and ballooning in its ego as a world player. Perhaps at the cost of these poor. That is where his despair stems from.
Doctors usually dull their emotional response in order to be able to treat the patient who comes with a serious ailment. Many doctors, focusing on the case, wouldn't normally think of the circumstance, context, determinants and larger possibilities of ensuring health. But what if you do? How do you deal with that larger, more reflective, despair that comes from a wider understanding of a situation.
So in answer to my somewhat unintelligent (at any rate, less than insightful) question how did Anurag's position and call for 'health for all' differ from mine, he says, "Come to the hosiptal and see for yourselves. My despair is everyday, heightened by the paralysis I feel between my extensive knowledge and practical impotence in relation to what I see each moment".

Srivats
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Like Anurag, and working in the same district of the country which is certainly not the most deprived by any stretch, I have recently been feeling overwhelmed by the grim, complex, sad, tangled lives of people in our work -mostly with mental disorder, intellectual disability, stifling poverty and pushed down by exploitation and lack of access to sensible compassionate health care. Our efforts to engage with community based support feel inept and presumptuous and insiginificant.
Like Mira, I also feel genuinely alarmed by this highly dysfunctional health system of India that is degenerating and unravelling further in front of our eyes - and so incisevely summarised in the Lancet editorial on Modi health policy last week.
I feel particularly gutted by the cut in ICDS budget - iunder 5 nutrition and pre-school education are surely one of the most critical factors for life long health.
For me MFC is a beacon of encouragement, hope and activism in teh face of such despair and degeneration and I think its important to really dig into the complexity of chronic diseases and ill health ,,, and move past trite vertical solutions and also believe we must give some time on ways to move forward and seek change in the current policy environment a.. . so we can all chase away the black darkness and light our small candles. And encourage each other with sparks of hope.
Kaaren
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