

Rameshwar Sharma Oration

Probably Indian Institute of Health Management Research or
Sawai Man Singh Medical College

Jaipur, India

mid-February 1981

Dr Sharma was a principal of the Sawai Man Singh Medical College and a founder, in 1984, of the Indian Institute of Health Management Research.

A letter from Nana Henderson describes plans to travel from Delhi to Jaipur on Feb 13 1981.

File RAMESHWAR SHARMA ORATION
JAIPUR, INDIA FEB, 1981

Privilege & honor to be asked to give the 1st R-S Oration.

Rameshwar Sharma

The appellation of distinguished teacher is the highest one ^{one can give} ~~a colleague in the ICA~~
~~the 1st~~ ^{1st} professor of Preventive & Social Medicine in Rajasthan will be seen in retrospect to have been ~~of the most~~ a turning point in medicine.
~~the~~ ^{once}, highest calling for a physician was surgery and subsequently other specialties, we are all - throughout the world - coming to realize that the basic ^{improvement} ~~solution~~ of health among the people must come not through the high tech. of heart transplants and elaborate reconstructive surgery but through ^{simplified and effective methods} ~~the~~ prevention of diseases in communities - thro therapies which can be applied simply and to large numbers of people.

I salute you sir, as a pioneer - much as at our own institution, Johns Hopkins, the names of Osler and Welch and Cushing evoke the image of pioneers in medicine, in pathology and in surgery ^{and McCallum ~~of~~ ^{of} ~~front~~ ⁱⁿ ~~nutritional~~ ^{and} ~~guidance~~ ^{of} ~~guidance~~} - but, in these days, they were but one of a kind on a faculty - [which] ^{faculties} today ~~are~~ number in the ^{in the} ~~more~~ ^{than} 100's.

The most difficult task is to begin - as the Chinese aphorism states, "a journey of ^{a thousand leagues} ~~words~~ begins with a single step". The first step, however is the most difficult and this you have taken, ^{at} the ^{first} step into ~~the~~ future in which preventive & social medicine ^{is} the foundation of our future efforts in the practice of medicine ^{world}.

I should also like to acknowledge my indebtedness to Dr. T.P. Jain, ^{a most worthy colleague} ^{of Dr. Sharma} a classmate ^{at Johns Hopkins 20 yrs. ago} and, even as a classmate, a teacher - one who constantly reminded all of us that ^{the} public health in ~~America~~ we learned had other and greater dimensions when viewed in an international context. Therefore which I spent at Johns Hopkins was twice enriched simply and explicitly because of the presence of Dr. Jain.

12 / 30000000

India - costs (2)
- no shortage of manpower
- organization
- target

Lesson learned from smallpox

Prog. really began, as you know, on 1 Jan 1967 - following the decision of the WHO to undertake a 10 year prog. of the eradication of smallpox.

Most important decision - objective "0" cases of smallpox.

Until then - millions of cases.

An inconsequential step but, even today, many progs. in medicine defined not in terms of objectives but "processes".

i.e. "give health education" "improve diet" "administer vaccine"
Why? What are we trying to achieve? (EXPAND)

To reach the objective, we obviously had to measure how many cases there were & our progress was based on reducing that number.

1967 - completeness of reporting 131000.

+ Process to improve -

National reports.

Local reports - to get each health unit to report each week re. cases seen.

Criticized for this - why have teams simply collecting data. They should be vaccinating.

+ Each case, however, was in a sense a failure. It should not have occurred.

Analysis of why the case occurred helped each country to change its strategy.

e.g. 1st vac. vs. revac.

Afghan prog. to vac. ♀ in pouch.

+ In brief - the reporting system and analysis of these characteristics - "surveillance" represented evaluation. Evaluation, in turn, altered strategy and in this sense, it was the key factor in program management.

How many persons were vaccinated? Did not record that data at WHO.

Countries used these data in assessing progress of teams.

average 78×10^6 / yr. world-wide (contrast malaria Ethiopia 220×10^6 / yr.)

Little money -> Thus the need, in the program, to involve health services at all levels to the maximum extent possible.

+ In Africa - added some smallpox staff to help direct the effort, to teach local staff, to deal with emergencies - in general, about 1 worker / 100,000 pop. Progs. were different but objective was the same.

+ In India, Bangladesh, Pakistan - problem was ^{really} different than Africa

- Recall well an assessment in India in 1967. Among other things, looked at cost of vac. in every dif. Districts. Costs ranged from 2 to 20 Rupees per vaccination performed. In Africa, < 1 Rupee.

Serly. comment - can't afford to do eradication. They ^{didn't} can't afford the expensive control program it now is getting

- I personally was ^{amazed} ~~amazed~~ by the vast no. of reasonably well-trained health workers. In no other part of the world had I seen so many staff with so much training and yet not achieving what they set out to do.

+ Essential factor lacking was surveillance and evaluation and supervision. Ranganathan pioneered in this effort.

1973 - village by village search programs began involving ^{thousands} of health workers but with assessment teams checking to see that they did their jobs. Senior staff left their desks to see what really happened in the field. ^{From} ~~At~~ natl. level, many senior officials travelled extensively into the field - M.D. Sharma, PN Bose, Mahendra Singh + many others. WHO likewise. State and District officials did the same.

The workers took an interest, strategies changed.

First search in Oct. 1973 - last case in India May 1975.

Two yrs. later - last case in Africa May 1980 - eradication officially

Missed 10 yr. goal - by 9 mos. and 20 days. ^{declared by WHO}

- ~~What~~ What did smallpox teach us?

+ Each country found it had vastly greater resources of manpower and expertise than it realized. That with little additional money but much better organization, it could achieve miracles in improving the health of its people.

+ A program to succeed had to have clear-cut objectives
Specific Measurable Achievable Realistic Time limited.

Successful interventions have known this for a long time.

+ A program whose objective is "Health for All in the Year 2000" has no program at all - only a slogan.

³ + Management is The sine qua non but management cannot be executed from behind the desk.

As we move to the future, there is yet a further important ingredient that must be added. University faculties and Government services must work much more closely together. Those in the university whose resp. is to ~~then~~ study and to learn about activities & progr. around the world must be personally acquainted with ~~the~~ progr. in their own country. They can and must contribute to the improvement of local ~~plans~~ programs, plans and strategies and must be able to impart to students what the real world is and how it functions. I find in most countries that the universities and the local health depts. might just as well be on different planets. This is preposterous.

• At Hopkins
HPA -

COEH - ill. by James Bay.

• For me, ~~it~~ it is a privilege to serve as Dean of America's oldest and now the world's largest school of Public Health.

Faculty
Budget. 34×10^6 27 courses yr.
 272×10^6

Expect $\sim 1/3$ ↑ in size over the next 5 yrs. -

Admire what clin. colleagues are doing, but our concern is broader - the health of the people.