

parents coming to see me. . . . I got scared because they were all not with me.

Now I have got cured. I have survived because of God. In my village I am the only one who has become Christian. God has given me good mental strength. Now there is no problem and I am happy.

I was going in a different way. . . . I used to see even X films. My mood would become one of despair. . . . Now I do not have any bad habits . . . there is not even a small fault in my life. I must go on a straight way. I have the confidence that my mind can stay steady. . . . I will be at my work or at home . . . just like normal.

R: In the ICU, I have no memory. In the ward I can remember the tube in my neck, but they removed that in one day.

After the accident, I don't know what happened, my mind changed. . . . I did not have the idea that I wanted to die . . . when I woke up in the ward, I had no memory of what happened and only when they told me I realized. . . . It must have been due to mental feeling . . . even if I was unconscious what I did was wrong. Nobody should ask me why you did it. At that time I was like a mad man . . . there are many worries in my life, but I don't lose hope. My will to live is so strong. I have two businesses and after discharge I have set up a granite business that is doing well . . . always I do not allow my friends to feel depressed and feel that they want to end their lives.

NOTES

1. Intermediate syndrome is the new onset weakness of extra-ocular, facial, neck, proximal limb and respiratory muscles that occurs 48–72 hours after acute organophosphate poisoning (Wadia 1974 and Senenayake 1987)
2. These six cases are among twenty-five cases of OP poisoning who were admitted to our medicine unit as part of a study of neuromuscular or intermediate syndrome in acute OP poisoning (Khan 2001). These six cases were chosen based on unusual aspect of their clinical behavior that provided new learning about OP poisoning.

Peoples' Struggles Producing a Curative Public Health for AIDS

Anand Zachariah

Acquired Immune Deficiency Syndrome (AIDS) has the potential to teach us how to think and act politically in relation to difficult diseases. To see this it is necessary to look at AIDS from a historical perspective that is attentive to the specific contexts in which the different strategies and negotiations to address the disease evolved. This chapter attempts to trace the changes in the conceptualisation of AIDS since the early 1980s.

During the past twenty-five years many Third World countries have made treatment of AIDS an essential complement to prevention in governmental public health care. This has not happened for any other disease except for TB and leprosy, where the specific goals are to reduce transmission in the former and eradicate disease in the latter both from a prevention perspective. This provision of curative treatment for the patient as an essential component of a public health programme runs against the current governmental trend to focus on disease prevention and leave clinical services to the private sector. AIDS medicine it would seem has also transformed the patient into a person who can make legitimate demands on medical institutions, governments and pharmaceutical companies. This shift from the patient seen as a passive body to be administered treatment, to an active participant in the making of medical knowledge and public health policy may be unique in the history of disease in Western medicine. We attempt to understand the changes in the nature of medical discourse that have occurred through AIDS, the context within which they have taken place and the possibilities they offer about thinking medicine in India.

This chapter is divided into two parts. The first part is a brief overview of the scientific history of AIDS treatment research. It is a tale of positive science, application and gradual improvement through focused endeavor. In the second part we examine the history of the political battles fought around AIDS treatment focusing on, 1) the impact of the AIDS movement on the framework of treatment research in the US and the development of highly active anti-retroviral therapy (HAART), 2) the Brazilian freedom struggle enunciation of the right to health care and the development

of cost-effective model of AIDS treatment linked to prevention, 3) the Global advocacy movement's influence on the WHO and pharmaceutical industry to provide universal access to treatment through the 3 by 5 initiative, and 4) the changing concepts of public health through the national AIDS programme in India today. This second part thus narrates the long history of the struggles, negotiations and battles that marked the evolution of AIDS treatment across the world. This story complicates the clean and direct march of positive science towards an ideal cure, muddying its path and telling us how it was inflected by patient demands.

Finally we discuss the possibilities these transformations offer in thinking about other diseases and public health problems.

ANTI-RETROVIRAL TREATMENT: TWO TALES

Historical Overview of the Biomedical Development of HAART

The recent history of AIDS treatment research and the development of highly active anti-retroviral treatment (HAART) from the perspective of Western science would emphasise the evolution of understanding the biology of the virus in drug development and treatment trials. This history would refer to how the study of critical enzymes in the virus life cycle, reverse transcriptase and protease have enabled the development of drugs that target these enzymes such as nucleoside reverse transcriptase inhibitors (NRTI), non-nucleoside reverse transcriptase inhibitors (NNRTI) and protease inhibitors (PI). It would provide an account of treatment trials, from single, to double and finally to triple drug regimens with increasing efficacy. It would emphasise that the demonstration of maximal and durable suppression of viral replication with clinical trials of triple drug combinations (two NRTIs and one PI or NNRTI) have led to these becoming the standard of treatment across the world. Such an account would conclude that HAART therapy represents a major scientific advance that has impacted on the AIDS epidemic with the decline of hospital admissions and AIDS deaths in US and the closure of AIDS wards. It would underline the shift of AIDS from a once incurable disease to another chronic controllable disease.

The Political History of AIDS Research

Early activism's impact on scientific research protocol and practice: The development of HAART. At the time of the early epidemic in the US the government simply went into denial, and it was left to the gay groups to

provide assistance and support for affected people. The gay community was pushed to the wall, with the panic and public outcry that stemmed from the AIDS epidemic. Bathhouses and gay bars were closing. Friends were dying. Life and culture were ceasing to exist. The gay community realised that neither the government, nor the scientific and medical community would be able to initiate the response that was required to stem the epidemic that was a virtual holocaust for their group. People in the movement realised that if things were not speeded up, many of the activists would be dead before a treatment was found. In that moment, they developed strategic partnerships, took the medical community, government and pharma by the neck, demanding that they to need to find a treatment that will prevent them from dying, a treatment on their own terms, a health that they desired.

ACT UP (AIDS coalition to Unleash Power) was an initiative of the gay community that was crucial to development of and access to anti-retroviral therapy. In the context of lack of public support they built links with other affected groups, IV drug users, women's groups, civil rights groups, haemophiliacs and immigrant communities. For instance, Ryan White, a child with haemophilia and AIDS who was sent out of school, became a strong campaigner for the HIV/AIDS issues. The links between haemophiliacs and the gay community led to the Ryan White Bill for government support of programmes run by patient groups (Brahm 2004). ACT UP demonstrated radicalised political strategies in the given setting of public apathy regarding the AIDS problem. Some examples of their politics include frequent street marches, closure of Wall Street, blockade of Federal Drug Administration (FDA) offices and pharma headquarters, stopping TV stations, underground railway and churches services. All these raised the public attention that AIDS received (Brahm 2004).

ACT UP activists influenced the development of ART in several ways. They ensured that FDA speeded up its drug trial regulatory processes. In response to their pressure, drug trials were farmed out to private agencies encouraging many more trials to be conducted. Surrogate markers such as the CD4 count were accepted as relevant outcomes for drug trials thereby shortening the trial period. While FDA had stated that only 2 drugs would be licensed between 1989 and 1991, four drugs were finally approved by 1989. In response to ACT UP demands, FDA accepted that patient groups would be involved in all stages of trial planning and implementation. The first such trial was with didanosine. This trial also accepted the demand for "expanded access" whereby patients who were ineligible for trial enrollment could access the drug outside the trial (Medley n.d. 2). In the case of saquinavir, the first protease inhibitor, Treatment Access Group (TAG) a break off group from ACT UP

directly negotiated with Bristol Squibb Mayer to pressure release of trial data, speed regulatory processes and make the drug available (Medley nd.1). ACT UP presented its own comprehensive research agenda at the Fifth International AIDS conference at Montreal in 1989, which they said was the first by a patient group or for that matter by any group (Medley n.d. 2).

The AIDS movement through its struggles has seemingly transformed the format of research, the relationship between the patient, the doctor and the discourse of medicine. In the AIDS context, the patient is thus no longer a passive biomedical object presenting a pathology; he intervenes actively in the process of finding a cure. Research in AIDS treatment now requires the explicit permission of the subject, who has right to information about the treatment and the right to refuse to participate.

The AIDS movement has also shaped policy to meet patients' legitimate political demands. Activists sat on committees that determined research funding, shortened the time to trial completion and drug licensing, ensured mechanisms for people to enroll in trials and access drugs outside trials, and saw to it that trial results were available to affected communities. They were able to do this by lobbying with the government, medical community and pharmaceutical companies. The effect was to make research goals, policies, strategies and investment responsive to the patient. While on the one hand, the government and research establishment were forced to yield and modify their rigid stances on scientific research norms, the industry was forced to commit more time, effort and money to meet the priority of patient needs.

Never before in history has a patient group taken charge of a disease. In that transformation, they have set in process changes in the biomedical discourse, the nature of medical objects and rules, in the category of patient and doctor, in medical institutions, in the concepts of the right to health and public health, in the pharma logic and in trade laws.

Aids cure and human rights in the Brazilian context. While HAART was widely available in Western countries from the late 1990s, World Bank continued to advocate that Third World countries' maintain their focus on HIV prevention, as it was economically unviable to provide treatment. At this point the cost of HAART in India was Rs 40,000 per month. This debate changed with the Brazilian experience that showed that it was possible to provide treatment and prevention through the national health system in an equitable manner with cost saving and improved economic productivity (Galvao 2005). How was Brazil able to do this? And in what context did Brazil's treatment programme emerge?

Brazil's struggle against dictatorship, the formation of the democratic constitution in 1988 and the first election in 1990 were closely linked to the AIDS issue. When the first cases of AIDS were detected in 1983, health officials and affected people in Sao Paulo (which was the epicentre of the epidemic) demanded health rights for affected people and insisted on the availability of treatment. One of the groups involved in the political struggle against dictatorship was the "Sanitary Reform Movement", a loose affiliation of health workers, political parties, trade unions, academics and churches. Several of the dissidents and activists suffered from AIDS. This group, many of whom were actively involved in the early response to the AIDS epidemic in Sao Paulo, demanded a health system that was responsive to the people (Galvao 2005).

Two of the important ideas in the freedom struggle were citizenship (the state's commitment to the people) and solidarity (people's commitment to each other and society's commitment to prevent discrimination). The movement against dictatorship had different elements reflecting a society where there was much discrimination based on race, gender and social group. However the solidarity built between the groups in their fight against dictatorship fostered a spirit against discrimination due to HIV/AIDS. A key election issue was the right to health. The Sanitary Reform Movement stated that the right to health stemmed from a right to health care. Prevention without care, was likened to "civil death", and was seen as discrimination. Providing medical care for people with HIV would ensure that they got their due as equal citizens. Only the removal of discrimination through the provision of cure would provide a convincing backdrop for prevention to be effective and acceptable.

When the opposition won the election in 1990, members of the Sanitary Reform Movement became senior health officials and were involved in the formation of the "National Unitary Health System" based on the Sao Paulo model. The new constitution committed the country to the right to health care. The Unitary health system's AIDS care programme was based on the following principles:

- Equal access to care
- Integration of care and prevention
- Social control where local governments were responsible for implementation of health programmes
- Central funding

Initially ART drugs were not available in the health system. However several legal cases were fought on the basis of the constitutional right to health care, on viral load testing and second line treatment. In 1996 the government passed a law ensuring access to free drugs across the

health system for a set of diseases including HIV, TB, STD and trachoma. HAART therapy became available in the late 1990s not just through the government, but also at all points where people accessed the health care system.

Brazil has also focused on development of its local pharmaceutical industry, which now manufactures 7 anti-retrovirals and provides about 18 per cent of the country's requirement. In 1971 the country had enacted a law that provided the right to manufacture patented drugs. When the law had to be revised to recognise international patent regimes, they introduced a legal provision to enable local generic drug manufacture if the patented drug was not manufactured in Brazil within three years of patent issue. In 2003 Brazil issued compulsory licenses for the local production of Nelfinavir (produced by Roche), Lopinavir/Ritonavir (Abbott) and Efavirenz (Merck) and then gave notice to these companies to reduce costs of these drugs thereby forcing price reductions. In 2004 it was estimated that 154,000 people were receiving AIDS care at a health cost of US \$426 million of which 80 per cent was spent on treatment. This cost had not increased in the six years of the functioning of the programme. The efficacy of the AIDS programme was evident in the falling incidence, 50 per cent reduction in AIDS mortality and 70 per cent reduction in in-hospital admission days.

The experience of Brazil was crucial in the international lobbying for universal access to ARVs. Brazil was also in a position to export drugs, and to transfer technology to countries that could not manufacture them. Despite the liberalization and structural adjustment programme of the World Bank that encouraged divestments in welfare and health, the Brazilian government has maintained its commitment to AIDS care.

The political ferment that occurred in the context of Brazil's struggle against dictatorship was crucial to two primary changes in the idea of health care: a) community involvement and control; and b) the idea of a right to health that combines care and prevention. When compared with the previous phase of ACT UP activism, the Brazilian experience shows how the political commitments of those elected to govern the nation forced the state to set aside a sufficient budget, provide a system for AIDS care and exert pressure on multinational organizations to reduce sale prices of the drugs.

International activism and the provision of universal access to treatment—the 3 by 5 initiative. At the end of the 1990s, the sheer gap between countries that did and did not have ART was receiving significant international attention. At this time AIDS was being viewed as a developmental issue linked to poverty. Groups involved in Third World debt, such as

Jubilee 2000 and Drop in Debt as well as anti-globalisation groups who were fighting big pharma, joined hands with AIDS activists to protest at international events such as the World Bank/IMF meetings and together formed the Global Treatment Access Movement (Brahm 2004).

Activists, academics, government representatives, affected people, NGOs and international agencies met at the international AIDS conference at Durban in 2000, in the context of the looming epidemic in Africa. The conference occurred against the backdrop of experiences of countries such as Brazil that had shown the successful implementation of self-funded ART programmes.

In an act which indicated the mood of that moment, South African High Court Justice Edwin Cameron described his own story of developing AIDS at the conference: "Amidst the poverty of Africa I stand before you because I am able to purchase health and vigour. I am here because I can pay for life itself" (Mirken 2001). The speech crystallised sentiments in favour of providing treatment to countries which could not then access care, and underscored the need to cut drug prices. There was a rejection of the current opinion that treatment should be available only to people and countries who could afford it, and that the poor and the developing world must only focus on prevention. It was felt that international funding must be found to support drug treatment and companies should be forced to reduce the cost of drugs. A consensus formed at the Durban conference, that if prevention was to succeed it must be integrated with care and treatment must be made available to all who need it.

In 2001, 39 multinational pharmaceutical companies together filed a lawsuit against the South African government and its plans to issue compulsory licenses for generic anti-retrovirals. In March 2001, the Global Treatment Access Movement staged massive protests in Pretoria, Washington, Paris and London. In April 2001, a large march was held in front of the World Bank/IMF meetings in Washington. Within two months the company conglomerate withdrew their lawsuit (Brahm 2004). It is important to understand that this was not simply a change of pharmaceutical heart. On the one hand the climate in which the international law system had to enforce patent and intellectual rights turned against the interests of the pharmaceutical industries. On the other hand, the international coalition of AIDS activism ensured that domestic activism in the First World mounted pressure on the pharmaceutical industry and their activity abroad.

Almost immediately after, the Indian firm Cipla offered to sell three antiretroviral drugs at US \$350 per patient per year (\$ 1 per day). Brazil too dropped its anti-retroviral prices. International multi-nationals

responded by further prize cuts (see figure 17.1). This led to a 40-fold reduction of drug costs (Perez-Casas 2001).

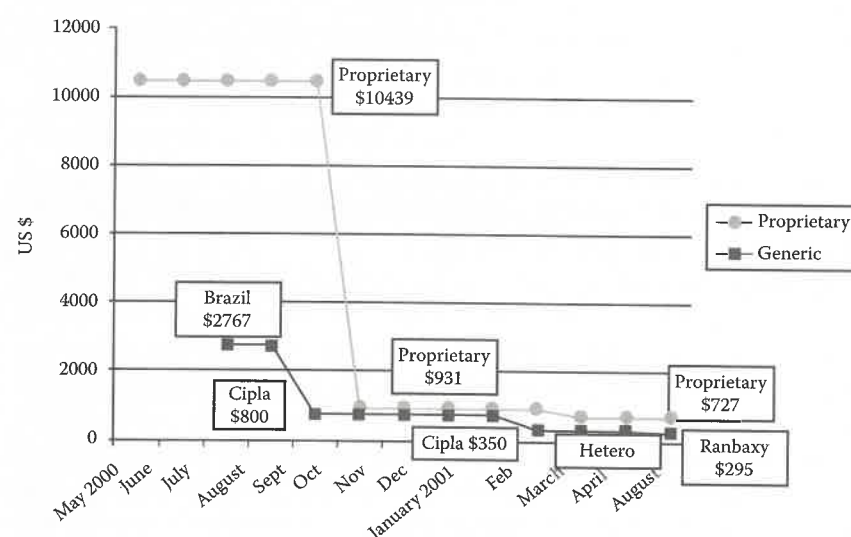


Figure 17.1: The effects of generic competition. Sample AIDS triple combination: lowest world prices per patient per year (stavudine (d4T) + lamivudine (3TC) + nevirapine)

Source: Perez-Casas et al. 2001.

It was against this background that Kofi Annan presented a goal of universal access to ART at the United Nations General Assembly Special Session (UNGASS) on HIV/AIDS in June 2001. He suggested that a global effort that linked care and prevention must be initiated. He proposed that a global fund should be created to provide universal access to HIV treatment to 3 million people by 2005. As the UNGASS meeting progressed, large contingents of AIDS activists from across the world held demonstrations in New York in support of this idea. At the end of this meeting, all the WHO countries supported this proposal.

In December 2003 the WHO and UNAIDS came out with the programme "3 by 5 initiative" which envisaged use of common and simplified guidelines, reliable supply of medications, better diagnostics, training and national advocacy. 192 member countries endorsed this strategy. The WHO then worked with member countries to set up local ART programmes (WHO n.d.).

As a result of this strategy, by December 2006 the number of people on ART has increased to 2,015,000. In sub-Saharan Africa about 1.3 million

people are receiving treatment (28 per cent coverage), 280,000 in East, South and South East Asia (19 per cent coverage), 20,000 in Eastern Europe and Central Asia (15 per cent coverage) and 355,000 in Latin America and Caribbean (72 per cent coverage). In India up to 2007, 137 government ART centres provide free ART to 118,052 adults, and 8347 children. In many areas the demand outstrips the provision of ART. Ninety countries are implementing national treatment programmes for ART. The programme has shown that large-scale treatment initiative is achievable, effective and affordable (WHO n.d.).

The informal coalition of movements across the world was able to highlight the inequitable distribution of AIDS treatment in the background of experience of the gay movement in the US and demonstration of a cost-effective model of AIDS prevention and care in Brazil. These groups were able to build on these earlier transformations by pressuring the WHO to set up the universal access to treatment programme and simultaneously forcing pharmaceutical companies to reduce the cost of drugs.

Transformations in concepts of AIDS and the public health programme in India. In this last section, we examine the structure of the AIDS programme in India keeping in view the impact of the AIDS movement discussed in earlier sections.

Despite the AIDS programme being the best-funded governmental disease control programme, it has a skeletal administration called the National AIDS Control Organization (NACO). The thrust activities of NACO are the targeted intervention (TI) programmes focused on individuals at high risk of acquiring HIV infection, sex workers, their clients, truckers, IV drug users, transgender communities. In 2007, NACO was overseeing 790 TIs that were focusing on 869,206 people (NACO Online n.d.). Unlike all other government health programmes, nearly all these TIs are implemented by non-governmental organisations that are recruited by different state AIDS societies. NACO and the state AIDS societies have retained largely administrative functions such as regulation of blood safety, sentinel surveillance, condom promotion, mass media and programme planning.

Traditional prevention programmes in the public health system such as malaria eradication and family planning are administered to large "populations" through generalised measures of education, broadcast pest control (like spraying to control mosquitoes), vasectomies and immunisation. These top down programmes reflect a vertical administrative structure that is minimally sensitive to the needs of the communities that are being targeted. Unlike these traditional prevention programmes, AIDS prevention programmes are often run by affected

groups themselves. There are many examples of organizations consisting of or working with sex workers, IV drug users and transgender community who have implemented TIs on behalf of the government for themselves. They are therefore able to design the intervention to meet local needs and priorities. A study of the sex worker intervention project at Sonagachi in West Bengal organised by their own worker cooperative shows that activities are molded to address their own concerns (Durbar n.d.). They include training of peer leaders, political organisation, education of sex workers and clients, supplying condoms, running STD clinics, initiating income generation projects, dealing with police and mafia, working towards legislation for sex workers and support for children of sex workers. Many interventions today, such as the SESA project among transgender community in Tamil Nadu attempts to help individuals to be in better control of their circumstances, trying to make the environment more safe and working towards solidarity among those affected as well as providing treatment (TAIVHS n.d.). A key concept in HIV AIDS prevention is that of targeting specific populations that are vulnerable due to complex circumstances such as poverty, gender, marriage, an unstable family situation, and a lack of knowledge of and access to medical care. Although these targeted interventions are based on the concept of "risky populations", in practice they tend to be communitarian and reflect an approach different from the administrative formatting of public health.

There are many instances of patient support groups that perform a variety of activities including conducting meetings, obtaining employment opportunities, visiting homes, addressing legal and social issues and assisting doctors and hospitals in follow-up of patients. For example the government employs counselors from the Tamil Nadu Positive Peoples' Network at every district hospital. Another example is that of the Indian network of positive people that has set up their own treatment programme at Namakkal including home care, out patient clinics, in-patient care and provision of ART (INPPLUS n.d.). Today, positive peoples groups are required stakeholders for policy decision-making at every level from the local to the international. Positive peoples' groups are also making demands of the government and health system such as second line ART, declassification of homosexuality, providing ART for sex workers and an AIDS law that provides for rights of affected people. In the context of AIDS, some possibilities have opened for the patient to become a peer group member, counselor, and policy advisor and even to play some doctoring roles.

HIV/AIDS interventions in India as in other locations have thus tended to mark a shift from the "patient/risk-population" as a passive

administrative target to the possibility of their participation and involvement in both prevention and care.

The hallmarks of the AIDS programme are the involvement of NGOs, a communitarian approach addressing underlying structural factors and the provision of curative treatment as an integral part of the public health approach. We would argue that these characteristics of the AIDS programme are a result of the particular transformations in knowledge related to AIDS that led to the central role of the patient in research and policy, the link between curative medicine and prevention, access to curative medicine as an essential human right and a communitarian model of care.

CONCLUSION

It is clear from this second narrative of struggles around AIDS that peoples' movements have forced transformations in our conceptualisation of disease and approaches to public health.

The structure of disease as a concept appears to be changing in a historical sense as a result of this movement. From being an administrative category, formed in the medical perception of eighteenth and nineteenth century Europe, the concept of disease as exemplified in AIDS in the late twentieth century has become more in the nature of a negotiable political object. In turn, the diseased body in the context of AIDS ceases to be a passive element of a "population" that is administered public health. The patient as activist generates the resources to participate in the medical intervention. In the process subtle changes seem to have occurred in which the disease, while remaining biomedical, loses its administrative force.

In the debate between prevention and cure, we have shown that peoples' struggles for universal access to treatment through a public health system have formed a counterweight against the primarily prevention based governmental policies favored by neoliberalism and promoted by the World Bank. Through their negotiations they have been able to reframe a public health for AIDS that has to a certain extent maintained a priority for people.

What is the potential effect of these changes in the discourse of AIDS on other diseases and other health problems? Does the AIDS treatment process provide an alternative model for health care in India to that based on the model of vertical prevention programmes? The following are the first steps towards understanding these issues:

Perhaps the first thing to note is that the biomedical model of medicine in the case of AIDS is not wedded so strongly to the economics

of capital in the pharmaceutical industry. Given sufficient public and international pressure, the pharmaceutical giants may see value in being socially responsible. In a climate of adverse political opinion, they may remain open to negotiation rather than be driven by the profit principle to seek recourse to international law. International activism is also able to force effective domestic political opinion against the pharmaceutical giants. This crack between the logic of biomedical research and the pharmaceutical industry's profit motive is an important gain from the AIDS struggle story.

Second, the vertical model of public health, which has been a structural feature of the primary health care system in India, has in the context of AIDS changed its emphasis and focus to a measurable degree—not only toward cure, but also toward a more community oriented, designed and driven model of autonomous health care. In many ways the AIDS model of healthcare harks back to the idea of comprehensive health care proposed by the Alma-Ata agenda, and in that sense opposing the preventive orientation of the Selective Primary Health Care approach (see Srivatsan, in this volume). It is also important for us to note that this progressive turn has been achieved in negotiation with and struggle against an increasing globalisation of business and liberalisation of the state apparatus.

Thirdly, the flexible health care model of the AIDS programme has had to function at different interlocking domains by means of agreements, negotiations, partnerships and acts of trust at different levels across the globe. It would be utopian to imagine that a local initiative could provide the extremely encouraging results of the AIDS struggle. The success of AIDS activism has hinged on the non-uniform and evolving global consensus between powerful administrators, politicians, world organizations, chief executives, small NGO activists, political activists, thinkers, and myriad minor figures that has made it work.

Reclaiming Primary Care: Managing Depression and Anxiety in a Different Framework

K. S. Jacob

Many investigations have established the prevalence of depression in primary care (Ustun and Sartorius 1995). Numerous studies from India have also documented depression, anxiety and common mental disorders in general hospital settings (Channabasavanna, Sriram and Kumar, 1995; Pothen et al. 2003). The prevalence estimates have ranged from 10 to 50 per cent of patients attending primary care with an average of about a quarter to a third suffering from such conditions (Ustun and Sartorius 1995).

The high prevalence of these disorders and the magnitude of disability and distress have been the focus of efforts to manage them within the context of primary care (Paykel and Priest 1992; Priest 1991). Educating general practitioners (GPs), preparing practice guidelines and conducting courses to improve their clinical skill have been attempted (Gask et al. 1988). The World Health Organization (WHO) has developed diagnostic algorithms in order to make diagnosis easier (WHO n.d.). It has recommended protocols for the management of such presentations (WHO 1996). These efforts were basically attempts to retool tertiary care protocols for large scale application at a primary level. The expectation was that depression would be managed in primary care.

Nevertheless, despite such expectations, the detection rate for depression in primary care continues to be low. Despite piloting, field studies and acceptance by academic GPs, the watered-down tertiary care psychiatric approach, when employed in primary care, has few takers in actual practice in the West (Kendrick 2000; Heath 1999) or in India (Jacob 2003). The copious case-finding instruments and screening questionnaires are too cumbersome for routine use. The diagnostic criteria are numerous, elaborate and difficult to apply in everyday primary care practice. The prevailing culture of psychiatry in primary care borrows heavily from academic and tertiary care psychiatry and attempts to adapt it to the reality of primary care (Jacob 2006a). The compromise is uneasy,