socialist health review

Editorial Correspondence :
Socialist Health Review,
19 June Blossom Society,
60 A, Pali Road, Bandra (West)
Bombay - 400 050 India

Printed at :
Omega Printers, 316, Dr. S.P. Mukherjee Road,
Belgaum 590001 Karnataka

Annual Contribution Rates :
Rs. 20/- for individuals
Rs 30/- for institutions
US $20 for the US, Europe and Japan
US $15 for other countries
We have special rates for developing countries.

(Contributions to be made out in favour of Socialist Health Review.)

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PEOPLE IN HEALTH CARE

No other profession enjoys the amount of adulation or gets its share of brick bats as does the medical profession. The problems of ill-health being what they are in our country, every discussion and debate on such issues revolves around the question of availability of doctors. This factor has assumed such a major importance that the doctor-population ratio has come to be accepted as a standard measurement of health services and indirectly of the health of a population. In this process the important contribution made by the other categories of health workers remains invisible only to come up when they strike work.

The central role doctors play in diagnosing and treating diseases is not merely confined to the provision of such services but extends to the entire field of health care including the right to define what constitutes disease and the right to treat it. The medical profession argues that if high quality services are to be made available and if 'purity' of medical practice is to be maintained it is essential that the profession retains complete control through registration and legislation. Further, the medical profession argues that diagnosing and prescribing are superior to all other skills and only those who possess such skills have the necessary authority to direct the course of health itself. That all such arguments merely form a facade for maintaining monopoly over a valuable commodity can be seen by looking at the way medical practice evolved into its present professional status.

The Beginnings of Medicine as a Profession

The emergence of the medical profession can be traced to 14th-15th century Europe which witnessed a class alliance between the upper middle class male 'regular' doctors and the feudal church leading to the ruthless extermination of other healers, mostly women, through well organised witch-hunts. Similarly, two centuries later in America the 'regulars' tried to gain monopoly over medical practice by attempting to pass state legislation in collusion with the emerging industrial and commercial bourgeoisie. Initially such attempts met with mass protests which culminated into a popular health movement. Unfortunately, the effort against legislation could not be sustained and the movement degenerated into a number of medical sects.

The 'regulars' attempt at cornering the market for their expertise was based on two factors. Firstly, the 'regulars' need to eliminate competition now arose as, for the first time, the practice of medicine was being viewed a full time economic activity. Secondly, if this activity was to bring in a substantial income, it was necessary to improve the image of the activity by giving it a professional status. As a mark of distinction the regulars adopted the Hippocratic oath and code of ethics as their standard. It is important to note that all this took place before medicine had attained any scientific aura or had developed any rational medical interventions. In fact, the regulars of that time practised what was known as heroic therapy which included blood-letting, purging and applying leeches among other such horriffic remedies.

With the support of the industrial and commercial bourgeoisie, it was just a matter of time before specific and effective interventions in the disease process developed which further consolidated the power the medical profession had gained through legislation and the physical extermination of other healers. It was this monopoly that shaped the form and content of medical care to its present form. The predominant hospital structure and the emergence of other categories of workers such as the nurses, laboratory, x-ray technicians, pharmacists and others has evolved and revolved around the functions that a doctor performed.

It was also not a mere accident that nursing emerged as a suitable profession for women or that it was subordinated to doctoring. By the time medical practice had become established as the domain of male regular doctors, women had been eliminated from health care for all practical purposes. The authority that doctors had in defining normality allowed them the power to advance pseudo-scientific theories and sexist arguments regarding the intellectual capabilities of women to prevent them from entering medical colleges. Women from the upper classes were increasingly being told to conserve their energies for the supreme function of being a woman, that is procreation, and were therefore forced to lead a sedentary life. For the women from this class who did not or could not marry, life had little option. Apart from teaching there was hardly any respectable 'genteel', non-

industrial occupation which would be socially acceptable and at the same time provide a certain level of economic independence. The goal of Florence Nightingale, the 19th century reformer was to create a paid job in health care for women. To make it acceptable to doctors Nightingale demonstrated in the battle field of the Crimean war that nursing would remain subordinate to doctoring and her attempt to make the occupation acceptable to women was to draw analogies between nursing and housework. The doctor-nurse relationship was projected as a husband-wife interaction and nursing was stated to be 'natural' to women, as it coincided with what was considered to be her natural biolgical function. Since Nightingale's effort was to create a job for the women in health care she made it quite clear that it would in no way question the supremacy of doctors or the subordinate position of nursing. Feminist historians however question the acceptance of nursing as a *natural* sexual division of labour. By taking patriarchy as an analytical category they have tried to argue that what is generally considered a natural sexual division of labour is in reality a *social* division of labour which designates men to be superior to women in all social interactions, concerning men and women.

The heritage handed down to the nursing occupation by Nightingale and other reformers has left its indelible mark on the issues identified by the nursing profession in the later years. Nurses have taken up issues related to registration, professional status and for a certain degree of organisational autonomy. But at no time has the nursing profession questioned its subordinate position. In fact one of the barriers for expanding the nurses role to a nurse-practitioner came from the nurses association in the US, who were reluctant to accept the responsibility for diagnosing and treating.

In India one could say that the health care system expanded only after independence. Although on the whole its evolution was similar to the development that took place in the West, there were certain dissimilarities. For instance, even as far back as 1883 several universities in India began to accept women as medical students. The Bhore committee in its recommendations at 1946 stated that at least 20-30 percent of seats in medical colleges should be reserved for women students. The change in attitude of the profession towards women students was perhaps related to the constraints placed by the purdah system on women in general which prevented the male medical profession's entry into areas such as maternal and child health. The post independent years have seen attempts to provide medical services through an alternative health care structure by establishing primary health centres and subcentres to cover rural populations. But throughout all these developments adequate care was taken to ensure that the monopoly exercised by doctors would be maintained and remain unquestioned.

The Bhore committee stated categorically that only the physicians trained in allopathy, should be called doctors and the doctor was to be the unquestioned leader of the medical team whether it was in the operating room or in the primary health centre. It emphasised the training of one level of doctors and recommended the abolition of the Licenciate course. Without analysing the class background of the doctors or their class interests the members of the committee hoped that training sufficient number of doctors would ensure that they would opt for the villages. That the committee was not sufficiently interested in the other categories of health personnel can be seen by the number of pages devoted in their report on the training of doctors and all other categories of workers. Later committees too have emphasised the role of doctors at the cost of neglecting all other health personnel. The need to train a 'lower' category of practitioner is discussed time and again but is always rejected on the plea that it would lead to quackery. At the same time when the suggestions that a 'lower' level of nurse be trained was made by the nursing council it was greeted as the most feasible solution given the low resources available in the country. Similarly when the Shrivastav committee made its recommendation in 1975 for training village level workers, it also allayed the fears of the medical profession by stating that since the role of these functionaries was educational, their curative skills would be limited to just a few remedies for simple day to day illnesses.

The end result of all such actions has been to create a structure which is rigidly hierarchical reflecting the class structure in the broader society. Just the way the economic status or caste of a person largely influences his/her future position in any socio-economic activity, in medical practice too these factors very often determined which level of hierarchy s/he will occupy in the health structure. This streamlining into 'suitable' rung in the hierarchy is generally mediated through the person's performance in and access to education. For instance, the three categories of nursing personnel we have in India that is the B.Sc. nurse, the Registered

Nurse Registered Midwife (RNRM) and the Auxiliary Nurse Midwife (ANM) required different levels of educational qualifications to enter into their respective training schools. This determines the class that will be predominant in each of these categories which is further consolidated by the differential salary structure and status afforded to these three categories in the nursing profession.

Since medical care is a valuable commodity and the right to provide it has been appropriated by doctors, all other categories of health workers and the functions they perform remain subordinate to that of doctors. This monopoly is often carried to ridiculous lengths, such as the prohibition on nurses to start an intravenous drip or give an intravenous injection.

Reports discussing the problems of health personnel have also mostly focused on the problems faced by doctors. One hears repeatedly that doctors have to face innumerable problems such as lack of educational facilities for their children, lack of 'entertainment' in the village and less opportunities for professional growth; and that unless these facilities are provided it would be unrealistic to expect doctors to work in the villages. But these 'problems' really pale in significance if one considers the difficulties an ANM faces during the course of her work.

Nurses : Problems They Face

The problem nurses face needs to be dealt with separately. Their contribution has been mostly towards the care of patients, although they perform important technical tasks too. The rural health services rest largely on the functioning of female health workers and their non-performance could very well paralyse the entire rural health network. Yet their status within the structure of health services has remained one of subordination. Attempts in the past to improve the status and image of nursing has very often been limited to increasing the content of the curricula or the technical content of their work. But this only ends up in reemphasising the fact that 'caring' as a function cannot be held on par with that of diagnosing and prescribing.

As women, nurses have an added problem of sexual harassment which they have to continuously face both within and outside their work situation. One reads of newspaper reports of nurses who are molested, who commit suicide because of sexual abuse or are murdered for their unwillingness to be casual sexual partner. One could hazard a guess that the women health workers in rural areas are probably exposed to such problems to a greater extent. This is not because the rural males are different from their urban counterparts but rather the situation that the nurses are in makes them more vulnerable. Isolated as they are in remote villages, with little support from other health workers these women health workers suffer in silence out of sheer economic necessity to retain their jobs. This could also be the reason why such incidents are under-reported.

Although this problem has been recognised as a major constraint there has been no systematic effort to document these incidents or evolve support systems to tackle such problems. Addition of self defense into all nursing curricula as a skill to be developed by nursing students could perhaps be one such way. But a more realistic solution would only emerge if nurses' unions take up this issue seriously to launch a struggle to make their work place safe. Indeed for such struggles to succeed they will have to become part of much larger struggle of all women. The top two categories of nursing personnel are generally better placed to form unions as they work in hospitals and are physically proximate. The ANMs on the other hand who work mostly in the PHCs and subcentres have little opportunity to come together to raise their collective demand.

The work force employed in the hospital industry is similar yet distinct from that employed in other industries. The distinction lies firstly in the fact that these functionaries work on raw materials (patients) to produce a non-quantifiable product 'health'. Secondly, the physicians and sometimes the nurses who occupy the higher level of hierarchy view themselves as professionals rather than as workers. This often contrasts with the attitude of non-medical hospital workers who view their activity merely as a job. But the situation is changing now. Doctors, nurses and other 'professional' health workers are getting unionised and demanding more and more job benefits, fixed duty hours and overtime pay, in the process assuming the form of wage earners. But even when such issues are taken up they try to use their 'professional' status to push their point. For instance, in the recent strike by the interns from medical colleges in Delhi, a placard was used with the legend 'Doctors lathi charged! What next!'

Although the demands of the 'professional' categories are similar to that of non-medical hospital

workers there is little attempt to identify these issues as common issues and to unionising on the basis of their identity as workers.

One of the limitations of this perspective as well as the whole issue on 'People in Health Care' is that we have concentrated on health workers functioning as part of the allopathic system of medicine. We really know very little about health workers belonging to other systems of medicine in India, in terms of their role and status. Further even among the workers in the allopathic system very little information is available about non-physician health workers.

Finally, a word about the people on whom the 'people in health care' work upon. As patients they are the most powerless in the interaction that takes place in a health care set up. They are neither in a position to direct the course of their treatment nor can they demand a social accountability from health personnel. The self-help movement in the west has been a reaction to such powerlessness. It remains to be seen whether the concept of self-help can ever become a viable alternative to the present system as it exists today.

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In this issue :

Sujit K. Das explores the much debated subject of the class location of doctors and queries the stereotypical definition of medical care as a commodity. Rajkumari Narang looks at various studies in anaemia to illustrate her contention that the choice and treatment of problems in medical research is rarely governed by factors such as people's needs. Imrana Quadeer examines the impact of the rural social and economic realities on the Community Health Worker's Scheme. Sumathi Nair takes a closer look at four Commumity Health Projects and asks what their relevance is today. The issue also carries two articles outside the theme of People in Health Care. Ekbal reviews the marxist critiques of the Ilichian School and Amalendu Das throws light on dust hazards faced by coal miners.

DOCTORS IN HEALTH CARE
Their Role and Class Location

sujit k das

Doctors have played a central role in health care services. In India medicine has enjoyed both state and popular support since the independence. State health services expanded rapidly as did the number of doctors. Many of these doctors went into private practice or migrated to other countries and others into the state health services. This article explores the much debated subject of the class location of the medical profession. Is the general practitioner a productive labourer or a capitalist ? Does the doctor in service belong to the working class ? The author draws attention to the effect of the state sector on the medical profession and traces the growing agitational movements and organisation of state doctors in the country, with special emphasis on West Bengal. Against this backdrop he queries the stereotypical definition of medical care as a commodity.

Doctors are the most important people in health care. Even the official expert group on health, after unrestrained criticism of the doctor-dependence of our health system, concedes "Moreover, the doctor as the leader of the team can play an important role and influence the values and the quality of caring among the whole staff if he shows these concerns himself" (HFA, 1981). Radical critiques on health care call for reversal of the doctor-dependence of the health system but nevertheless wish for a change towards socialisation and social orientation of the medical profession. Popularly, doctors are looked upon as next to gods since they deal with life and death and no wonder doctors are often beaten up when a patient dies or there is allegation of negligence on the part of the doctor. The popular view offers the medical profession the key position in health care; expects it to protect the health of the people; regards it as the greatest depository of knowledge and wisdom regarding health; believes that the weakness of the health care service is due to lack of adequate number of doctors. From the Presidents of India down to the Taluk functionaries they have all been exhorting the medical profession to be patriotic enough to go to the remote villages and stay there to serve the under-privileged rural people.

Surprisingly few attempts have been made to investigate, analyse and understand the medical profession in the perspective of concrete reality. Despite its crucial role, the medical profession is commonly assessed on the basis of subjectivism. Just as the modern medicine had been borrowed from the west, the Indian critiques of the Indian medical profession appear, more often than not, to have been borrowed from the western radicals. The profession had hardly been looked into as what it is, but often analysed on the basis of what it should be.

Development of the Profession

In India the art and practice of healing devolved on to a group of socially engaged men, and several systems of medicine developed and have survived till to-day. Each system was somewhat well-developed corpus of knowledge and its practice had traditionally been taken up by successive generations. Following the changes in the relations of production and exchange, independent practitioners emerged. Later, systems of modern scientific medicine (allopathy) and Homeopathy came from the west and took roots.

In the 19th century, modern medicine had little to offer. The 20th century, heralded the appearance and development of a scientific basis and since the thirties, appearance of chemotherapy and improved surgical techniques created a surge of interest in, and attraction towards, modern medicine owing to its dramatic life-saving achievements. Popular attraction received a further acceleration around and after the second world war as a result of the invention of newer wonder drugs and technology. The practice of modern medicine, likewise, earned a heightened respectability and soon rapidly emerged as a profitable livelihood.

Demands for the expansion of the hospital services have been raised from all corners. The situation is a parallel of what prevailed during the expansion of hospital services in the National Health Service (NHS) of UK. "For the politician, it might be assumed, there could be no better advertisement than a shining new hospital: a visible symbol of his or her commitment to improving the peoples'

health. For the doctors, new hospitals meant the opportunity to practise what is considered to be higher quality medicine. For the consumer, in turn, new hospitals surely meant better services with higher standards of treatment (Klien, 1984). No wonder therefore, in a market economy, almost all aspiring doctors moved towards the practice of curative medicine with its life-saving and relief-producing implements. Iliffe has put it succinctly, "Just as abortion would be a sacrament if men became pregnant, so health professionals would stampede into preventive work if prevention could be made into a marketable commodity" (Iliffe, 1983).

Introduction of welfare activity by the state saw the expansion of state health care service and the number of health personnel increased rapidly (Table I). Later, indigenous systems and homoeopathy, for reasons not discussed here, also received state patronage.

Table I

Year	No. of Med. Colleges	Students admitted	Qualified
50-51	28	2675	1557
60-61	60	5874	3387
70-71	95	12029	10407
80-81	106	10934	12170

Figures are incomplete as a few centres failed to report.

Source : Health Statistics of India (1982) : C.B.H.I., Ministry of Health & F.W., Govt. of India.

Table II Year 1981.

Total No. registered	Went abroad	Returned from abroad	Regd. in Employment	No. admitted in P.G. Courses	Total No. Regd. Doctors in other systems
268,712	4766	2381	16406	8241	382,686

Source : Health Statistics of India (1982) and University of Calcutta.

These doctors opted for private practice or other employment or post-graduate education for specialisation, or migration to foreign countries. For the last few years more than 2000 doctors have been settling abroad annually. There is no available data to indicate the number of doctors engaged in each category but the distribution follows the market situation and economic compulsion. Old pattern of general practice recruits less and less. Number of women doctors has been steadily increasing since 1976-1977 and they generally settle towards certain culturally chosen occupations e.g. gynaecology and obstetrics, pediatrics, pathology, plastic surgery, anaesthesiology, non-clinical disciplines in medical colleges and also dental surgery. Most of the women opt for employment and independent women private practitioners prefer G & O and Pediatrics. Unemployment is a late development (Table II).

Class and the Medical Profession

Private Practice and General Practice

In West Bengal, approximately 70 percent doctors are engaged in private practice. They include independent practitioners, Insurance Medical Practitioners of ESI (M.B.) Scheme, part time practitioners of the state and private sector employees. The General practice has been changing with changing social relations, scientific developments and cultural attitudes. In earlier times, the general practitioners (GP) could not demand any consultation fee and had to distribute drugs to his clients. He then used to incorporate what he considered to be his due consultation fee, within the price of the drug. As a result, the consumption of non-essential drugs and compounded drugs was high. Also the actual price of a compounded drug is difficult to check and verify. Later, consultation fee has gradually been introduced and has received public acceptance, resulting in the development of a class of GPs who are only prescribers.

Indian society has a long tradition of voluntary efforts for charitable medical care to the community. In fact, a good number of clinics and hospitals had been established through philanthropic endeavours. In order to earn and maintain 'nobility', the price doctors had to pay was to attend to emergency patients, give free 'service' to a few indigent patients and offer honorary service in the voluntary institutions. Besides respect, speedy recognition and fame, this attachment to charitable institutions used to bring other material returns. The doctor used to test the emerging therapeutic techniques on poor patients without informed consent and without risk and later employ the technique thus perfected, in cases of paying clientele in the private practice. Actually, the situtation is so advantageous that there is serious competition among the contending doctors to secure honorary employment in the charitable medical establishments. A sort of corrupt practice was also rampant where the patients had to pay the honorary doctor in order to avail of the free hospital service. This malpractice has now been almost eliminated in West Bengal due to higher level of consciousness of the people, but is still in vogue in many other states.

The GP therefore, acts as a retailer of drugs; sells his skilled labour, designated as 'service' to

individual buyers; and it may further be argued that he employs his knowledge and skill as capital and sells the product of his own labour in the market as commodity. Is he a productive labourer or capitalist? Karl Marx, in his inquiry into the social status of independent handicraftsmen and peasants as well as that of producers of non-material production e.g. artists, actors, teachers physicians, etc., said "It is possible that these producers, working with their own means of production, not only reproduce their labour power but create surplus value, while their position enables them to appropriate for themselves their own surplus-labour. ..... And here we come up against a peculiarity that is characteristic of a society in which one definite mode of production predominates, even though not all productive relations have been subordinated to it. ... The means of production become capital only in so far as they have become seperated from labourer and confront labour as an independent power. But in the case referred to the producer – the labourer is the possessor, the owner, of his means of production. They are therefore not capital, any more than in relation to them he is a wage-labourer" (Marx). The GP is actually engaged in a precapitalist mode of production, but nevertheless produces commodity of use value and sells it for exchange value. Our much maligned GP is not altogether a demon or blood sucker. He is just a small commodity producer who still renders essential service which the state is unable to provide for. A close study of the GP will reveal how the western medicine took roots here, changed the health culture and in the process changed its own.

Speed of expansion of the market of private practice has lately been thwarted and is gradually being squeezed for several reasons. Increase in the purchasing capacity of the people cannot keep pace with the increase in the number of doctors thrown into the market. Secondly, expansion of the state sector in medical care has been impressive and concentrated in the urban areas and these are totally free or heavily subsidised. Socially dominant classes who can afford to purchase medical care, have been able to capture the largest share of the free/subsidised state service. As a result, private sector medicare did not develop to the expected level. Thirdly, private practice has a latent period to reach profitability. Lately, increasing numbers from the lower income groups have been recruited in the medical profession, who cannot afford to sustain this latent period. All these have resulted in increasing trend towards employment and migration abroad, unemployment and underemployment.

Doctor-in-Service

Expansion of organised medical care service through state, public undertakings, ESI, big private industry and voluntary organisations has resulted in a marked increase in the number of doctors in employment. Though private medical practitioners still constitute about 3/4th of the medical profession, the doctors-in-service attract the major, if not entire, attention in any debate on health care owing to the fact that the organised sector is the trend-setter and almost always features in planning and debate In this context, the present discussion dwells largely on the doctors-in-service among the practitioners of modern medicine. However, no discussion on the medical profession or for that matter, medical care is compreshensive unless it also includes private practitioners of modern medicine and of the other systems.

The non-practising employed doctor is actually a wage earner destined to identify himself with the aspirations of similar wage-workers of the so-called white-collar category. Though the 'noble profession' ideology provides an excellent instrument for the private practitioners to maximise profit in their trade, it has ironically proved to be a constraint in the way of fulfilling his aspirations. Because of the stigma of 'noble profession', he cannot claim fixed duty hours; cannot claim 'overtime' i.e. extra remuneration for extra work; cannot employ 'red-tapism' in his daily work-load; cannot even utilise his earned leave to escape from the drudgery of frequent emergency duties. He is further handicapped in regard to democratic rights so much so that unionisation of doctors is frowned upon by the society; agitative action is taboo; call for strike in hospitals is taken to be sheer blasphemy. On top of it, the doctor has little hold in the administration of medical care and in the matters of policy-making, programming and power hierarchy, the doctor is placed in a lower position subordinate to the generalist administrator But more about this later.

Do they, then, belong to the working class? The question has never been raised or debated. On this issue, the dogmatic marxists adhere to Reductionist ideology. "Reductionism involves a version of historical materialism which presents all social phenomena as 'reducible' to, or explicable in terms of, the 'economic base'. Thus political struggles or social ideologies are explained as manifestations or 'reflections' of economic forces. In this presentation marxism is reduced to asset of

relatively simple and universal 'laws'. ..... Such a position is guilty of 'essentialism', that is of seeing the economy as embodying the essence of all social phenomena which are then simply expressed or made manifest in the social world" (Hunt, 1978). This methodology necessarily attempts to define classes at the economic level and attaches little importance to the forces operating at the political and ideological level Working class is differentiated by the difference between productive and unproductive labour. Mere wage-earning or labour-selling do not provide entitlement for entry into the working class. "The working class in the capitalist mode of production is that which performs the productive labour in that mode of production. ..... Although every worker is a wage-earner, every wage-earner is certainly not a worker, for not every wage-earner is engaged in productive labour" (Poulantzas, 1975). While in cases of white-collar wage-workers of the industry, transport and mercantile enterprises, Marx concludes that they are productive labourers, the physicians-actors-teachers etc. are also productive labourers. He observes, when they sell their labour power (manual or mental) in a capitalist establishment which appropriates their surplus labour and makes a profit by selling the products as commodities. But he adds, "All these manifestations of capitalist production in this sphere are so insignificant compared with the totality of production that they can be left entirely out of account" (Marx, 1978).

Technology, capitalist organisation of production and productive forces are much more developed now than at Marx's time, though the development of medical care service as a sector of capitalist industry is still rudimentary in India. The new working class of advanced capitalism — the technicians, engineers, scientists etc. — is held, by Serge Mallet, not only to be revolutionary but the 'avant-garde' of the revolutionary socialist movement (Mallet, 1975). Services have long been developed into profit making industry in the developed countries.

Here in India, doctors as wage-earners are now commonplace. To what class do they belong? The established left still subscribes to the liberal concept of health care and therefore, has yet to face this question. The progressive view, however, is confusing, to say the least. "The capitalist can organise the production of surplus value through the provision of health care and can realise higher profits in this service industry. It is immaterial whether the surplus value is realised directly through the productive activities in the clinics and hospitals owned by the Capitalist or indirectly, through the provision of health care by the State to maintain or increase the productive capacity of the labour." (Jesani and Prakash, 1984). Such an assertion is based on dubious premises that medical service has developed into an industry; that the State also acts as a productive enterprise; and that State Health Care Service is an organised investment by the capitalist class on the industrial productive labour.

What then is the status of the producers of 'health care'? The above assertion automatically places the employed doctors into the category of the working class. But alas, the entire medical profession carries, in the radical viewpoint, the same class background as the bourgeoisie and performs its predestined social task of legitimising-strengthening and maintaining the bourgeois medicine. Why this confusion? "The mere quantum of the so-called marxist analysis of health, done in the West has so impressed us that we have literally lifted their formulations and transplanted them on the Indian scene, without even thinking whether they are applicable. Further, in our hurry to fill in the gaps in our knowledge, we have concentrated on theory of health and medicine. That theory, however has been sought by filling the accepted theoretical constructs with Indian data and developments rather than beginning with health and health services itself to test the assumptions as well as the theoretical constructs" (Quadeer, 1984). In other words, in order to understand and analyse its status, role, trend and potential in health care, we have to make an actual study of the medical profession in its concrete reality.

Professionalism

"Professionalism within health care is based on the idea of 'service' and on the practice of trade. It is a market concept expressed in the relationship between a customer (the patient), a tradesman (the professional) and assorted suppliers (the drug industry, other superior professionals). Trade secrets are necessary for the maintenance of the market relationship, and permit professionals to define themselves as special, and beyond the control of those ignorant of these "trade secrets". The autonomy of health professionals — particularly doctors rest on the range of their trade secrets" (Iliffe 1983). With this conception it follows that professionalism could be curbed or even abolished with the

abolition of market economy i. e. private trade or commodity market in health care. This appears to be another instance of radical presumption. Professionalism is not a creed peculiar to the medical profession nor to the bourgeois ideology. Professionalism not only regins in private medical trade but also exists among the employed non-practising professionals, among the medical teachers of non-clinical disciplines and among the doctors engaged in public health work.

Professionalism exists in pre-capitalist economy and continues in the post-revolutionary societies where the ownership of the means of production has undergone a change and private trade almost abolished. In a round table discussion on private medical practice organised by WHO, it has been revealed that private practice, in certain forms exists and is developing in the socialist countries (Roemer, 1984). Medical co-operatives are springing up where state-employed doctors are allowed to spend upto two hours a day and are entitled to a 50 percent share of the payment received from the patients in cash for the services rendered. Even in China, barefoot doctors who are essentially paramedics, are allowed part-time private practice. A common practice developing in these countries is that of giving gifts to doctors in hospitals and often the gifts are relatively large amounts of money. All this is done to ensure better quality of service (which is by no means certain). How is the quality of service to be determined ? How are measures and gradations to be made ? There is as yet no acceptable indicator or scale. Hence, quality will be determined differently by different social ideologies and health cultures, and the latter are manipulated by professionalism. Specialisation and mystification are only other facets or instruments of professionalism utilised to maximise the price of medical service in private practice.

Specialisation, however, is not an exclusive exploitative imposition. It is also an integral part of social division of labour, not only unavoidable but necessary in any social formation including the one based on non-exploitative mode of production. What is relevant is not to confuse social division of labour with capitals' division of labour. In an analysis of modern chemical industry in UK Nichols and Beynon have shown that though technical division of labour is a must in any industry in any mode of production, in the capitalist mode the technical imperatives are subordinated to political imperatives and technology exists to serve and augment capital. "Certainly in any mode of production, given the existence of specialised training, some men will be more technically competent to solve certain problems than others This is so obvious as to hardly require stating. But something else which should also be obvious is often ignored. For concern with the technical structure of complexes like Riverside (the factory site) can also too easily obscure the fact that they are not even designed to make chemicals, but to make chemicals for profit The reality is that their division of labour is capital's division of labour ..... (Nichols and Benyon, 1977) Professionalism, also, could make its contributions in the struggle against the ruling class and the state. The history of the development of health care service in Great Britain has shown that the professionalism of the doctors thwarted, at different stages, the attempts of the state to reduce or withdraw the medical benefits demanded by the people. Here in India also, professionalism often reinforces the demands of the people for the egalitarian distribution of medical services against the discriminatory practice of the state.

What do we expect from the doctors? Here, the bourgeois, left, radical and popular views converge and appear as if grossly influenced by the ideology of professionalism. A doctor should render utmost efforts irrespective of the socio-economic status of the patient; should always ungrudgingly serve emergency patients without consideration to his own convenience; should always be guided by the code of ethics formulated by the profession; should act as a friend-philosopher-guide to the patient; should exude hope and confidence in his conduct etc. etc. Concomitantly, the community accorded certain privileges to the profession. The doctor knows best; he should not be questioned; he has the unchallengeable right to handle and manipulate the patient's body; his good faith is taken for granted even in cases of the patient's death and disability.

What do the doctors think about their own role expectation? In a large study in two medical college hospitals in Tamilnadu, Venkatratnam revealed that the doctors' understanding of their role expectation is a composite of their own individual perception, occupational compulsions and organisational (professional and institutional) principles (Venkatraman, 1979). Role expectation comprises of professional, academic, research, managerial and social. Many interesting facts and controversial issues regarding doctors' responsibility towards patients, role towards other health workers, requirements of teaching-training-research, level of

communication with patients, social responsibility and so on have been revealed in the above study and these should be analysed before rushing to issuing sermons on doctors' role expectation. Peculiarly, the ICMR-ICSSR report, while castigating the profession for its negative attitude towards preventive and promotive health care recommends for their 'alternative model' of health care service that "the doctors will still continue to play an important role in the new health care system. But this will not be over-dominating and will be confined more and more to the curative aspects of the referral and specialized services for which they are trained" (HFA 1981).

Universally, the understanding of role expectation of the doctors suffers from an idealistic approach. All expect the doctor to be humane, shorn of commercial urge, dedicated to patient's welfare, imbibed with principles of social justice etc etc. No one asks why the doctor should follow such a model or what objective conditions may compel him to do so? Or for that matter, what objective conditions persuade the doctor to do as he does?

Perception of role performance differs between the professionals and the consumers for obvious reasons. Confusing and paradoxical situations prevail. While the State hospitals and the doctors are almost always on the dock by the consumers and mass media for the severe shortcomings in role performance, the very same hospitals and the professionals are very much in demand for their high quality and indispensible medical service. True, the service is attractive because it is free. But even amongst affluent consumers the notion prevails that the hospital doctors are more skillful, knowledgeable and equipped. Generally, the doctors' notion on role performance is that they do their best under the given circumstances and they could do more if they have a free hand in the administration which is responsible for the constraints. The factors underlying these confusions and paradoxes are being unravelled by the growing momentum of the organised movement of the doctors.

Doctor's Organisations and Agitations : West Bengal

Medical practitioners got themselves organised under Indian Medical Association in the thirties. Later, practitioners of each speciality discipline built up separate associations. The basis of these associations is professionalism, academic and pseudo-academic. It should be mentioned that non-clinical and even public health disciplines organised their own associations. But the associations could not cope with the task of tackling the emerging aspirations of the employed doctors. In fact, a contradiction developed between them. Ironically, the bone of contention was economic as well as ideological. The ideology of professionalism appeared to be a drawback for the service-doctors. The pay packet of service was unattractive not only in comparison with the income in private practice but also compared unfavourably with that of the similar category of government officers, for instance the civil service, or the engineering service. This situation had been a hangover from the British days when doctor's pay packet was deliberately kept low with the understanding that they would make it up with the earning from private practice, a privilege then enjoyed by all service-doctors. Later, with the expansion of the state sector, more and more doctors had been employed on non-practising basis but this principle of wage policy did not change.

In matters of job requirement, job perquisites and job satisfaction, there was nothing glamourous to look forward to. Duty hours was virtually feudal - a doctor was 'on call' for 24 hours a day for emergency need and seven days a week; almost all health centres in the rural areas were manned by one doctor in each; there was no ceiling on the number of patients one had to attend daily; a rural medical officer, in addition to his clinical duties, was entrusted with the tasks of family planning, MCH, School Health, Immunisation, Epidemic Control Administration and what not. System of recognition and appreciation of good and dedicated service was absent. Avenues for higher education, promotion, research, or even a transfer to a better post after a scheduled period of service, were severely limited. Because of longer period of training to acquire qualification, a doctor usually enters service at a later period compared to others and consequently is entitled to a lower pension and lesser amount in the retirement benefits.

The state hospitals were always understaffed and underequipped and hence, the scope of practicing what the doctor was trained for, was thereby limited. On top of these, the health administration was run by the generalist administrators. These people had no career attachment to the health department; were not answerable for failure or mismanagement; had no inclination to learn the problems of the health care service as well as of the employees. The doctor had no voice in health planning, hospital service development and technical development. The autonomy enjoyed by the profession

in regard to clinical practice in the NHS of UK was not even partly granted to the doctors here. On the other hand, the political authorities found it convenient to put the blame on doctors and other health workers for all their failures, misdeeds and incompetence in the health sector. Consequently, doctors and the health workers, as they were the ones, at the counter, had to suffer the burden of public wrath in the form of physical assault, humiliation, abuse and so on.

What did the doctors do to overcome these adversities? It is worth while to note that the state service was last in the list of priorities of a new medical graduate. The order being private practice, specialisation, migration abroad and if all fail — then he opts for service. Lately, because of competition, the options have shrank greatly and large numbers are now competing among themselves for limited state service; doctors from Orissa, Assam, Bihar, Bangladesh are now applicants to the West Bengal State Service.

In this situation how have the service-doctors reacted? Quality has been the first victim and expectedly so. No matter whether 50 or 500 attend the outpatients clinic the experienced doctor manages to tackle them within 3 hours or so. In a 100-bed hospital, 200 patients stay indoor regularly but the same number of doctors and health workers treat them without spending any additional time in the hospital. The next escape route is private practice — both authorised and unauthorised. In west Bengal except in the case of clinical teachers of the majority of medical colleges and doctors in the district and subdivisional hospitals, private practice is not allowed. In fact, 7/8th of the State doctors are non-practising. The States of Orissa, Andhra, Maharashtra, Punjab, Hariana and others have either entirely or partly non-practising state service. Some other states have indicated that they will too follow suit. The entire Union government and the public undertakings sector is non-practising. Expectedly, most doctors aspire for the limited practising privilege of the service and in the non-practising sector, unauthorised private practice is growing wherever there is scope and opportunity.

The question of the alleged reluctance of the doctors to serve in the rural institutions should be understood and analysed with this background in mind. Concerned people have swallowed the government propaganda that because of such reluctance on the part of the doctors, the government despite earnest efforts and liberal financial allocation, fails to provide medical care to the rural people. By absorbing this propaganda uncritically, the health activists on the one hand, unwittingly agree with the government that medical care is synonymous with the presence of a doctor, fall in another trap that provides for offering barefoot doctors Homoeopaths-Ayurveds and simple home remedies for the villagers in the garb of tradition, indigenous culture and community medicine. The fact is otherwise. It is deliberate government policy to keep the service conditions of the rural medical officers unfavourable with a view to discourage the doctors from taking up rural postings; and in this attempt, one must admit, the government has been successful to the exent that even the occasional few socially conscious people-oriented young doctors, after a stint of rural service, try their utmost to move to the urban area or quit. The Siddhartha Roy Congress government's regulation of 1974 stipulated that physicians with specialist degrees would enjoy a higher pay, a special allowance and would be exempt from rural postings. It was only natural that young doctors went in for specialisation just for the sake of avoiding rural posting, if not for higher emoluments. The Left Front government has not felt it necessary to change the regulation" (The Statesman, 1985). This policy in fact, induced even those doctors, who had already settled in the rural areas, to move for any type of specialisation and settle in urban areas. Does it show reluctance on the part of the doctors or that of the government? Lately, the Marxist Left Front government in West Bengal introduced against the protest of the medical profession, a short term three year medical course to train up doctors who would fill up the rural vacancies. Next year, the junior doctors in the State launched agitation for jobs in the State service and demanded that all rural posts be immediately filled up by currently eligible 3000 unemployed young medical graduates. Under public pressure, the Left Front publicly declared that there were no such vacancies and they were unable to provide jobs, not even in the rural areas. The short-term medical course had to be wound up In any case, the discrimination against the rural medical officers persists. No one, of course, raises the question why doctors, of all people, must go and serve the villagers who are ignored in respect of all other consumer goods: It must be understood that the recent organised demand of the junior doctors for rural appointment is not due to any sudden surge of patriotism but simply due to pressure of unemployment.

In course of time, however, the consoling compensation through private practice turned out to be insufficient. Service-doctors and junior doctors ventured to organise their own bodies on trade union basis to voice their grievances which did not find deserving place in the earlier professional bodies like IMA which was dominated by private practitioners. In 1973, junior doctors launched a movement in West Bengal demanding better pay and service conditions, and better provisions in the State hospitals They had to go on strike and come out partially successful by obtaining pay hikes. In 1974, the State doctors (in alliance with the State engineers) resorted to strike for 41 days but maintaining the emergency services. Their demands were not only economic but encroached on the political and ideological level. They demanded exclusive executive power for the scientists, technologists and professionals in the scientific and technical departments of the State administration which were the preserve of the generalists, and parity in pay scale with the Indian Administrative Service (IAS). This agitation generated intense debate throughout the country and the issue has not yet been settled. The West Bengal government ultimately made a few concessions but unfortunately, with the subsequent imposition of Emergency in the country, the terms of the agreement were not implimented, leaders were sacked and doctors terrorised. The fall out of this agitation was visible elsewhere; the pay scale of the doctors in the Union government and public undertakings were soon revised upwards to bring it on par with that of the IAS at the lower level.

This agitation made a breakthrough on several grounds. People saw to their surprise that renowned professors and principals of the medical colleges, eminent specialists and senior engineers holding high ranks in the state service, walking in processions, squatting on the pavements and holding street-corner meetings. It then struck them as a novelty that the 'noble' doctors could resort to agitative ways that befit only common workers. Doctors, it was stressed, had no right to jeopordise the well being of the patients by striking. This agitation, perhaps for the first time, focussed people's attention on the affairs of the medical service, particularly into the government assertion that the doctors and health workers were responsible for all the ills in the system. This agitation was followed by a series of agitative movements all over the country, mostly by the junior doctors but also by the state doctors in Delhi, UP, Orissa, Assam, Maharastra Andhra, Bihar - though with different demands as was expected owing to different levels of development. Everywhere, organisations of service-doctors sprang up independent of the IMA. The agitation in West Bengal also brought changes in the orientation of Bengal IMA, which despite its long history of co-operation with the government had to come out actively in support of the service-doctors and junior doctors.

Sporadic movements on various issues such as reduction of job burden, physical security at the work-site, better provisions for emergency care, improvement of rural medicare and more scope for higher education have taken place culminating in the 1983 statewide movement. The junior doctors demanded, besides better pay, service conditions and provisions for emergency care and a health policy with priority to preventive care. The Left Front Government took recourse to unprecedented repressive measures using party cadres and the police. Brutal police violence on the junior doctors brought state doctors onto the scene, also in an unprecedented manner. Perhaps for the first time in the world, state doctors in their strike action withdrew from the emergency services. This was an organised retaliation of the doctors against organised terrorism of the Left Front government who reiterated the earlier declaration of the Congress regime that the doctors had no right to strike. The government had also earlier started denying the doctors the right to any agitative activity. This was strange and definitely unacceptable to doctors who had to earn democratic rights through hard struggle in 1974 when the conduct rules for the government servant had been revised. The doctors received, unprecedented public support even though they committed such so-called anti-humanitarian acts as deserting the emergency counters. The government finally had to withdraw the victimisation and punitive measures and concede the immediate demands of the strikers.

There are now indications that service doctors are now beginning to realise that the aspirations of their occupation are directly related with the nature, object, standard and extent of the state health care services. They have now raised the demand for clear declaration of the aims and objects of the state health policy and a controlling role in implementation, a plea to share responsibility with power. The service-doctors in West Bengal demanded that free state medicare be exclusively reserved for the indigent population only, which produced indignant protests not only from the privileged middle class

but a few political parties with 'Left' labels. Different mass organisations are now holding meetings and seminars on the health policy and state health acare administrtion There has also been a renewed spurt in the agitative movement of the junior doctors and service-doctors in other states for instance Bihar, UP, Orissa, Maharastra and Delhi.

These organised movements of the service-doctors brought many undiscussed issues into public attention. Should the doctors be treated as a special occupational group with limited democratic rights and additional responsibilities to society? And if so, why? What are then the limits of the forms of agitation for the doctors, if they have grievances to agitate for? Are the doctors also entitled to fixed duty hours just like others? Why should doctors alone have a moral or social obligation to serve the villagers who are deprived of, and are discriminated against in respect of all other commodities and services? Should the generalists enjoy the power and the doctors bear the responsibility of state health care service? And finally, who doctors are primarily responsible to, the employer or to the patients or to their professional ethics?

The foregoing development and issues persuade us to take a new approach — the marxist approach — to determine the role expectation and analyse the role performance of the medical profession. In a market economy, the medical profession cannot but be governed by its rules and to expect them to swim against the current is an utterly idealistic proposition. The service-doctors tend to behave as other wage-workers do. They try to extract as much wage with as little labour as possible, in contrast with the employer's tendency to extract as much labour with as little wage. It is all very well and easy to define 'medical care' as a commodity in the capitalist mode of production but it needs explaining how the universally free state medicare remains a commodity and behaves as a commodity. Or what here is the relation of production between the owners of the means of production and the sellers of labour power? It needs study to understand why the primary need of food-clothing-shelter is denied to a dying citizen but free medicare service is demanded and created and, the nature of the class struggle that brings about this state response. All these studies in the concrete reality of the Indian situation will bring us back to the question of class identification.

Conclusion

"The separate individuals form a class in so far as they have to carry on a common battle against another class; in other respects they are on hostile terms with each other as competitors. On the other hand, the class in its turn assumes an independent existence as against the individuals, so that the latter find their conditions of life predetermined, and have their position in life and hence their personal development assigned to them by their class, thus becoming subsumed under it" (Marx and Engels 1976). The individual's role in the production process, his location in the social relations of production, the productive or unproductive nature of his labour - all these form the basis of inquiry. But as regards the identification of class, the common interest, common behaviour and common action, which are often independent of individual wills, — or the common outlook towards social events, political and ideological orientations — are also important and often act as positive forces. To this Engels has drawn attention: "The economic situation is the basis, but the various elements of the superstructure-political forms of the class struggle and its results, to wit. Constitutions established by the victorious class after a successful battle etc., juridical forms, and even the reflexes of all these actual struggles in the brains of the participants, political, juristic, philosophical theories, religious views and their further development into systems of dogmas - also exercise their influence upon the course of the historical struggles and in many cases preponderate in determining their form" (Marx and Engels 1965). In order to understand the social role of a group of similarly placed wage-earners, their historical development in relation to the changes in the mode and relations of production as well as their political and ideological expressions vis-a-vis the dominant political and ideological current in the given society, are to be studied. Class is actually, a historically developed, ideologically shaped and economically determined dynamic relationship expressed through class struggle. Thompson's notion of class reveals this aspect. "By class I understand a historical phenomenon, unifying a number of disparate and seemingly unconnected events, both in the raw material of experience and in consciousness. I emphasize that it is a historical phenomenon, I do not see class as 'structure' nor even as 'category', but as something which in fact happens (and can be shown to have happened) in human relationships.... Like any other relationship, it is a fluency which evades analysis if we attempt to stop it dead at any given moment and anatomize its structure.... The relationship must always be embodied in real people and in a real context" (Thompson 1982).

The social role of the employed section of the medical profession is therefore, determined by their role in the dominant mode of production and by their interaction classes in the social events. Sellers of labour power primarily sell their labour power to earn a living not to produce commodities. By the complexity of social division of labour, some have greater interest in their products while others have greater interest in the production process. Each of the occupations has an ideologically determined skill, status and price. All have common despair in unemployment and all undergo the similar feeling of inferiority, helplessness, subordination and subjugation in relation to their employers. Vic Allen, thus describing the wage-earners, concludes that bourgeois sociological stratification of different hierarchical classes and the reductionist categorisation of productive and unproductive labourer without empirical substantation, will not be helpful in an attempt to differentiate between wage earners (Allen 1978). In the case of health professionals, the study should go much deeper and wider. Health and medicine are not mere sterile figures or say, mortality and morbidity statistics. Illness involves pain, fear and desperation in real life and these saturate the milieu wherein medical care operates. Cultural instincts and ideological creeds strongly influence and occasionally determine medicine and medicare. Medicine in its practice and institutional forms is not merely commercial exploitation or oppressive power relations imposed by the dominant class — as radicalism may have us believe — but is a resultant of class struggle, of antagonistic and non-antagonistic contradictions between classes; of interactions at the economic, political and ideological levels.

The question of the role and behaviour of the medical profession is relevant to the building up of a Peoples Health Movement (PHM). PHM is not merely imparting health education to the individual or community. PHM does not end with the exposure of the inadequacy and exploitative nature of capitalist medicine. PHM needs to acquire expertise, to develop sound scientific basis of egalitarian health system, to search for the mechanics of building up of a socialist health culture and to strive for subordination of medical science to social needs and aspirations. It is a stupendous task and the role of the health professionals is crucial. This necessitates objective study of the profession before theorising study of the developing contradiction in the profession and the nature of the contradiction; the dialectics of the medicine; the development of the elements of socialist medicine during bourgeois dominance; the dialectics of cultural change and development. In the ensuing struggle the weapons of the bourgeois science and technology ought to be counterpoised by the weapons of peoples' science and technology. Involvement of the medical personnel will not be determined by humanist exhortation or so called deprofessionalisation but by class contradiction and class struggle. The medical profession or a section of it - be it categorised as the 'new petty bourgeois' (Poulantzas, 1975) or the 'new working class' (Mallet, 1975) will have its own determinant role to play and the PHM activists must need to analyse and understand this role in order to formulate the strategy and tactics in the emerging social events of the health sector.

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UPSIDE DOWN MEDICAL RESEARCH

The Case of Anaemia

rajkumari narang

What conditions and influences the development of medical research ? What motivates a researcher to choose a particular problem area ? Under colonial rule research was a monopoly of a small group of scientists, mostly British some Indian. Curiosity and the need for experimentation and perhaps some concern for the suffering generated a number of interesting and relevant studies. After the '50s the orientation and the ethos of medical research have changed — the problem areas are not those which benefit the majority but those which are most likely to bring recognition to the researcher. Even when occasionally, an area of relevance such as anaemia is chosen, it is looked upon as a purely medical problem, deemphasising the social and epidemiological aspects. This results in a medical/technological solution which can at best, provide temporary relief. The author critically reviews the studies on anaemia over the years to illustrate her contention that the choice and treatment of problems in medical research is rarely governed by factors such as people's needs

Doctors and scientists from the very early part of this century belonged to a privileged class trained and employed by the British and lacking in involvement with the needs of the native population. We find however that there is a certain amount of eagerness to learn, experiment, and change things inspite of the primitive technology and little basic knowledge in the field of physiology. Although the knowledge of science was incidental and the doctors were guided by the prevailing assumptions and biases of their class, the mood of liberalism sweeping the country encouraged them to be open in their pursuits.

The science of me cine was still young and technology not so well developed. The lack of sophisticated laboratories and equipment was compensated. it appears, by more sincere attempts to learn about the lives of the poor and to look at the wretchedness of their condition that resulted in killer diseases. Curiosity and the need to experiment were also important considerations of that time. Scientists were new to the discipline and had not yet mastered it, to start the manipulations so obvious in the seventies. and eighties. This could have been the result of moral concern or a more humanistic approach.

The independence movement, world war and the general political atmosphere could have diverted the efforts of the scientists to what were seen as the needs of the country, but there was a persistence and demermination to eradicate anaemia. The callousness of the later research is absent, though anaemia must have been uninteresting and unexciting to the whites (as a condition rarely encountered in the West) and the Indians bred in their tradition. In contrast after Independence when anaemia still tops the list of killers during childbirth, scientists are bored with the problem unless it lends itself to molecular manipulation and sophisticated technology use. There is no patience or concern with the lives of the poor, or with the neglect of women, and the environment of infection and infestation. The age of cold hard objective reasoning demanded ruthlessness with the poor. The human angle was side tracked and with that out went methodical epidemeological research. If anaemia has not disappeared with the iron pills — the country cannot stop its march to the 21st century with the electron microscope, ELISA, molecular biology, monoclonal antibodies and so on. "Socio-economic problems are not the concern of the scientists", as one award winning consultant scientist to international agencies remarked. Even technology has not been used for the poor. We have sensitive tests developed to detect diabetes (less than 5 percent have it) inborn errors of metabolism (prevalent in 1 in ten thousand or 1 lakh population), but the method of anaemia detection is the same as that we had in the thirties !

Research today has stepped out of the homes of the poor, by passing the dirty lanes, open drains, concrete monstrosities and smoke emitting factories, straight into the air-conditioned labs and test tubes. Problems that are rooted in an exploitative socio-economic system are sought to be solved from the rarefied atmosphere of the laboratories. Solutions to hunger and anaemia are sought through statistical manipulations of mean and standard deviation. It seems as if scientists are now fighting by proxy the battles of the ruling classes regarding food needs, minimum wages and hunger; their scientific vision can accept strips of data fed into the com-

puter, but not the living, half dead tired women who flock to the hospitals everyday. This myopia seems characteristic of our research today. This mechanical transfer of data reflecting the lives of the poor had occurred in the west almost 25 years ago. India seems to be one of the few developing countries trying to catch up in this field. The price we pay for the use of these advanced techniques is that we loose sight of the human being at the other end. Increasingly we isolate ourselves and our research from the human reality out there. The study of the historical research on anaemia serves as a paradigm.

Anaemia : A Case in Point

In 1915 Dr. A.L. Mudaliar in the Annual Clinical Report of the Raja Sir Ramaswamy Iyengar lying-in Hospital vividly described the clinical picture which cannot be improved any further. "The anaemia of pregnancy is a malignant type of anaemia that seems to be much more frequent than is supposed — it is not only a fairly common complication during pregnancy but is one of the most fatal complications. In 1914 the disease was responsible for 35 percent of the mortality — more frequent in multipara than in primipara, and has a very insidious onset; patients hardly realised the gravity of this condition till the whole body is swollen up and they get an attack of dyspnoea when they seek admission. Breathlessness on slight exertion and extreme weakness are prominent symptoms. An analysis of the blood shows reduction in the RBC - - - - " (Mudaliar, 1915). In 1927 Margaret Balfour from the Haffkine Institute, Bombay published her findings on Anaemia (Balfour, 1927). This is an important study by a white woman. Her meticulous observations betray her colonial background, but her concern for the enormity of the problem is real. As a woman she is also concerned about the maternal mortality due to anaemia much more than the other researchers of that time. The study is well documented with her starting observations, "In view of the frequency with which the disease occurs in India, it is surprising how little attention it has attracted", a fact which is true to this day. She adds, "This is no doubt partly owing to the fact that little obstetric practice is in the hands of medical practitioners". (Balfour, 1927). It was a period when the medical profession seriously believed that only they could understand problems and change the whole face of society. They feel that the key to the health of the community lay in their hands. Even Balfour identifies her hurdles typically "It is notoriously difficult to get a correct history from hospital patients in India" is her starting shot. The formal training of the doctor was obviously not different then. The framework in which they functioned had nothing to do with the real lives of the people. Any patient who deviated from the textbook pattern of disease was non-compliant or difficult. The woman's real experience of pain and illhealth did not fit into the classical patterns of disease. Doctors expected direct, well-defined, specific answers to their curt questions whereas the woman's understanding of pain was different. This socio-cultural void has only increased with time because today doctors donot even demand answers to questions any longer. They already know it all and have no time to ask the questions.

Nevertheless Balfour's research is exhaustive because she finds that anaemia is not just anaemia but is associated with a host of other problems such as fever 83 3 percent, diarrhoea 38 percent, Albuminurea 30 percent ,liver enlargement 8 percent, spleen enlargement 18 percent, oedema 100 percent, vomiting 40 percent, sore tongue 31 percent, Epistaxis 7 cases and weakness — always (It is heartening to note that an important symptom now dismissed as "subjective" and "imaginary", was actually elicited and documented). Her startling findings of 42 percent maternal mortality and 53 percent stillbirths led to the recognition of the fact that Anaemia had to be tackled somehow.

Her treatment consisted of rest, diet, iron, blood injections (i.m).. She also visited the homes of the poor anaemics and attempted to link up the problem with the lives of the women (a rare quality compared with the clinical detachment of the present day doctors). Since the incidence of anaemia was higher among the Muslims in her study she states "— The main cause of this is probably the purdah condition under which Mohammedan women live. The poorer classes are confined in a single room where they lead a very inactive life. Hindu women, though under the same general conditions as regards poverty, overcrowding and epidemics, do not observe purdah in Bombay and so have a freer life '. She continues, contradicting herself "- The Hindu woman does not go out much because customs and habits did not encourage it. - The work of the home does not require a great deal of activity, especially if it is shared by several women. Modern conveniences also tend to reduce domestic duties (sounds familiar) while modern principles regarding physical exercises and games for women have not yet taken root in India except in a few cases. A generation ago the women of the family ground

the corn daily and fetched water from the well. Now in Bombay atleast they buy the corn ready ground in the bazar and the pipes bring the water to the poor".

These observations betray the prevailing assumptions about women. Instead of recognising that these were much needed conveniences and looking for causes elsewhere she feels that the women had no right to look sick, flabby and unhealthy with anaemia and confuses inactiveness which is a symptom of severe anaemia with the cause.

The major flaw in the study was, however, the fact that only women with haemoglobin (Hb) levels less than 50 percent were considered anaemic. Now the normal Hb level in the West was 14 gms. whereas the normal detected in the Indian poor was between 9.5 to 10 gms. Hence 50 percent (4.5 — 5gms.) of the normal in India was obviously a very precariously low cut-off point. (The cut-off point for anaemia in pregnancy today is Hb less than 11 gms). Obviously the actual incidence of anaemia in Balfour's study was much higher. She had no problems accepting lower standards for Indians. This is true of the other researchers too. They may not have had the expertise then, but they did have the information of higher standards being applied in Britain. They did not find it necessary to question the norms, nor did this upset them. *It is not surprising that science rejected and gave credence to the Britisher's view of the quality of the Natives life. In fact scientists strengthened these myths. To this day Science has fought shy on the challenges of racism, facism, sexism, or social inequalities. It has conveniently toed the line of the dominant ideology and under the garb of scientific truth has disallowed debates and questions.* In fact scientists employed by the government are true, lawful servants ! In spite of Balfour's incidence of 10 to 20 percent (the prevailing figures are 60-70 percent) the high maternal mortality rate led her to postulate a toxic condition associated with pregnancy. She could not demonstrate cure with medicinal iron etc., because we know that treatment for anaemia is very long drawn out.

In the same year McSwiney recorded 43 cases of anaemia (McSwiney, 1927). Unfortunately the hospital stay of the women and treatment was for a few days only, because women came only when they were critical and did not stay long enough to get treated after delivery. She was convinced that follow-up of the patients was not possible as "They were all poor and ignorant folk who became restless after some weeks of improvement and bitterly resented the innumerable injections and demanded their discharge at the earliest moment". McSwiney like today's doctors was unaware that women's labour was needed to run the home and care for the children and that she could not allow herself the luxury of treatment in the hospital ! McSwiney however talks of preventive treatment early in pregnancy to be followed up to term to see whether anaemia could be prevented.

The search for a "cause" of anaemia continued and in the meanwhile experiments on animals were carried out with two diets "a Hindu Diet" and a "Muslim Diet" (Wills and Mehta 1930). But it was too early to 'detect" iron deficiency anaemia by manipulating diets because contributing factors were many including Malaria, Kalazar, Syphilis, and host of other infections

In 1932 A.L. Mudaliar and K. Narsimha Rao from the Government Hospital for women and Children, Madras reported their detailed study of anaemia (Mudaliar and Rao, 1932). Their criteira for Anaemia continued to be (4.5-5.0 gms). But they had made attempts to focus on the multiple factors such as gastric acidity diet infections and others, and postulated the following theories to explain the cause of this killer disease: 1) Infective theory 2) Vitamin deficiency 3) Toxemia 4) Deficiency of Anti-anaemia factor.

A Landmark in Anaemia Studies : 1940s

Upto this point the studies were not organised, but by 1942 L.E. Napier and Neal Edwards published their report financed by the Indian Research Fund Association (IRFA) which was a major document - and has, I think, come nearest to defining the problem (Napier and Edwards 1942). It dealt with most of the questions including Haematological techniques and included a guide for research and extension work. It is a landmark in the field of anaemia.

Part I deals with a short history of anaemia research in India and it was documented that Dr. V.R. Khanolkar was investigating into the Hb standards in health and disease. The findings of the earlier Anaemia Sub-Committee appointed by the Scientific Advisory Board of IRFA, in 1939 by MI Neal Edwards, V R. Khanolkar and S S. Sokhey was also reviewed, where the major conclusions were that the cause of anaemia is 'common to a large percentage of the population though the dominant cause will be different" and recommended a study of "normal Hb"

and incidence of Anaemia including the effect of treatment. They had also recommended the study of clinical data and diet intakes in pregnant and non-pregnant women during and after pregnancy (Napier and Edwards 1942).

The report also accepted that "In the past anaemia has attracted less attention than it deserved, partly on account of the general attitude of complacency that is adopted towards a disease state not commonly associated with a high mortality and partly on account of a physiological misconception, namely that the normal Hb in the blood of persons living in tropical countries is lower than that of the residents of the temperate climate. The misconception regarding the Hb level in the tropics has now been fully exposed — Anaemia is a very important factor in causing death in infections and other diseases in which, had the patient started with full complements of blood — they would have recovered ..." (Napier and Edwards 1942). At last there was some light at the end of the tunnel.

The report also reviews the work done on pregnancy anaemia. Significant reviews are those of Margarget Balfour where she reported that anaemia was responsible for 61.9 percent of all maternal deaths in Bombay and 35.6 percent in India (Balfour, 1927). Neal Edwards, with data from the Women Hospital gave an incidence of anaemia 49.5 per thousand pregnant women in 1936 (taking Hb less than 50 percent) and Napier and Dasgupta's figures of 158/1000 pregnant coolie women in Assam (Napier and Dasgupta, 1937).

The earlier studies had found that the causes of maternal mortality was in the following order : (1) Sepsis, (2) Anaemia and (3) Eclampsia, and report that among the cases of sepsis which heads the list, there are many cases in which if the patients had not been severely anaemic as well, they would have recovered. (It was also known that in Britain and Wales, anaemia was the cause of only 0.05 percent maternal deaths).

The review of the epidemeological data shows that the associated problems such as fevers, syphilis and other infections were very important and reported that "the discrepencies in the findings of the different observers may well be explained on the grounds that there are multiple causes and that these are not equally represnted in the various series of different observers".

Reviewing the haemoglobin level from various parts of India they seem to miss the important finding related to the socio-economic gradient reflected in the following figures.

	Indian	West
Men	14.5 — 16.0	14.5 — 16.0
Men (Coolies)	12.63	
Women (Students)	13.73	
Women (Middle Class)	12.63	
Women (Coolies)	10.5	
Women (Coolies) (Pregnant)	9.22	

Hb levels in gms/100 ml.

According to the table the poor and specially women were at a disadvantage at the start of pregnancy. This "normal" low Hb levels resulted in anaemia at the onset of pregnancy when the needs are more, and by the end of pregnancy, the condition was so critical (Hb less than 5 gms) that their symptoms were of heart failure.

They were also surprised that the coolie population of both Assam and Shivrajpur in Maharashtra had the same Hb. levels, but less than the Western levels. They at last postulated economic and dietary factors, because in 1936 Napier and Dasgupta had given iron to coolies and raised their Hb to 12 gms and had suggested that there was another limiting factor too (obviously food) (Napier and Dasgupta, 1936). In another experiment by the same authors they found that coolies who were well fed for four weeks before iron therapy showed better responses than those who were not given food (Napier and Dasgupta, 1937 b). The haemoglobin of the well fed group had come up to the levels of healthy men.

Another finding by Napier and Dasgupta was that when the obviously anaemic women had been excluded, the mean Hb was much the same as amongst non-pregnant normal women (Napier and Dasgupta, 1937 a).

Given the limitations of 1942 the scientists were very close to the truth by virtue of their keenness and determination to get to the truth. They were not looking for easy solutions yet. The major findings can be summed up :

(1) that the food intake was low in anaemics; (2) there was a massive hookworm infection; (3) there was inadequate iron intake; (4) Associated infections and other infestations. (Mitra, 1939). They had no knowledge of the following yet because science had yet to unveil some of the mysteries of the cell.

(1) The mechanics of the cell cycle, and haemoglobin synthesis; (2) Need for folic acid and other nutrients; (3) Results of experiments with radio active substances. Inspite of the limitations of that time they humbly accepted the fact that "the essential difference between the study and the treatment of a case in a sanitary advanced country on the one hand and a sanitary backward country such as India on the other is that in the latter one has always to make one's study against a background of widespread infections such as malaria and hookworms, and of malnutrition both general and special. Each infection and each food deficiency must be considered as possible contributory factors ... ".

Part III of the report is optimistic because the authors are convinced that anaemia can be prevented and perhaps special anaemia clinics would help understand the "social, environmental and dietary factors ... ". It would also help treatment and research. They felt that the "hit and miss procedures" were wasteful and expensive, and the severe cases were being admitted to purdah hospitals where the facilities were absent and the pathologist who saw the slide never saw the patient. Hence "the background, environmental and personal diet and family customs must be given the same consideration as is applied to the blood slide and clinical findings".

There is a chapter on the details for conducting an anaemia enquiry and research. It is very well thought out with the women as the centre, and not the scientists ego, pet hypothesis or personal ambitions. They suggest that "questions should be intelligently considered and not mechanically noted. For example in a meat eating family the mother who may be the subject of investigations may herself take practically no meat if she eats what remains after the other members of the family have eaten. Similarly lack of sunlight entering a particular room where the woman spends 24 hours a day may be in fact of more importance than the degree of ventilation of the room".

The approach is sympathetic and explores qualitative details beyond the narrow confines of "science" as will be obvious in the more recent work on anaemia. There is another interesting human observation differentiating the moderate anaemia from severe. The authors are surprised and find it worthwhile to document that in "Moderate anaemia" the patient usually makes no complaints and is found on routine enquiry. On enquiry she may admit to feeling tired, but many women expect this in pregnancy and think nothing of it. (Today we have lost even this sensitivity that the medical profession had in 1942 ! It is seen as a subjective symptom and therefore not to be relied on). In severe anaemia there may or may not be presenting symptoms. The degree of anaemia which may develop without symptoms is a testimony to the low standard of well-being with which many women seem satisfied. Questioning will reveal increasing lassitude, shortness of breath, palpitation and swelling of the feet and face ... ".

The recommendations and the propaganda leaflets are again documents with well thought out solutions to tackle the teaching of anaemia and even "A method of haemoglobin estimation should be taught to every midwife ... " has been suggested. They cry out for early detection, and regular examination of the pregnant women.

The propaganda leaflets could be used even today because they deal with the questions of a good diet, special foods, medicinal iron, care and so on and also notes the responsibility of men " ... It is in the hands of the fathers and husbands to take steps to prevent the mother's suffering and ensure their health and safety during pregnancy and childbirth".

This optimism was understandable, because science had opened up new frontiers and the combination of scientific knowledge with the resolve to apply it for the good of womankind made everything seem possible. *The whole attempt appears like a dream today and anaemia still tops the list of killers during child birth followed by sepsis and eclampsia.*

Abortive Search for Quick Cures

Independence saw the report of Dr. S. Pandit published in 1948 entitled *Causes of maternal mortality* (Pandit 1948) — positive report still in the same optimistic mood. But major research bodies like ICMR were not touched by the strong winds of change sweeping the country. There was no sense of urgency, only clinical detachment for the next 10-15 years. Normal levels of Hb were worked out and the role of folic acid and iron confirmed. Instead of getting on with eradication, scientists

betrayed their contempt for the poor people with studies like *Role of rice diet contributing to increased fertility* (Annual Report NRL, 1956). They had jumped on to the band wagon of population control even before they were invited. From this time onwards one finds them bending over backwards to please the powers that be and "science was placed at the service of the ruling classes" even when the rest of the country and the bourgeoisie was talking of plans, people, democracy rights etc. The scientists were not impressed. They had internalised the ruling class contempt for people's lives and food needs and a lot of time was spent looking into Ducks egg protein and its virtues and the role of mothers milk in causing malnutrition. The studies on anaemia were secondary. An important finding in 1956-57 was allowed to pass by because it was not exciting or sophisticated enough (Annual Report, NRL, 1957). It was down to earth and pedestrian. The study showed that iron cooking vessels helped in increasing the iron content of foods cooked in them. Such a study obviously would not lead to international and national recognition and awards, and one could not "claim" anything for this - hence the disinterest. By now research had turned into an industry which could churn out huge spin offs for scientists in terms of patients, trips abroad, publications and awards! The new breed of scientists were not going to settle for simple iron cooking vessels.

A search for a miracle and a quick cure was launched to put an end to the nagging problem and to claim credit for having wiped out anaemia. The environment, foods, infections, poverty had to be bypassed, "All that takes time" as one of them exclaims. In the sixties sketchy details of iron needs were worked out by simple additions of the need during pregnancy, lactation, menstruation and by 1969 Dr. C. Gopalan announced the findings that iron and folic acid would be distributed all over the country as a National programme (Gopalan, 1969).

He said "Till such time as we are able to bring about a significant improvement and diversifications in the dietaries of the poor sections of our population, the *practical* (emphasis mine) answer to this problem must lie in the systematic distribution of iron to our poor pregnant women through MCH centres and PHCs". (Note the significant patronising tone!) Even this is recommended in the latter half of pregnancy because "A significant proportion of the poor pregnant women can be reached only in the latter half of pregnancy". The researcher's pragmatism must be appreciated along with his candid confession! This reflects how the researcher has stopped identifying with the subjects of research and has instead objectified them. By 1970 Dr. Gopalan even announced the well worked out doses of iron to wish away the problem of anaemia from all segments of the population (Gopalan 1970). Dr. Gopalan was of course oblivious of the problems of long distance storage, distribution, lack of commitment of the staff, the felt need of the women, the massive problem due to inadequate food, overwork, infection and anaemia was reduced to a farce, by the pill. It was not the fault of the women that it did not work. Any wonder it has not even been evaluated!

In the meantime the WHO in 1968 had recommended fortification of food with iron, one of the exciting new suggestions that would increase iron in food, and do away with pills (WHO, 1968). Hence work was started at the National Institute of Nutrition to identify the chemical composition of an iron compound that would mix well with common salt (which is consumed by all). The research was time consuming because the hurdles are numerous. The drug (tonic) industry watched this progress with apprehension but they need not have feared because since iodine fortification of salt in the goitre area had been a failure - it was a foregone conclusion that this research would remain a curiosity until such time as the system became really concerned with the poor.

Upside Down Research : 1970s

In the seventies it was forgotten that anaemia was still a killer, it again became an "exciting problem" and gained fresh recognition. Anaemia means less blood, less oxygen and (?) alteration in utilisation of food for energy for work, with many other associated changes. Hence while the researchers now marked time waiting for anaemia to disappear, their curiosity was raised with questions of anaemia and immune response, anaemia and work output (we had studies on the same plantation coolies in the Nilgiris by Dr. Rahamatullah, who made anaemic women (Mean Hb. 6.2 gms.) work and calculated the increase in work after they were given iron (Rahamatullah, 1983). There were also studies of alteration in the immune response in anaemics, and other molecular level changes such as changes in enzymes functions.

In the meantime by the late seventies, when anaemia could not be wished away nor used for "exciting" research we have a breed of scientists

who were willing to flog a deadhorse—the pay offs would be recognition, awards etc. It was obvious that anaemia had to be presented differently. Hence statistical jugglery was resorted to in thousands of anaemics showing that anaemia had a role in prematurity, stillbirths, abortion, IUCD, Pill use, maternal and child morbidity, toxaemia, body weights, arms circumference, skinfold thickness, sore tongue etc. Research had now been turned upside down. (Ann. Reps. NIN 1979-83) *The causes of anaemia were no longer important — the correlations with absurd parameters started, and by a process of elimination the researchers arrived at the "Risk Care Approach" a bastard of the eighties* — an attempt at planning for the 21st century by efficient and smooth salesmanship based on statistical manipulations (ICMR, 1985). It states that indices of MCH care like low birth weight and prematurity rates — have not shown the decrease commensurate with expansion of health services — an attempt to cover the entire vulnerable population (pregnant and lactating women, infants and children) with the available limited health man power — might have prevented effective functioning and resulted in lack of perceptible impact.... and "Dealing with problems of large magnitude with available limited resources, adapting a risk care approach might pay higher dividends —"

The health care system was now using the language of the stock exchange. The philosophy being that since only a small section of women are really in the "risk group" — contributing to mortality, the others may be in the border line — and never mind about them — they should be identified and treated. There is no concern for the quality of life, the nagging tiredness and the inability to work. Further it is felt that in the rural communities it is not possible for the doctor to visit far flung areas and hence one must find out the minimum number of antenatal visits needed. (Ann Rep NIN, 1982).

By process of statistical elimination the following women are placed in the "Risk Group". Hb - less than 8 gms Wt - less than 40 kg; Ht - less than 140 cm. Any other problems during the earlier pregnancies.

Other scientists impatient with the slow progress of the tablets devised ingenous methods of injecting the whole dose of iron into women (who had Hb less than 8 gm.). Exploiting the popularity of injections in our country, scientists recommend large scale injections of iron to overcome the non-compliance of the patients and cover up thus our lack of will and perseverance in tackling the problem of anaemia. (Note the similarity to the use of Net-en in F.P. Programmes).

Considering the huge government funding that goes into research today, the question that faces us is one of ethics What is the researchers' responsiblity to society? What are the attitudes and assumptions that should inform his/her research? Is s/he justified in sacrificing even scientific rigour to expediency. Should not a sense of humility underline every piece of research undertaken and attempts be made to make it relevant to the needs of the people? Today the role of science in solving the problems of the people is being increasingly questioned. If the scientists do not recognise how enormously privileged they are at the cost of the country and attempt to fulfil even the limited tasks before them they are in danger of rapidly becoming redundant.

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SOCIAL DYNAMICS OF HEALTH CARE

The Community Health Workers Scheme in Shahdol District

imrana quadeer

The Community Health Workers Scheme was introduced ostensibly to promote people's participation in the delivery of health care. The scheme did not however envisage other changes in the health infrastructure or incorporate new developmental strategies. The article examines the impact of the rural social and economic realities on the scheme in Shahdol district of Madhya Pradesh where it was introduced in 1977. It shows that the prevailing network of linkages which serve only to increase and strengthen the hold of the elite, have fully absorbed and distorted the scheme. The poor who were the supposed beneficiaries, had no say in either the decision-making or the running of the scheme. The author concludes that in the absence of efforts to either change the social matrix or at least control some of the key components, schemes such as this one are bound to fail.

The Community Health Workers (CHW) Scheme was introduced to the Indian health services panorama with many promises. It was to promote people's participation, provide health care to the poor and deprived rural population, and be the vanguard of Primary Health Care in the Indian setting. A constant refrain in the planning process was the need to revive self-sufficiency in Primary Health Care and make it a part of the broad developmental process.

The scheme however, was introduced without any significant changes in the health service infrastructure which was to support it. It simply took over the responsibility of implementing the existing health programmes without any review of priorities and the technologies used. The general developmental strategies remained as stagnant as ever and above all - despite all the laudable objectives - the rural population was treated as one homogenous mass without taking into account the reality of social classes and their dynamics. The implications for the working of the scheme were quite serious. This paper examines the impact of the rural social and economic realities on the working of the scheme. It is based on a part of data collected for a study of the CHW Scheme in the pilot blocks of district Shahdol in Madhya Pradesh. The research team consisted of three research investigators.

Methodology

Our hypothesis was that the Scheme's actual performance would be determined by the nature of social dynamics in the area and the official efforts made to overcome the constraints imposed by these dynamics. The aspects that we focussed upon were : (a) Social and economic stratification of the rural population; (b) the links of CHWs with the village strata; (c) the links between strata which indirectly influenced the behaviour of its members; and (d) the links with the personnel of the health services.

These were the areas which we explored through observations, interviews and group discussions with people of different strata, the CHWs and the PHC staff.

The study population consisted of the first pilot Block selected for the implementation of the CHWs scheme. This Block had a population of 39,642 with 109 villages in all.

General surveys were conducted in 34 villages from where CHWs were selected and in 4 villages which did not have CHWs. These surveys were used to understand (a) the socio-economic background of the villages, (b) to explore the views of village residents regarding the scheme and their CHWs, (c) to collect information about the CHW, and (d) to assess the status of other developmental programmes.

For the purpose of this survey, two strata were identified : the "elite" who were defined as the surplus producing farmers, regular government employees, and those who held official positions of Sarpanch or Upsarpanch; and the "poor" who were the marginal or subsistence farmers and the landless labourers. From both the strata, a 10 percent purposive sample of households was interviewed singly or in groups. The total number of households in the villages covered was 3,743 and their population was 20,534. Out of this the sample covered 193 elite and 2194 poor households. The malaria worker's house list was used for the purpose of identification and 1 to 2 days were spent in each village by the three investigators.

In six selected villages where the 'best'[3] CHWs resided an intensive survey was carried out. About one-two months were spent in each village. For this in depth study three strata of households were identified based on landholdings and employment. These only roughly coincided with what we considered well-off households, subsistence farmers, marginal farmers and landless labourers but they sufficiently reflected the economic stratification of the village population.[5] The categories were of households owing 0 to 5 acres of land, more than 5 to 10 acres of land and more than 10 acres of land along with those having permanent employment in the government services (Table 1).

The intensive study provided qualitative data on socio-economic aspect of village life, health and health care services, developmental programmes, CHW's work and popularity, and his interactions with PHC personnel as well as the people. For quantification of some of these, an interview schedule was administered to a 30 per cent stratified random sample of households.

In addition to these surveys the PHC personnel were observed and interviewed in detail regarding their views and support to the scheme. This was cross-checked with the CHWs as well.

The Pilot Block and the Socio-economic Back ground of it's People

Covering an area of 5125 sq.km., this Block retained parts of the forest which covered the entire district 30 years back. It had 19 panchayats (all Reserved) and 109 villages. Except for one railway line and two metal roads which cut across the Block, its transport was mostly through mud roads. It had a coal mine, and a thermal power station was being proposed within its boundaries. The Block had a higer secondary School, 72 primary schools and 10 junior high schools. Its tribal population was 25,704 and scheduled caste population was 1830.

Size and Social Composition of Villages Surveyed

All the villages were predominantly tribal. They could be grouped into 12 villages which had a few Scheduled Caste households (group I), 15 villages with 1-2 households of the Hindu upper castes (group II). 7 which had 10 percent or more households belonging to the upper castes (group III), and 4 where the muslim population was significant (group IV).

Although these villages were commonly referred to as tribal villages, they could be called tribal only to the extent that the majority of their residents belonged to one tribe or the other. The organisation of these villages, their economic relations and their social rules had little which could be called exclusively tribal. The small minority of non-tribals in the village maintained a posture of superiority and freely referred to the adivasis (tribals) as "Stupid' and "lazy", and blamed their character for their impoverished living conditions. A slightly deeper look into the dynamics of these villages, however, brought out the real mechanics of these characterisations.

Economic Stratification

Estimation of households owning 0 to 5 acres of land (poor) and those owning more than 10 acres of land or employed (well-off) gave an idea of the economic stratification in these villages (Table 2).

The stratification, seen against the social background of the villages, brought out some interesting features of socio-economic patterns. Six out of the seven villages of group III had the largest numbers of well-off farmers. Most of these villages were also the larger villages of the Block which were well-connected and provided employment to a significant percentage of their own population. Secondly, employment in the colliery was a significant reason for the observed percentages of well-off households in all villages, especially Group I and Group II villages. Villages of Group IV alone had no such households. Most of their Muslim and tribal inhabitants worked as rickshaw-pullers or as wage-labour in the nearby town.

Another striking characteristic of the pattern was that percentage of households owning not more than five acres of land increased from Group IV to Group I. It was also evident that the non-tribals generally constituted the bulk of the well-off farmers or the employed residents of the village whereas the adivasis were the poor, landless, or marginal farmers. Though all non-adivasis were not always well-off, invariably the Brahmins, Thakurs and Jaiswals, if they did not have sufficient landholdings, had the few available government jobs and had captured whatever other employment opportunities existed in the area.

Yet another feature that emerged was the large number of poor and ill-fed people in spite of a significant number having land. Only in 19 villages the percentage of landless was 30 percent or above. Thus, having land was not necessarily a guarantee against poverty. It was not uncommon to find

households who owned land but had no means to use it. Often the land was too difficult and unproductive to labour upon. So they preferred to do wage labour rather than toil on an unpredictable piece of land.

The Web of Life

The pressures of production processes knit the people to gether into a web of social relations the terms of which were determined by the nature of production, the intensity of needs, and by the paucity of economic alternatives in and around the area. Agriculture was the major activity binding people together. The marginal and poor farmers owned 1 - 5 acres of land and were able to produce grain which sufficed for 2—6 months. Together with the landless they constituted 31-80 percent of the surveyed population. These farmers depended upon their labour to earn for the rest of the year. The subsistence farmers were those who owned land and could produce enough for the year with family labour alone. The rest we called middle farmers or the well-off farmers who employed labour and also managed to produce some surplus. They constituted 0—45 percent of the households.

The forms of labour exchange varied from fixed period contracts "Harvahi", daily payments in barter system "bani mazdoori", to free use of the plough for two days in exchange of five days of labour "Podika", and loaning of bullocks for a season in exchange of grains. The wages were either two kilos of paddy or Kodu a course grain daily or 240 kilos of paddy or Kodu for four months of Harvahi. Sometimes, instead of this, the Harvahi was given 12 kilos of grain to sow on a piece of land. The produce was his except for the land rent that was deducted. Yet another form of exchange was working free of cost for each other at the time of sowing and harvesting, a practice most common among poor and marginal farmers. Wage labour was uncommon and money as payment was offered only by farmers who were essentially colliery employees. Very often even these terms were not available to people who then depended upon collection of forest produce and fire wood.

The subsistence farmers using family labour just about managed to eke out a living. Their sole concern was to remain operational and they consequently tended to keep aloof, being always on the look-out for odd jobs to supplement their income.

The artisans were few (Basorth, Agaria, Chamar, Lohar and Kumhar castes). Their trade was dwindling in the face of competition put up by the growing industries. Many did wage labour and farming as well or had completely shifted over to these.

The non agricultural labour was yet another cog in the wheel, exploited both by the contractors and government agencies. Paid around Rupees three a day in spite of the existing minimum wages, the labourers had to seek employment with these very exploitative agencies because, firstly, the contractors and private businessmen were hand in glove with each other and secondly, there were no other alternatives.

Through these working relations, the poor found themselves entangled in an exploitative network but knew of no ways to get out of it. Even though the well-off farmers were unable to provide work to all who needed it, they wielded power through their ability to provide odd loans (of seed, grains and money) and "sifarish", (influence).

The well-off were thus left alone to make their own profits, not just through land but through most of the administrative agencies which existed in the area and which were supposed to deliver help and relief to the poor. One example of this was the Panchayats, which worked as tools to soak up public resources for private purposes. The Block Development Officer worked through them and through the village elite and so managed to reach only a small section. The elite used their sources and their contacts to exercise their own power and to consolidate the conditions of their own family members. As a matter of fact, the word 'elite' in the context of these 38 villages is a misnomer. What we really had was a handful of not-so-affluent families who, either because of their caste Hindu background and past power, or because of their land holdings, had acquired respectable positions. 'Respectable' because they were the ones who entertained, hosted, and informed visiting officials, police personnel, and, at times, politicians, and they were the chosen few for delivering to the people whatever the Block administration had to offer. The intensive study showed that only a few in category III performed this role.

It was not uncommon to find that in these villages the lowly paid but most sought out positions of CHWs, Adult education tutors, and Rahatkar relief work mates had been captured by the same persons belonging to these families or the family of the Sarpanch or different members of his

clan. It was here, then, that caste and family loyalties began to influence the economic relations. The opportunities were few and unemployment vast. With the majority of adivasis being unacquainted with laws, rules, and functioning of the administrative system, it was not difficult to usurp (with the help of higher officials) what was meant for them. Still better was the practice of including one or two of them, giving them a few crumbs, and getting their thumb impressions on the official papers. The divisions within the adivasis and the influence of Hinduism, which had brought in with it the concepts of superior and inferior tribes, helped to ward off any dissent. The Raj Gonds, who considered themselves Khsatriyas (Thakurs) through their social superiority as well as land ownership, were the closest to the bureaucracy.

The landless and poor lived in fear of the local administrative machinery. In the event of an encounter they would rather let the 'Bare log' (big people, the rich) of the village play the intermediary than face them on their own. It was a common practice to pay the Sarpanch to get one's work done rather than do it oneself. The officials, however, perferred a system of direct payment. The police and the Patwari were the two most feared officials. Every village had people complaining of land disputes where, simply because they could not pay them, either their land was transferred to others or they were threatened with 'benami'. The experience at the Tehsil office was no different, where every clerk wanted his pound of flesh. If any one tried to bypass this system he either never got his work done or he was so entangled with the "rules" and "laws" and all the loopholes that go with them that he was left utterly bewildered. It was basically to avoid this unfamiliar world of "Kanoon" (law) that the people were forced to part with their hard earned money. It was no wonder that they were mortally afraid of the "Sahibs".

The petty traders who brought off the produce of the farmer or their forest collections were another link in the chain of exploitation. Since people needed oil, salt, clothes, and other necessities they had to exchange some of their produce for money. This exchange occurred at harvest time when grain prices were lowest and the poor farmer invariably lost in this exchange. He in fact lost twice because, soon after his own stocks finished he had to go back to the same traders who now sold him his grain at double the price. Similarly, the forest produce collected by the villagers were bought at throwaway prices and the same were sold at 200 percent profit in the market.

Introduction of the CHW Scheme

It was within such conditions that the CHW Scheme was introduced in the Block from 2nd October 1977. The implementation was done in a hurry. The PHC staff had only a week to inform panchayats, do the propaganda in the villages, complete the formalities of selection and make logistic arrangements for the training programme. The staff had severe reservations about the principles of the scheme (that health care through non-professionals is possible) and the abilities of the local population. Also, they were reluctant to take any additional work responsibility so they followed the dotted lines of the state circulars and did not bother to take initiatives in preventing the selections from being distorted by the existing power balance.

Selection Procedure

The result was that the selections were left to the discretion of the panchayat and therefore, effectively, to the whims of the Sarpanch or the Upsarpanch. In the majority of the panchayats, neither were all panchayat members contacted, nor all villagers were informed. Only those applicants were encouraged whom Sarpanches favoured. Very often the PHC in fact strengthened the hands of the Sarpanch in selecting undesirable candidates due to caste, class, and religious links and justified themselves by saying, "if others are doing it why shouldn't I". For 40 positions only 54 applications were forwarded, of which from 30 villages single applications were received. In ten villages the tie was either between members of the elite (mostly non-tribals) or among the many relatives of the sarpanch. In two cases rejected candidates were finally accomodated by creating new village clusters for them. This showed that not only the supervising staff but also the doctors and the Block Development Officer participated in the manipulations. According to some of the PHC staff members, "most of the Thakur and Brahmin candidates were no good compared to some adivasi candidates. But the lower educational level of the latter were used as an excuse to reject them". They felt, "relations and connections were more important than qualities" and said "the discretionary powers of the selection board always favoured the elite".

Of the 36 CHWs interviewed, 22 said they were informed by the Sarpanch about the scheme, 12 said the PHC staff told them, and only 2 had heard

of it from their friends. Invariably, those called by the Sarpanch were asked to apply for the training. None was told to inform others.

The general survey as well as the intensive study revealed that the majority of the people had no information regarding the scheme in general or the selections in their villages. This was particularly so for category I where 88.2 percent expressed no knowledge of selections (Table 3) Among those who expressed knowledge of the selection process, none thought it was their responsibility also. People considered Sarpanch or the hospital to be responsible for selection of CHWs in 45-50 percent of the households.

Background of CHW

Sixty percent population of the block was of scheduled tribes or castes. Despite this, of the 37 CHWs selected, only 20 were from adivasi households and none from the scheduled castes. The reasons for such distortions began to unfold when we looked at the socio-economic backgrounds of these CHWs.

Social Background : The majority of the CHWs were Brahmins and Thakurs among the non-tribals. Even the lower caste Hindus had a very marginal representation (Table 4). It was revealing that the tribal CHWs came largely from those villages where the entire population was either tribal or some lower caste Hindus lived there. In those villages where 10 percent population or more was caste Hindus or muslims, invariably all CHWs were non-tribals. Even in those villages where only 1-2 caste Hindu families resided 53 percent CHWs were non-tribal.

Our data further shows that except for seven CHWs who were not related to the Panchayat members, all others either had links with past or present panchayats or were themselves Sarpanches or Upsarpanches (Table 5). These links were common to adivasi and non-adivasi CHWs and indicated close-knit elite groupings whose members kept interchanging their positions in the power capture game. Yet another link of the CHWs was with influential families of their villages (Table 5c). If we take this into account then even out of the seven CHWs we are left with only four who could claim no links with the power elite !

Land Holdings and Occupation The land-holding pattern of the CHWs was very different from that of the general population. It reflected their links with the landed sections (Table 6). It also brought out the differences between the tribal and the non-tribal elite quite clearly. Not only the tribals owned comparatively less land, their families alone depended upon wage labour. Only three out of 20 tribal families had an employed member while among the non-tribals six out of 16 had employed members.

The CHWs themselves had varied occupations in addition to their health work. Eight did farming also, four were big contractors, and four had become professional practitioners of sorts. Eight had managed to get the supervisor's jobs in relief projects while two had become tutors in the adult education scheme. Another three had managed to get both these jobs at the same time while the remaining seven did odd jobs like taking contracts for bidi leaves, shopkeeping and so on. The relevant fact is that the 17 who owned over 15 acres also held the most paying occupations like contract work, professions of sorts, and large farms ! Also it was significant that, despite a scarcity of jobs, this small group had managed to acquire multiple employment.

Education and Age Twenty percent and 30 percent of the adivasi CHWs were high school and middle pass respectively as against 41 percent and 47 percent of nonadivasis with similar achievements. The low achievements of adivasis only underlined the irrelevance of making middle school a criteria for selection.

The desirable age of a CHW was to be over 25 years of age. In this Block however, twenty three (64 percent) were under 25 years of age.

Performance The general survey data helped to group CHWs into four groups based on people's responses. Of the 34 villages, in 15 the elite as well as the poor talked well of their CHWs, in 4 the elite talked well but the poor wer divided, in another 12 the poor as a whole were dissatisfied, and in three both categories of households were dissatisfied.

The elite, despite their satisfaction, said that the CHWs were useful only for minor illness. They were neither aware of the scope of principles of the scheme nor of the duties of CHWs. He was considered a paid PHC employee. The non-tribal elite were often patronising towards their tribal CHWs. For example, they commented, "He is the only educated one among them and education has put some sense in him"; "The poor fellow can treat only according

to his intelligence, how can he go beyond"; or, "The boy is sincere, he always comes to ask if any thing is required". For the non-tribal CHWs however, the tone changed to "He is very intelligent and we hope that he would be considered for more than just a Swasth Rakshak". "He does so much more than the health worker and is still so poorly paid"; or "The non-tribals have done well in all spheres and CHW is no exception". The well-off tribals, on the other hand, were protective about their own tribal CHWs and even tried to cover up their faults, but if they had a non-tribal CHW, they were cautious and respectful and talked in appreciative but subservient tones of the 'Bhaiyyaji' or 'Babu' (big brother).

In villages where the poor were divided in their opinions the population was generally mixed. Here the social group to which the CHW belonged invariably favoured him, like in villages Medki, Dhawrai and Khickkiri. In Badwahi the Brahmin CHW was unpopular among all the tribal poor except for the Baigas who expressed satisfaction. Baigas also happened to be a landless majority who worked for the Brahmins and were almost bonded to them as labourers.

According to the poor the CHWs charged for giving them drugs and often even for chlorinating wells. They said that instead of visting the houses of the poor the CHWs preferred to go to the nearby villages where they could practise easily. The Harijans complained that their houses were never visited, "He is for the 'bare log' and not us", "We dare not ask for help, if he gives something it is our good fortune but there is none with such a fortune". Despite their views this section of the villagers was keen not to get into trouble for talking, "We don't want any more trouble".

In villages where the CHW did not reside, people were familiar with his curative functions but had not seen their CHW for months together. When people's views of their CHWs are seen against the data on the CHWs' socio-economic backgrounds, some of the trends that emerge are revealing. All CHWs who were given satisfactory rating by the poor as well as the rich were tribals except for 1 out of 15 in this group. On the other hand, those who were not liked by the poor but liked by the elite were non-tribals, mostly, 9 out of 12 CHWs in the group. The distribution of tribal : non tribal in the other two groups was 2:2 and 1:2. Given the distribution of villages, it naturally follows that the popularity of CHWs among the elite as well as the poor was higher in purely tribal villages (58.3 percent), where CHWs were also mostly tribals, whereas their unpopularity among the poor alone was higher among the mixed villages, 8 out of 12, i.e. 84 percent villages, where most CHWs were non-tribals.

In addition to the findings of the general survey the intensive study of six villages brought out the following significant findings.

Nature of Services Provided by the best CHWs

These CHWs were considered helpful by the people. However, their performance over the year had declined remarkably. Thus in the villages where they did not live they had stopped paying their usual visits or they went only once or twice a month. In the residential villages also, people felt that the CHWs initial enthusiasm had died down. Even then they agreed that the CHWs did help in illness. Their utility in minor illness was acknowledged but there was a significant difference in the response of the three categories.

Allopathic treatment was used alone or in combination with other forms of treatment by 55.0 percent, 76.8 percent and 92.2 percent of the households in category I, II, and III respectively. The reasons for this difference were more economic rather than a matter of preference. An important fact was that the CHWs were the source of allopathic treatment (alone or with other sources) in 39.0 percent households of category I and 26 percent in category II and III. Apart from this higher dependence of the poor on CHWs, it was also important that the poor combined CHWs with traditional healers and the well-off with hospitals (Table 7.)

For major illness the use of allopathy was markedly higher in all categories (80 percent or more) but the use of CHWs was much less. Even then, out of all households using allopathy, the highest use of CHWs was by category I (40 percent), the lowest by category III (14.8 percent). This was an interesting finding which indicated that the poor now had health care facilities which they did not have before. The information on the CHWs' preventive activities, their free accessibility and their practice patterns however, reveals the nature of this success.

CHW's preventive activities in the area of chlorination of wells, maternal and child health, education and environmental sanitation were almost negligible. Only 31.7 percent category I households (as against 0.9-2 percent of the first two

categories) said CHWs chlorinated wells in their houses and even they were not aware of their other activities (Table 8).

In the beginning the CHWs used to visit different areas of their residential village and the villages alloted to them but this had now become a rarity. People now had to request them to see a patient. Though these CHWs helped according to most people, 29 percent households in category I said that the CHWs refused to come and see a patient. Also, 28 percent of the poor said that he charged for injections - indulged in private practice - as against 16.7 percent and 3.9 percent in category II and III (Table - 8). In addition, in case of major illness, even category I households paid in 84 percent of illness although they used CHWs to the maximum 40 percent This indicated that though the CHWs were mainly used by category I, the trend showed replacement of the "traditional Gunia" a by a "modern Gunia" rather than emergence of self-help and self-sufficiency.

Supervision : The scheme envisaged supervision by the community in administrative matters and the PHC in technical matters. However, high percentages of households in the first two categories said they knew nothing about supervision (Table - 3). Even those who mentioned panchayats separated themselves from the responsibility since there was no identification with the panchayat at all. The Sarpanches themselves were least inclined to be active in this aspect. In fact since they were a party to the selections and mostly related to CHWs, even in cases where people were unhappy they found no reason to act against the CHW's interests. Of the 19 panchayats, none had taken any action against any CHW at any point of time nor made efforts to stream-line the CHW's activities.

Five CHWs were themselves Sarpanches and Upsarpanches and they said that their panchayats had no directives about the panchayat's supervisory responsibilities. Even among the CHWs, only 3.5 percent had heard of the panchayat's supervisory role.

The technical supervision by the PHC staff was more a bone of contention rather than an asset. The Health Workers attempted to pass on their work to CHWs, boss over them and treat them as subordinates. The CHWs resented this once they realised that the PHC workers were more interested in private practice. Some were also able to retaliate given their social status and acquaintance in the village. The extent to which this conflict developed was largely determined by the socio-economic backgrounds of the CHWs The non-tribal CHWs were assertive, dominating and socially powerful. They either cared little for the paramedical workers or were treated well by them out of sheer desperation. Among the tribals, the resourceful CHWs (Sarpanches or well-off) managed better since their local status was important but the others fared poorly. They were not only not given any help by the various PHC workers but also treated with much contempt.

The role of the senior staff at the PHC and district levels was not much different. All the doctors and most of administrative staff came from non-tribal caste Hindu backgrounds and had their own views of the social reality. In their busy schedules of working for Family Planning programme, Rahatkars, office administration, and looking after the 'VIP' visitors, the District Health Officers' only contact with the people of the area was through their private practice. For them the 'locals' were a mass of backward and unintelligent humanity with whom it was difficult to communicate. Condescendingly, the DHOs let the PHC medical officers handle the scheme. They themselves were hardly familiar with it. According to the two consecutive DHOs, 'What can these untrained locals do; let them atleast help our health workers". For them, even the village Mukaddams and the Sarpanches were "unintelligent people". Given the choice, they were for closing the scheme any day.

At the PHC, except for one medical officer (out of four) all the rest were either indifferent or vocally against the scheme even though they agreed that the CHWs were giving some help to people where their own workers had failed. Interestingly enough, all these medical officers used the CHWs influence to get referred cases for their private practice. This link was strong and in return some CHWs were patronised by the medical officers. Their usual answer for letting things pass was, "we have no control over the CHWs and the Panchayat doesn't act. Even if we report something there is too much political interference and we know that except for getting unpopular we won't gain much".

Discussion

Our data projects a pattern of social reality wherein a handful of the non-tribal elite in collaboration with the well-off tribals controlled the majority of the poor — individually through terms of work and collectively through social institutions like

panchayats. Both tribal and non-tribal poor had little access to the Block's developmental agencies. The areas general backwardness precluded alternatives to the existing pattern of living. Further, there was a general lack of information and education and the interaction of the majority of the poor with the outside world was extremely restricted. This meant that their dependence on the elite and the dole provided by the state was total. As a result, the two in collaboration got away with many acts of ommission about which the people may know but could do nothing.

In such a setting, the exercise of giving "people's health in people's hand" through their 'elected representatives' may sound good on paper but is bound to get mutated by the social matrix within which it is placed. This is what happened to the CHW Scheme in Shahdol. Though officially it was a voluntary scheme, a scheme of the people, it continued to run — despite reminders from the state — as yet another of the government's unsuccessful schemes.

The relevant aspect of the problem is that though the scheme did not work according to plans, the CHWs did cater to certain needs of the village population. It is thus apparent that while the explicit design of the CHW Scheme had not worked, there was an implicit design to its functioning. This design can only be recognised when we look at the linkages of the CHWs with the other categories, as suggested by the hypothesis of our study.

Links between social classes

The influences of the existing socio-economic configurations on the working of the scheme are clearly visible through our data. The supremacy of a small group of landed elite who controlled the local resources and also the channeling of government funds, created a situation wherein the appropriation of resource and labour had become a part of life. The CHW Scheme provided employment and therefore could not escape the general trend. Appropriation of opportunities provided by it not only brought economic assets for the local elites and their families but also an opportunity to strengthen their social positions by favouring some who mattered. The undemocratic functioning of the panchayats only made the task easier. Following the initial grabbing of positions however, the enthusiasm reflected by the panchayats dwindled into apathy and disinterest when it came to supervision and control. In other words, after providing patronage to their favourites the panchayats resumed their usual slumber.

It is also important to realise that the Panchayats could get away with this usurpation of the scheme only because people were in no position to protest against those who controlled the implementing institutions, given their social and economic as well as political dependence.

Given the domination of a small section of the population, there was no social pressure on the selected CHWs. Those who did work had their own motives. They were either interested in building their social images or were politically motivated (as the CHWs of Gijri and Varamtola) or had monetary interests. They some times augmented their 'salaries' (honorarium) through indulging in private practice and nobody objected to it. Even those CHWs who were considered good by all showed preferential treatment towards category III households. They charged them less frequently, were readily available to them, and also provided some preventive services however meagre those may be. But the CHWs relationship with the well-off was contradictory. While they served them well, they were used less frequently by this section and only for minor illness. In return for their services though, the well-off protected and praised them and thus ensured the high cost of medical services for the poor.

The CHW in general knew that if they could humour the well-off they would be free to handle the rest the way they wanted. This trend of ignoring the poor was so dominant that even those few CHWs who came from the poorer families often tended to ignore their own kind and over a year, had learnt to reproduce the behaviour patterns of their better-placed colleagues. Thus, they were either practising in their own villages or going to areas where no CHWs were posted and the people knew nothing about the scheme so that they could sell the medicines with ease.

Despite their ambiguous beliefs the majority of the poor opted for allopathic treatment if they could afford it and had also realised the importance of chlorination of wells and vaccinations. In procurring these services however, the people had learnt that money, connections and 'sifarish' were the tools that worked. Voluntarism on the part of the provider and organised demand on the part of the recipients had not been a part of their experiential base as was clear from their experience

of the political processes which moulded the administration of the area.

Links of CHWs with Social Class

Yet another crucial link was between the CHWs and the existing social classes. This was responsible for the quality of selections as well as work of the CHWs. As we have seen, only 4 out of the 36 CHWs could be said to represent the average villager. The rest had their connections with the present or previous office bearers in the Panchayat or came from the better-off families possessing large acreages of land or other business. Since this section of the village population appropriated all resources coming for rural development the CHW scheme was also appropriated. This explains the atypical background of the majority of CHWs as also their ability to acquire other employment. Consequently, not only were there a large number of non-tribal CHWs but the quality of their work in general was affected in several ways.

Firstly, since the CHWs were given the protection of the elite they could do almost what they wished without being answerable or accountable to anybody. In turn the panchayats, the statutory body responsible for their supervision, took no action against them.

Secondly, since the CHWs joined the scheme as a means to augment their income or status they concentrated almost entirely on curative work. Whatever little preventive measures they implemented in the beginning was also given up over time or else they would even charge for chlorinating wells.

Thirdly, since income generation was possible only through charging for their services and furthermore, since they could not very well charge those elite families through whose benevolence they had become CHWs, the brunt of paying for their practice was borne by the poor. Additionally, it should be remembered that the poor had no one else to go to while the well-off preferred to go to alternative health facilities like doctors and hospitals — particularly so in case of major illness. This explains the paradoxical situation of the poor using the CHW more and paying more too.

Fourthly, most of the CHWs were appointed through the agency of the Sarpanch or Upsarpanch but once they themselves became familiar with the bureaucracy and the government officials they began to develop their own alternative income sources. Thus, the post of Sarpanch would become far more lucrative as would the positions of Rahatkar mate or petty contractor. As a consequence, these alternatively more profitable occupations would demand more of their time and energy, and the quality of work in community health would decline. Even the house visits being done initially would stop.

Fifthly, even those few tribal CHWs who came from poorer families were drawn into the search for better incomes and thus began to ignore their own social strata. It would be unrealistic in such a context to expect them to remain devoted to the cause of the poor.

Links with the Health Bureaucracy

The notion of their own social and technical supremacy generated a feeling of contempt for the CHWs among health workers at various levels of the health services hierarchy. The result was indifference, condescending tolerance, and disinterest among the senior officials, and jealousies and resetment between paramedical workers and CHWs who had captured the clients of the field workers and had now replaced them as doctors!

The health and welfare bureaucracy did nothing to reverse these trends. Given their own needs and links with the local elite they only used these patterns for making profits. They in fact, often protected the defaulting CHWs and never made efforts to streamline their work by either putting pressure on the panchayats or their own organisation. In the process they only reinforced the existing patterns rather than improve them.

Conclusions

Given the indifference, inefficiency and ineffectiveness of the health bureaucracy, the powerful hold of the elite, and the collaboration of the well-off tribals as well as the administrative bureaucracy of the district, the prevailing network of linkages had fully absorbed and distorted the CHW Scheme. The poor, in whose name the scheme was launched, were made to pay heavily for receiving some medical care while they had neither a say in decision-making nor a hand in the running of the scheme. It is a paradox that the well-off, who used the CHWs the least, were also the ones who were bestowed with the CHWs' attention and the poor, who used them the most, had to beg, plead, and wait. This 'success' that the scheme boasts of is certainly not an achievement but a reflection of the dire need of the toiling people.

Our study concludes that people's participation in a health care scheme cannot be an isolated event. The degree of participation (or non-participation) is determined by the overall socio-economic relationships which bind a population and within which all schemes have to function. It is these links with the larger system that decide the success or failure of a scheme. Though confined to a Block, our study identifies the social linkages which influence the scheme and underlines the fact that it is the nature of these linkages which is crucial for the scheme wherever it is introduced.

The experience of Shahdol teaches us that in the absence of efforts to either change the social matrix, or at least control the key components influencing the scheme, or offering people a taste of free preventive and curative health care services, to expect that people will hail the CHW Scheme as their own and that they will also have the strength to control a truant CHW, is far from being realistic. This, in fact, amounts to protecting the holy cow of people's "participation", irrespective of its social context.

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Notes

1. Those farmers who could sell their produce for profit or could save it for the coming year.
   (These villages were mostly so poor that indentification of such households was never a problem and every one knew which households could save or sell after consuming two meals.)
2. Judged on the basis of opinions of villagers, PHC doctors and paramedicals.
3. This stratification was used firstly, because it sufficed for the purpose of the larger study, and secondly because the information required was easily available. For a more rigorous class analysis however, land holding alone is not sufficient.

Table – 1

Categorisation using Land Holding and Employment Status in the Intensive Study Villages

Village	Category - I		Category II		Category III				Total
	0-5 acres	% of up to 5 acres	5-10 acres		Over 10 acres		Employed		
	No.		No.	%	No.	%	No.	%	
Gijri	43	48.2	10	11.2	0	-	36	40.4	89
Barbaspur	62	52.5	3	2.8	3	2.8	33	31.7	104
Maliagoda	26	29.1	39	43.8	17	19.1	7	7.8	89
Kumurdu	47	43.0	35	39.3	18	16.5	9	8.2	109
Badwahi	143	69.0	44	21.2	10	4.8	10	4.8	107
Varam Tola	21	52.5	5	12.5	3	3.3	11	27.5	40
	345	54.0	136	21.3	51	7.9	106	16.6	638

Table 2

Distribution of surveyed villages according to the percentage of 0-5 acre land owning and well-off households in the four Groups of villages.

% of 0-5 acre land owning households	Group I Villages %	Group II Villages %	Group III Villages %	Group IV Villages %	Group I & II together %
upto 50	4 (33)	4 (27)	1 (14)	0	8 (30)
51-75	6 (50)	8 (53)	4 (57)	2 (50)	14 (52)
76-90	2 (17)	3 (20)	2 (29)	2 (50)	5 (18)
% of well-off households					
0-5	9 (75)	8 (53.3)	1 (14.2)	4 (100)	
5-10	1 (8.3)	3 (20)	4 (57.1)	0	
10-15	1 (8.3)	2 (13.3)	1 (14.2)	0	
15	1(8.3)	2 (13.3)	1 (14.2)	0	

See PP. 97 to 100 for tables 3 to 8.

COMMUNITY HEALTH PROJECTS: AT THE CROSSROADS ?

sumathi nair

Any number of alternative experiments in community health have come up in the last decade. This article takes a closer look at four such projects which have today become models for others. The article is not an attempt to run down any one or other project or its founder. Rather, it raises relevant questions about the contribution of these projects to health and development, their overall perspective, and the manner in which they are organised and administered.

The early 70's was a period for a general spurt in development activities of different kinds. This was the time when some of the major community health projects were started. It is over a decade now since they have been established and their effectiveness in achieving the goals initially set up is now under review.

A careful study of these projects would reveal various conflicting aspects which deserve deeper study. All these projects have, over the years, come to revolve around the founders, while the people centred thrust they had set out to achieve has not been realised. Yet their contribution to the field of community health cannot be denied.

The focus of this article is to try and analyse what led to the present situation — the limitations inherent in such projects and the other contributory factors. I must add that this article is not an attempt to run down any one or other project or its founder. Admittedly it is far easier to be analytical in retrospect, than it must have been to have visualised the pitfalls before the event.

For the purpose of this exercise, I will take four well-known health/development projects — Gonoshasthya Kendra (GK) Bangladesh, the Jamkhed Project, Maharashtra, the Deenabandu Project, Tamil Nadu, and the Comprehensive Rural Operations Service Society (CROSS) project, Bhongir, Nalgonda District, AP. My comments are based on personal experience, literature and personal communications.

Gonoshasthya Kendra (G K): In 1971 during the Bangladesh war of liberation, a few doctors, of whom Dr. Choudhary was one, set up a hospital for the care of the wounded, which moved into a rural area after the war and started a community health project in Savar, near Dhaka. This Peoples, Health Project is now funded by foreign donors. Today they have 65 trained paramedics (mostly women), nine of whom are village based. They undertake health work, run a school, pharmaceutical factory, a women's centre and have formed agricultural cooperatives. They are today sought after by the government and international bodies, for the health training they provide. GK has "arrived" — they have further plans for expansion.

Jamkhed : The comprehensive Rural Health Project was founded by Drs. Rajnikant and Mabel Arole in 1971 in Jamkhed, Ahmednagar Dist., Maharashtra in 30 villages (covers 60 villages now). They set up a project to deliver health care in rural areas, implementing the village health worker scheme, involving community participation. They also gradually included training in agriculture, provision of safe drinking water, employment schemes, nonformal education etc. They have been receiving some support from donors abroad. The Drs. Arole were given the Magsaysay award for their work in this field.

The Deenabandu Project : Drs. Prem and Hari John started their work in Deenabandhupuram some miles from Vellore in Tamil Nadu in 1972-73. They gradually shifted their focus from "help to all" — to helping the needy. A community health programme was started and village health workers were trained. They are supported largely by the organisation called World Neighbours. Here too, the doctors realised that ill-health had to be tackled in a broad and integrated manner taking all factors leading to poverty into account. They have, for this, started several programmes — economic loans, agriculture and animal husbandry, literacy classes etc.

CROSS : Founded by M. Kurien in 1975 with the intention of "empowering the poor", they undertook the work of organising the poor to fight for their rights. Starting with less than a 100 villages with funds from donor agencies abroad, the organisation has expanded today, to reportedly, 500 villages in and around Bhongir, in Nalagonda District of Andhra Pradesh. The programmes include providing economic loans, training in agriculture and animal husbandry, health and adult literacy, to the poorer sections of the villages. Their major achievement has been the formation of sangams for men and

women, in each village, where the problems they face and the programmes offered, are discussed. CROSS is today supposedly one of the leading development groups in the country.

The founders of these projects are all doctors (except for Kurien) who had been trained within the established medical system and yet had the vision to conceive of an alternative approach to health, one for which few models were available at that time. Besides, all these groups, spoke in terms of "community participation". It was perhaps the spread of leftist ideas at that time that influenced these non-political groups with the ideals of democracy and people's rule. Kurien and Choudhary, in particular, had connections with the communist parties of their countries. One therefore assumes that their notions of people's participation was based on a relatively better understanding of the rural situation and the power structures that operated within it.

The Drs. Arole and Drs. John, on the other hand, were more influenced by the christian missionary spirit and were thus keen on doing "service to the need" (John & John, 1984). To them people's participation had a different meaning. "We started his as a total community programme for the rich and the poor alike, for we believed we had a duty to all "(John & John, 1984). Similarily Dr. Arole, talking about their selection of Jamkhed says, "At Jamkhed the leaders made arrangements to provide accomodation for the staff of approximately 20 people..... ..... The leaders also tried to understand the basic concepts of the project". (Arole 1980). When the leaders of a village are given such importance it is not likely that there could have been much participation by all sections in the village Drs. John admit that they gradually realised that their understanding was not right (John & John 1984).

Despite their differences in background and approach to start with, all of the project holders realised gradually that health was not a matter of merely delivering medical services, it was closely bound to the poverty of the people, their lack of food. Gradually the programmes expanded to improving agriculture and economic backwardness through the granting of loans, setting up of night schools and women's groups. They made attempts to tackle the problems which, as they saw it, lead to ill health.

With the loans provided — at GK it was 100 taka per person at first with a 4 percent interest to improve his agricultural production — some of the village folk did manage to improve their living conditions. All the villages that were adopted by CROSS in its initial years have at least one well today, for general use. Training in improved agricultural methods, on all projects have helped some of the poor to make the best use of the little they had. The non-formal educational classes, on all projects, taught some of the village people to read and know where to put their signature and so on. Basic arithmetic taught to the women at GK have helped them as they said, to run their small vegetable vending business more efficiently.

It is in two particular areas however — that of health (except at CROSS) and women's development that there has been a great advancement. This can be seen in the lives of the women, who have been involved in the project, particularly in Savar, but also in the other project areas. Many women who have only known oppression have now come to look on their lives with greater hope and confidence. The excitement this knowledge has generated was seen in the literacy classes at GK in the fact that a woman health worker found the courage to stand for panchayat elections at Jamkhed and in the militancy of the women at Bhongir (CROSS).

In the area of health all the areas mentioned have in the last decade registered a fall in the IMR, immunisation coverage of mother and child is high, the family planning acceptance rate is also far higher than the national average and the maternal mortality rate has fallen. The number of 'at risk' cases are provided with regular care and in case of emergencies immediate care is provided by the referal system, where operations too are conducted.

The improvement in the health status and the status of women in these areas, are more or less, directly as a result of the programmes undertaken. This has been achieved through consistent hard work over the years, the training provided to the paramedics is quite thorough and they are very conscious of the great responsibility placed on them. Today if there was to be a test of skills in dealing with rural health problems at the village level, between these paramedics and city trained doctors, the paramedics would come out in flying colours.

Inspite of the benefits these development programmes have conferred on the people of the area anyone with some understanding of developmental issues, who visits any of the four projects mentioned comes away with a feeling of disappointment and disquiet. Before visiting GK, it was, for me, from all I had read, a model project in community health

with the people directly involved in the programme. I looked forward with great anticipation to seeing the project, only to be disappointed from the first few hours itself. The project has a 100 acre campus with two large multiple-storied structures on it. As I entered the campus, I was made to wait at the gate before being taken to one of the senior paramedics I knew, just so that my reference could be cross checked. The women gate-keepers were in uniform and were there to see that all and sundry do not enter the place. This by itself was shocking—such a clearly hierarchical structure and such control did not, in my mind jell with a democratic set-up. The rest of my stay only led to confirm this impression.

Centralisation of Authority

Perhaps the other projects do not have such structures but certainly from all reports, these other projects too have a tacitly functioning hierarchy, which is fairly rigid with the sole decision maker/arbitrator on practically all issues, being those at the top, be it a Choudhary, Kurien, John or Arole. No doubt it is these few who have had both the vision and the longest exposure to the work undertaken and hence have a right to a certain amount of decision-making. But what of the others who also worked along with them over the years? There appears to be very little of sharing in the process of decision-making. This almost total authority that they wield was once defended by one project director who said, "After all I get the funds, so its for me to decide what I do with it". Perhaps the others would not put it quite so blatantly, but in essence this approach operates in their projects too. Another director is known to have sent in a proposal for a new scheme without consulting his senior colleagues, who came to know of it only when a member of the donor agency mentioned it a year later!

The major danger in such autocratic trends is that of the centralisation of power. Every major and often minor decision needs an okay from the people at the top. This becomes particularly difficult as the project expands and the work increases, as has happened in all four cases. Not only do the individuals at the top have to work harder — which any one familiar with these projects is witness to, many of the decisions get delayed and several are not followed up. Often field level coordinators do not feel confident enough to take on a responsibility they will later have to answer for. At times, issues instead of being settled at the village/cluster level, are brought by an individual directly to the chief so as to gain support for his point of view, before presenting it to the village sangam. In CROSS, for instance, the scope for such lobbying with the boss is immense. The "games of power", that eventually set in are in contradiction to the earlier vision of "community participation".

The trend described here is perhaps due to the lack of accountability the project heads enjoy. Maybe in the earlier phases of their growth they were accountable to their funders, or there might have been the danger of their funds being stopped. But as their fame and "success" increased they have now got a "carte blanche" on funding. Often no major uncomfortable questions are asked of the project holders nor are any but the barest stipulations made of them.

The project holder is theoretically not answerable to the people whom he has set out to serve. The people are not told very much about programme budgets, policies, apart from what is necessary for their day to day functioning. Yet the project directors, particularly in the early years of their work, have shown a sense of responsibility to the rural poor, perhaps because of their basic idealistic motivation. Nevertheless there is very little the people can do about changing policies, today. They are not taken into account.

As for the lay public, they could not care less about what goes on at these projects. The Government of India, had an uneasy relationship with such organisations earlier but now seems keen on formalising it. Toward this effort recently it was announced that henceforth all foreign funds to such projects would require central government clearance. Even if this is implemented strictly, the way this money is spent would be entirely decided by the project directors. Thus these directors have the field to themselves. A method of operation which does not have an inbuilt system of checks and balances is very likely to lead to absolute control by those in charge. This is not very healthy for those around them or for themselves.

The same authoritarianism also makes the project directors hypersensitive to criticism. They have received such accolades from the press, both national and international and are proud of their achievements, so much so, that they will put up with little criticism. A group of doctors wanting to do a critical evaluation of the Jamkhed project in 1980 were very specifically told that their report would have to be okayed by Dr. Arole before it went to the press. Such behaviour is but a symptom

of the malady but this too proves harmful to the project in the long run.

Cosmetic Changes, Not Structural : Why?

It is true that in all these projects, it is clearly recognised that the prevailing ill-health is due to the socio-economic backwarndness of the area. As a result the project directors have become concerned about the general betterment in the living conditions of the people apart from providing health care. Yet these efforts in the form of economic loans, agricultural inputs etc. described earlier are only superficial, cosmetic changes which do not bring about structural change. At the most they temporarily lull some people into believing that "something is being done". In the long run as we shall see, they do more harm than good. The dependency of the target population on the project increases. Worse still, those among the poor who do get benefits from the projects, are envied by those who do not — this is as true of every one of the four projects described as of other such projects. In fact, this sometimes leads to village feuds. While at GK I was told of a case where non-beneficiaries implicated a beneficiary in a police case. The conflicts in the fragmented, caste ridden village situation thus get further aggravated by these efforts.

Such a superficial approach to the solving of deeprooted rural problems is particularly difficult to understand from people like Choudhary or Kurien who, considering their background, ought to have a clearer perception of the interplay of socio-political forces in society. One is naturally led to speculate on what could be the influences which result in this deviation from their original goal. Four possible reasons could be :

(1) Constraints placed by donor agencies — despite their easy relationship with donor agencies today, these directors must have had certain conditions laid down for them in the early days of their effort. Perhaps it was tacitly made clear, that any attempt at fundamental change would not be supported. For example, in the earlier phase CROSS did try to organise the rural labourers. Gradually this activity stopped or was sporadic, over a small area, with the director being careful not to be present on such occasions. The donor agencies could perhaps have had a direct influence on the petering off of the radical approach.

(2) The reason for sticking to cosmetic change could also be that the radical approach is too demanding, too risky to be sustained over a long period. Most workers within such organisations join for "employment" and a "living wage" and not because of their 'commitment to a cause". They are, therefore, not too willing to risk their lives for the villagers they are supposed to represent. This is not to say that it has never happened. One paramedic at GK was, in 1976, murdered by the local people who were opposed to the change he was trying to bring about. Possibly there are other minor instances of acts of courage in other projects too, but, as the years go by, one gets to hear of few incidents of actual struggles with the local powers. As mentioned earlier the risk to one's life and sustainance of the project, is too great.

(3) Thus we come to the next factor in this tie-up— that of the groups gradually taking care not to antagonise the forces in power. There even appears to be an understanding among the local power groups the police and these organisations that each will leave other alone. The status-quo remains and basic change fails to occur. There is the example of a coordinator at CROSS who, with the blessings of the director, employs unpaid bonded labour on his farmlands, while he gets a salary from the organisation, for the "upliftment of the poor".

(4) These experiences have not in any way led to any deeper analysis of the problems which these projects both face and create. Or if such an analysis has been made none of the projects have acted upon it. Just as the different departments within the government have come to function independently of each other, inspite of knowing the need for inter-departmental coordination, so too on these projects the directors have had to narrow down their efforts to chiefly providing health care and superficial changes or things would become too difficult for them. All efforts at radically changing the health situation, has to remain at the verbal level. One would find that since it is so, once these directors withdraw from the area, the health situation in 5-10 years time would most probably revert to what it used to be before the doctors took over.

Models Which Are Not Replicable

The next major issue, is that of the replicability of these projects. It is not possible to replicate any of them unless one is an Arole, John or Choudhary. Sheila Zurbrigg points out that the success of the Jamkhed project led the Government to implement the Community Health Worker (CHW) scheme at the Primary Health Centre level in 1978 (Zurbrigg, 1983). And this was, as is

established today, a failure — for one thing the "essential ingredient of the 'model' project — a relationship between village level health worker and his/her community based on trust, committment and accountability to the poor village families" — was missing. This led her to ask, 'If the essential relationship of a CHW approach is therefore doomed when placed within the caste-class structure of society, what possibility is there for effective broad replication of the locally successful 'model' project?" (Zurbrigg, 1983). Similarly the present medical education does not generate, in doctors, any sense of commitment to the poor or their health problems. The medical system too, on the whole does not cater to the needs of the rural areas, much less the rural poor. Thus any question of the replicability of such projects is moot.

Related to this is the growing dependence of the people in a project area. When a project like any of these gets established its continued effectiveness over a period of time becomes heavily dependent on the presence of the individuals who started them. None of the projects functions in a manner which will enable it to carry on as before if the 'leader' were not there. The people in the project areas become dependent on them and their sustainance depends on the project. Even the health workers are rarely allowed to work independently (though some senior paramedics do so, to a certain extent, at Savar). As Prem and Hari John admit, "Of course, two independent control mechanisms do exist in the programme, more to see the effectiveness of the VHW than to "supervise" " (Zurbrigg, 1983). This inability to give up control becomes a decisive factor in determining the eventual nature of the project. This is the tragedy, that inspite of setting out to establish a people's project, even after a decade of work, the people cannot, or are not seen as being capable of running their own project.

Together with this is the notion of self-sufficiency. There has been a time in all the projects where there was some talk of making the project self-sufficient. Initially, at CROSS the idea was that the economic loans given to the poor would be returned in full and with this pool of money thus generated, fresh loans, without outside help, could be made. This could be done in several areas and gradually the economic loans programme could become self-sufficient. But this idea was not seen through and gradually the talk of self-sufficiency died down. With so much foreign funds available so easily where was the need to learn to be independent?

Here it must be said that perhaps a health project is difficult to sustain without funds — as some others have learned to their cost. But it is not impossible (Werner, 1978). Even assuming that a certain minimum of funding is necessary, surely some attempt to generate it locally could be made? It is interesting to note that this notion of self-sufficiency does bother Drs. Prem and Hari John. They however manage to side-step it, though not very convincingly, by saying "We had this problem until we realised that "Self-sufficiency" referred to the project, while what we were aiming to build at the community level was "self reliance". We were working towards building community capability in health care and hence self-reliance" (John-John). How can a people dependent on a project that is not self-sufficient, be taught to be self-reliant?

Another trend manifest in these circles today is the development of jargon and "management" techniques. Thus CROSS has a management consultant on call to tell them about "systems analysis" and "strategy planning" and so on, to help alleiviate rural poverty — the old methods having failed perhaps the new will succeed. Terms like "intersectoral integration", "integrated community" approach and so on are bandied about. They do this more, it would seem, to please the elite they interact with and the donor agencies, than to help solve any rural problem, for it is hard to believe that these founders still do not acknowledge that the essential question is one of sharing of power and its fruits by all.

What now ?

These projects have come a long way in the last 10 years — there were several points along the way where things could have changed for the better. But this was not to be. Now after having a positive impact on the health status of the people, their continued presence in the area is only likely to create fresh problems, as we have seen. It is time now that they either decided to gradually withdraw or radically change their strategy. The passing years have proved that these miniscule efforts do not really make any impact on the total health situation. They would be far more effective today if they undertake organising work among the rural poor and see that they demand that the existing government health facilities be made available to them.

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Work and Health : An Alternative Perspective

Bharat Patankar and Jogen Sengupta

The "work and health" question (SHR 1:3) is a historically specific one. Its meaning has changed with changes in the social structure. There are societies which do not face this problem at all. All these aspects of the problem have to be considered in formulating strategy and action in today's context.

There were societies which did not face the question of "work and health". These were societies which "work" is not defined in state, class, patriarchal, race or caste terms. Their vestiges exsit today. Not only that but in them "work" is not regarded as "struggle" with nature or an attempt to master nature. When male and female human beings think of themselves as part of nature and live and act accordingly, they cannnot separate "work" from play or pleasure. Appropriating from nature external to them does not become a thing separate from lively and creative intercourse with it. So the risks, hazards and dangers could not be considered as "work and health" issues, but as part of the total life of human beings along with nature.

Work and life got decisively separated from and turned against each other only after patriarchal, statist and class domination emerged. Casteist and later racist domination became part of these. It is only from this point that human existence and the enrichment of it becomes seen as a struggle with external nature, an attempt to achieve mastery over nature. It is only in such societies that the problems of health becomes seen as one of "work and health".

In these societies the life of the majority is decided not by themselves but by the state, males, dominating classes, castes and races. Once "work" got separated from other life it became the first health problem, giving rise to unhappiness and a sense of subjugation. This alienation was the first and greatest problem of "work and health", causing basic ill-health whether work contains other risks, hazards and dangers or not. People working under such conditions could not feel that part, the work part, of their lives as their own. Or they internalised this ill-health and became dehumanised apart from the attempts of struggle they gave against these conditions. This major aspect of ill-health because of work will remain in our lives until the end of various hierarchical subjugations and alienations from remaining nature, no matter what changes take place in the technology. The nature of this ill-health has taken various forms depending on changes in the social structures.

Technoloy is not separable from the process of subjugation of the people who work with it. It is not free from the type of relations of humans with nature. Its structure internalises these relations. The particular kind of technology we are experiencing today which is destroying the ecological balance and creating disastrous health problems for people working with it shows these internalised social relations. The fight against ill-health and the hazards of "modern technology" cannot simply mean dislodging the ruling class which controls it but a fight against all the practices and social relations which structure it.

Patriarchy and the sexual division of labour create distinct health problems for women and children. This happens not only in the fields and factories but also in home work (which is not considered work at all in the male chauvinist culture). This problem of work is related not only to surplus value creation and technology but also to specifically sexual and patriarchal relations. Without a study of this aspect of "work and health" one cannot deal with the ill-health of a majority of the population.

Casteist social division and division of labour have been creating problems of health related to work for more than thousands of years in India. Apart from class divisions, these forced the majority (in some cases a minority) of the people to do work which obviously creates health hazards and traumas of all kinds. Today, even wrapped in capitalist relations of production on a wide scale, casteism and racism are creating specific problems related to work.

Class and state domination is both a part of this picture and a major factor in themselves creating ill health related to work. While it is true that these dominations are very much concerned about extracting surplus or surplus value, it is not the sole concern they have. Whether capitalists or the state will spend resources for reducing health problems at work also depends on their concern to maintain their continuing existence as dominating sections. At certain conjunctures they might even bear losses

or invest in "non-profit-creating" measures to maintain health in the long term interest of appropriating surplus or surplus value. Such actions might be deceptive for anyone who sees the picture only as one of "continuous greediness to increase surplus value no matter what happens with the workers' health.

Today the new movements of ecology, health and safety groups in the unions, workers' control and grass-roots democracy, various kinds of peoples' science movements, women's health groups and so on are bringing forward studies and practice helpful to this question. Many left groups are becoming conscious of this aspect and trying to act accordingly. These are important advances and close coordination of all the movements, unions, organsations of the rural poor community organisations, cultural organisations will deepen and extend this movement. It will be a movement that may start with efforts to reduce ill health in fields, factories and homes, but it has to fight to abolish class, state, caste, and patriarchal domination along with abolishing the technological monstrosities specific to these dominations. This only can establish harmony with nature and abolish "work" itself, the first and basic cause of ill health.

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Need for Population Control Cannot Be Ignored

Vrijendra

The editorial perspective (SHR, I:4) by Manisha Gupte does an excellent job of summarising the marxist critique of Malthusian view on the 'problem of population'. However, the perspective gives rather an incomplete picture of the situation. It is true that the ideology of population control, as preached and practised in the poorer countries of the world, is primarily used to divert attention from the real issues and factors behind poverty and other related aspects of life for a vast majority of people.

The perspective fails to adequately emphasise the well established fact that in the experiences of today's developed market economies, the changes in the family size and population structure since Industrial Revolution followed a rise in living standards of population. It was also significantly affected by a host of legal and institutional measures adopted by the goverment of the day as the needs and priorities of the ruling classes changed. This, of course, only enforces the view that population control is a consequence of the development process and cannot be a substitute for necessary strutural changes in a system where a tiny minority is the prime beneficiary of the process of development.

Another important aspect that should have been reflected in the perspective is related to the changes in the pattern of population growth in the centrally planned economies of Eastern Eurpe, USSR and China in the last few decades. One does not have to agree with the details of alternative systems there to recognise the effectiveness of medical system in these countries and its impact on their population growth.

The idelogical misuse of the family planning and population control by the ruling classes in various countries of the world should not detract anyone from the possible disturbing effects of continuing high rates of population increase in large parts of the world. Again, one does not have to be a neoMalthusian to say that, unlike the historic experiences of the developed market econmies which could afford the 'natural' adjustments in their population growth and structure spread over a long period, the world as a global entity has to take cognizance of the natural resources and their potential growth as well as limits to growth as the global population continues to increase. Family planning and population control must constitue an explicit objective of any meaningful strategy of development. Population control cannot be a substitute for development; development without measures to check population growth is not likely to be very meaningful either.

I am quite surprised to see the benefits of birth control and contraceptives only briefly discussed under the sub-title of 'the feminist perspective', as if there were no socialist perspective of birth control! I am sure the author views the feminist perspective as integral to the socialist perspective, but she fails to clarify that benefits of birth-control and contraceptives have much wider implications for the society as a whole and must be recognised as such, apart from their effect on sexual mores of the society.

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Women, for obviovs reasons, are the direct (actual and potential) beneficiaries of the various methods of birth-control. They also are, as a result more prone to various, at times dubious, experiments in the field. But, quite surprisingly, again, the author has not even mentioned the the politics of number in relation to birth-control for men.

Another issue that deserves mention : I am greatly disappointed that a magazine like SHR does not have any leading feature on the health issues and the peoples' right to know potential and actual hazards to their health, associated with industries in which they either work or which are in the vicinity of their homes, except for a note-like article by Anurag Mehra. I am sure that despite your prior commitments, Bhopal tragedy deserves more importance than has been hitherto accorded. I hope your next issue on 'Health and Imperialism' will more than compensate for this omission and will also focus on the implications of this tragedy for the peoples' right to health and safety in addition to its other aspects rooted in the political economy of industrialisation in the poor countries of the world. And finally, hearty congratulations for timely production of SHR.

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Criticism of Tubectomies Unscientific

Anant Phadke

A frontal attack by Sucha Singh Gill in his *Politics of Birth Control Programme in India* (SHR I : 4) though not comprehensive enough, was very much needed. But he goes too far at the end of his article, and makes some very sweeping statements which can not stand a little deeper probing. The way he attacks and rejects tubectomies as a method of sterilisation is unscientific. It is superficial to criticise tubectomies by just saying that after tubectomies "back-ache, pelvic pain and other problems make the women chronically ill. In a survey conducted in Punjab, more than 80 percent of women complained of one or more problems after operation." There is a lot of literature on complications, complaints after tubectomies and it is widely known that many women wrongly attribute many of their health-problems, particularly back-ache to tubectomies. A survey merely reporting what women felt after tubectomies is too insufficient a basis for a sweeping criticism of tubectomies. A correct argument would be to point out that though incidence of complications due to tubectomies is not high in absolute terms, tubectomies should not be pushed when far more simpler and safer method of sterilisation is available for the male. Since the government and the medical system does not want to attack the patriarchy in the society, (they themselves help perpetuate it) it is pushing tubectomies, when in reality it should be used only in exceptional circumstances.

Gill's reasoning that birth control programme is "a serious attempt by the rulers to reduce the number of their enemies in order to reduce the risk to their oppressive regime" is quite off the mark. Increase in the number of pauperised population does not increase the chances of social revolution or even a revolt. It is the contradiction between developed capacities, aspirations of the people (as a result of capitalist development) on the one hand and their actual suppression (especially in periods of crisis) due to capitalist social relations that create possibilities of revolution.

Gill does not take into account the role of patriarchy in deciding the size of the family. The necessity of having male children; non-cooperation of husbands in family planning (both consequences of patriarchy) contribute to a larger size of the family even when women do not want more children. (In India every year, about half a million women undergo medical termination of pregnancy and about four to six million undergo abortion through unsafe methods which kill thousands of women every year. This shows that they many times do not want pregnancy.) It is true that unlike in middle and upper class families children in toiling classes do contribute to family's income. But they probably consume more than what they produce since upto the age of atleast three years they consume on an average, about a quarter (in terms of calories) of what adults consume without being able to contribute in production. Slightly older children look after younger children and spare adults for outside work. But the point is—was there a necessity of having this younger child in the first place?

High infant mortality and lack of old age security are the real justification of having a somewhat larger family. The rest is due to patriarchy and ignorance about family planning. Let us not gloss over this and indirectly justify any unnecessary burden on women due to patriarchy, ignorance...

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Women, for obviovs reasons, are the direct (actual and potential) beneficiaries of the various methods of birth-control. They also are, as a result more prone to various, at times dubious, experiments in the field. But, quite surprisingly, again, the author has not even mentioned the the politics of number in relation to birth-control for men.

Another issue that deserves mention : I am greatly disappointed that a magazine like SHR does not have any leading feature on the health issues and the peoples' right to know potential and actual hazards to their health, associated with industries in which they either work or which are in the vicinity of their homes, except for a note-like article by Anurag Mehra. I am sure that despite your prior commitments, Bhopal tragedy deserves more importance than has been hitherto accorded. I hope your next issue on 'Health and Imperialism' will more than compensate for this omission and will also focus on the implications of this tragedy for the peoples' right to health and safety in addition to its other aspects rooted in the political economy of industrialisation in the poor countries of the world. And finally, hearty congratulations for timely production of SHR.

17 March, 1985.

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Criticism of Tubectomies Unscientific

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REVOLUTIONARY IN FORM, REACTIONARY IN CONTENT
A Critique of Ivan Illich

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Ivan Illich's contribution to the analysis of health care and the Illichian school of thought which it has generated have contributed enormously to the strengthening of the basic tenets of bourgeois individualism. The school's very political basis together with its regressive solution to the problem make it reactionary in content. It serves the purposes of monopoly capital by promoting a victim blaming ideology, an anti-technological mode of medicine in commodity form and advocating a tightening of the medicare belt. The article presents a marxist critique of the basic theoretical and political postulates of Illich. It is largely based on two articles, (Vicente Navarro's "The Industrialisation of Fetishism" in 'Medicine Under Capitalism' (Prodist) New York, 1976, and Howard S. Berliner's 'Emerging Ideologies in Medicine' in 'The Review of Radical Political Economics' (9:1, 1977)).

In the last decade a number of books have appeared attacking clinical medicine in fundamental ways. Of these Ivan Illich's *Medical Nemesis* (Pantheon 1976) has received wide critical coverage in the popular as well as the academic media. Although Illich offers a highly informative and important critique of scientific medicine, in the final analysis he tries to suggest a reform of medicine along bourgeois ideological lines. This leads him to conclude that health is a function of our individual consumption pattern, that less medical care is better, so that working class would be better-off (healthier) in the long run by tightening their medical care belts.

The net impact of Illich is to serve the purposes of monopoly capital by : (1) Diverting attention from the economic sources of disease and collectively based response and advocating a victim-blaming ideology; (2) Undermining the petit bourgeois mode of medical care delivery leading to life style politics; and (3) Legitimising a cut-back of all forms of medical care services.

The Roots of the Crisis

There is no doubt that modern medicine is passing through a period of deep crisis in the developed countries outside the socialist block. The crisis of modern medicine reflects and is a part of the crisis of modern capitalism. Briefly, the cause of the crisis lies in the falling rate of profit due primarily to increasing variable capital costs (mainly wages and fringe benefits) not matched by increased productivity. Resumed accumulation requires the destruction of unproductive capitals and the diversion of variable capital (including social wages) towards new, relatively productive constant capital. Lowering variable capital costs involves both the diversion of labour and money away from the reproductive sector (health, education, labour, welfare) and the reorganisation of the reproductive sectors to place them more firmly in the control of capital. The health system has thus come under the scrutiny of capital to reduce those costs and help expediate the recovery process. An ideology which promotes anti technological (hence cheap) modes of medicine in commodity form is advantageous to capitalist's efforts to lower the costs of labour.

During periods of economic expansion and explicit class struggle, capital has been forced to provide greater medical care and preventive services for workers (raising its variable capital costs). As accumulation slackens the need to reduce those costs of reproducing labour heightens. As the costs of capital rise through expanding medical technology and through inflationary medical care reimbursement systems, without concomitant gains in terms of productivity, capital seeks to lower the level of health care provided. This struggle takes an added significance in a period of severe economic crisis.

Victim Blaming Ideology

As capitalism progresses and leaves increasingly dire health hazards in its wake, the technologically-oriented system of medicine tends to mask the origin of that morbidity by treating illness as an individual disorder through the use and purchase of commodities. Increases in disease morbidity and mortality and the increasing recognition that they are directly attributed to the capitalist mode of production cause concerns for capital on two distinct levels. It brings the legitimacy of capital into question at the point of production

as workers become more concerned about the effects of the production process on health, and it greatly increases the costs of providing medical care as workers spend more time off the job going through elaborate radiological, chemical and surgical therapies. The economic crisis exacerbates this struggle and thus capital tries to shift the responsibility for disease back to the worker—in this case through the promotion of victim-blaming ideology—and of individual solution for the worker defusing the class aspect of the morbidity.

Victim-blaming is not a new ideological response by capital. It has been used in education, welfare and even in health before. What is especially significant about this new wave is that, there is a chance that victim-blaming strategies may become the basis for public policy. In the west the popular media have been devoting a growing amount of space to life style changes and their positive contributions towards health. It is clear that this victim blaming epidemiology is getting wide circulation and acceptance.

Ideology of Industrialism

Illich is an articulate theoretician of the most prevalent and influential ideology used to explain our societies; i. e. the ideology of industrialism. The primary characteristic of that ideology is that the production requirements of the technological process and *Pari Passu* (at the same rate) of industrial organisations are the most important determinants of the nature and form of our western developed industrialised societies. In a fatalistic and almost deterministic way the former, the technological process, leads inevitably to the latter, the industrialisation of society. Moreover, according to the theorists of industrialism industrialisation has transcended and made irrelavant and *passe* the categories of property, ownership and social class. Indeed ownership loses its meaning as legitimisation of power. And control, now assumed to be divorced from ownership has passed from the owners of capital - capitalists - to the managers of that capital, and from there to the technocrats.

A final characteristic of industrialism is that it claims to be a universal process. In other words all societies regardless of their political structure, will evolve, according to the dictates of industrialisation. Indeed, according to a key component of that ideology, the theory of convergence, all societies will progress towards the urban industrial model of the future. Thus, socialism and capitalism are usually seen as two convergent roads to the same destination - the industrial model. Viewed in this way, the social problems of capitalist societies become not the problems of capitalism (an altogether *passe* category) but the problems of industrialisation.

Illich believes that industrialism is the main force shaping our societies and that unavoidable and irreparable damage accompanies industrial expansion in all sections, including medicine, education and so on. The industrialisation of medicine leads to the creation of a corpse of engineers — the medical profession — comparable to the technocrats of the main social formation of industrialised societies, the bureaucracy. Thus, the industrialisation of medicine means its professionalisation and bureaucratisation. And Illich believes that capitalism and socialism are indeed outmoded concepts since they are basically converging towards the same path of industrialisation that overwhelms and directs their social formations. In this interpretation, then, the class conflict has been replaced by the conflict between those at the top, the managers of the bureaucracies indispensable to the running of an industrialised society and those at the bottom, the consumers of the products — goods and services administered by those bureaucracies. As applied specifically to medicine, that conflict is the one between the medical bureaucracy, primarily the medical profession and medical care system; and the consumers, the patients. This antagonistic conflict appears as iatrogenesis (damage done by the provider) it is clinical when pain, sickness and death result from the provision of medical care; it is social when health policies reinforce an industrial organisation which generates dependency and ill-health, and it is structural, when medically - sponsored behaviour and delusion restrict the vital autonomy of people by undermining their competence in growing-up, caring for each other and aging.

How can we avoid and correct this iatrogenesis, the extensive damage done by the industrialisation of medicine? Before stating his own solution Illich briefly considers several other alternatives presently debated in political circles. In discussing solutions for clinical and social iatrogenesis, he especially rejects the socialisation alternative that he attributes to the equalising rhetoric of what are misleadingly termed the progressive forces among which he includes liberals and marxists. According to his normative conclusion, the redistribution of medical care implied in the socialisation alternative would make matters even worse since it would tend to further medicalise our population and create further dependencies on medical care. According to

Illich "less access to the present health system would, contrary to political rhetoric, benefit the poor". *In that respect Illich finds the creation of the National Health Services in Britain as a regressive not a progressive step.*

Instead of socialisation and its implied redistribution Illich recommends the following solutions for clinical and social iatrogenesis. The mode of production in medicine should be changed via its deprofessionalisation and debureaucratisation. He suggests that licensing and regulation of healers should disappear and concerns of where, when, how and from whom to receive care should be left to the choice of the individual. Collective responsibility for the health care should be reduced and individual responsibility should be maximised. Self-discipline, self interest, and self care should be the guiding principles for the individual in maintaining his health. In summary, each one should be made responsible for his own health.

As for the structural iatrogenesis, he again dismisses the alternative of socialisation and public control of the process of industrialisation, recommending instead the reversal of that process ie. breaking down the centralisation of industry and returning to the market mode. The essence of his strategy for correcting structural iatrogenesis, then is an anti-trust approach with strong doses not of Marx or even Keynes but of Friedman.

A major weakness of his evaluation is that he takes as an indicator of the effectiveness of medical care, indicators of cure. Indeed, he seems to confuse care, with cure. And in evaluating the effectiveness of medical care he does what most clinicians do; he analyses the degree to which medical intervention has reduced mortality and morbidity. In other words the effectiveness of health care intervention is analysed in terms of curing disease and avoiding mortality. But the limited evidence available indicates that medical care may reduce disability and discomfort in peoples' lives. For that taking care to occur, our medical care system would have to change very profoundly to better enable the system to provide that care. Still Illich does not seem to accept the possibility of creating another system in which the priorities would be opposite to those of the present ones, with emphasis given to care as opposed to cure service. Actually, Illich would not even welcome such a care-oriented system since it would increase the dependency of the individual on the physician and on the system of medical care, preventing the much needed self-reliance and autonomy.

Illich considers social iatrogenesis, the addictive behaviour of the population to medical care, to be the result of manipulation by the medical bureaucracy. He postulates that the consumer behaviour of our citizenry is primarily determined by its manipulation by the bureaucracies created as a result of industrialisation. The manipulation of addiction consumption and by bureaucracies (including medical care bureaucracy) is not the cause, as he postulates, but the symptom of the basic needs of the economic and social institutions of what he calls industrialised societies, the industrialised capitalist societies. Those bureaucracies, are the mere socialisation instruments of those needs ie. they reinforce and capitalise on what is already there — the need for consumption, consumption that reflects a dependency of individual on something that can be bought, either a pill, drug, a prescription or a car.

Actually those dependencies are mere symptoms of a more profound dependency that has been created in our citizenry not by industrialisation but by the capitalist mode of production and consumption - a mode of production that results in the majority of men and women in our societies having no control over the product of their work, and a mode of consumption in which the citizenry is directed and manipulated in their consumption of the products of their work. This dependency on consumption—this commodity fetishism—is intrinsically necesssary for the survival of a system that is based on commodity production. In the medical care system in capitalist system we find that (a) the alienation of the individual in his world of production leads him to the sphere of consumption of health services and that (b) the medical care bureaucracy is just administering those disturbances created by the nature of work and the alienating nature of the capitalist mode of production.

Illich finds structural iatrogenesis to be due to the culture of industrialisation. His solution for that iatrogenesis includes breaking down the industrial bureaucracies, and returning to self-reliance and enlightened self-interest. But by focussing on the medical bureaucracy as the 'enemy', Illich misses the point because those bureaucracies are the servant of a higher category of power - the dominant class. In the health sector power is primarily one of class, not of professional control. Indeed, the medical bureaucracy administers but does not control the health sector. We find then that the main conflict in the health sector replicates the conflict in the overall social system. And that conflict is primarily not between the providers and consumer, but between those that have a dominant influence in the health system (the corporate class and the upper middle class) who represent less than 20 percent of

(Contd. on page 100)

(*Contd. from page 94*)
of the population and control most of the health institutions, and the majority of the population (lower-middle class and working class) who represent 80 per cent of the population and who have no control whatsoever over either the production or the consumption of those health services. To focus then as Illich and majority of social critics do, on the conflict between consumers and medical providers as the most important conflict in the health sector, is to focus on a very limited and small part of the actual class conflict.

One of the functions of the services bureaucracies - including the medical bureaucracy - is to legitimise and protect the system and its power relation. One aspect of that protection is social control — the channelling of dissatisfaction which Illich introduces as structural iatrogenesis. But to believe that social control is due to the culture of medicine and the pervasiveness of industrialisation is to ignore the basic question of who regulates and most benefits from that control. An analysis of our societies shows that the service bureauracies — including the medical care ones - although willing accomplices in that control, are not the major benefactor. The ultimate benefactor of any social control intervention in any system is the dominant class in that system.

In short the major suggestion of Illich for solving our problems is self-reliance, self-care and autonomy of the individual - what can be described as lifestyle politics. This philosophy strengthens the basic ethical tenets of bourgeois individualism. Moreover, the lifestyle approach to politics serves to channel out of existence any conflicting tendencies against those structures that may arise in our society. The strategy of self-care assumes that the basic cause of an individual's sickness or unhealth is the individual citizen himself, and not the system and therefore the solution has to be primarily his and not the structural change of the economic and social system and its health sector. Contrary to what Illich and others postulate, the greatest potential for improving the health of our citizens is not primarily through changes in the behaviour of individuals, but primarily through changes in the patterns of control, structures and behaviour of the econmic and political system. The latter could lead to the former. But the reverse is not possible. Actually, it is precisely because of the impossibility of the reverse, and thus the lack of conflict between Illich's message and the basic tenets of the capitalistic economic system that his message, the lifestyle politics is and increasingly will be presented by the organs of the media as the resolution of our crisis and problem.

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DUST HAZARDS IN COAL MINES
A Brief Overview

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The global energy crisis of the last decade has provided an impetus to the development of coal resources which has, in turn, meant large scale indiscriminate mechanisation programmes. These have had disastrous consequences for the health of miners. The article highlights some of these health hazards which are being largely ignored by both the mining industry and the trade unions.

Of late the management of our nationalised coal industry has laid considerable stress on promoting the production of coal. And to achieve this end large scale mechanisation with borrowed foreign technology has been adopted. Critics from the Trade Union front have correctly identified the drawbacks of such a plan of reckless mechanisation. Lack of employment generation, high overhead cost that erodes the benefit of the economy of scale, dependence on foreign countries for spare parts of the machines are the important aspects of their criticism. But one important consequence (perhaps the most vital one) of reckless mechanisation seems to have escaped the attention of all concerned. This is the problem of health hazard which is increasing at an alarming rate.

It is unpalatably true that hazard has been synonymous with the term coal mining in India. The risk of fatal disasters to which the coal miners are exposed to is as great today as it has been during the days when coal mines were owned privately — Chasnala (1975), Jitpur (1978), Hariladih (1983) disaster. The introduction of sophisticated machines has in no way reduced the chances of such accidents. But that is a different story altogether. Here the attention is intended to be drawn towards that kind of hazards which silently, slowly and steadily shorten the life span of the miners, or make them physically disabled even when there is no massive disaster in the mines.

Coal mines are inherently unhealthy places to work. Not only in underground mines, but also in open cast quarries where giant earth movers are used, the workers inhale large amounts of dust, fumes and gases which cause many killer diseases - mainly respiratory in nature. They include influenza, asthma, emphysema, stomach and lung cancer, hypertension, Pneumoconiosis and bronchitis. The most fatal of all respiratory diseases is Pneumoconiosis commonly known as black lung disease which is incurable. (See SHR : I : 3, December 1984).

It is caused by the inhalation and retention of respirable coal mine dust in the lower lungs. A noticeable dose-response relationship usually appears when exposure continues for a decade or so. Coal worker's pneumoconiosis is classified into levels of ascending severity from simple to complicated by X-ray diagnosis. Continuous dust exposure can accelerate a case of simple pneumoconiosis to more advanced stages. Miners with progressive massive fibrosis are usually totally disabled. If the dust concentration is still higher, emergence of pneumoconiosis is earlier. Some miners seem to be more vulnerable than others and this vulnerability is yet to be explained. Habit of smoking appears to have no significant role in causing pneumoconiosis among the miners. It certainly contributes to lung impairment to a miner as it does to any non-miner. It has been established with a fair amount of certainty that it is dust, be it coal or otherwise, which can cause pneumoconiosis among the miners. So dust is identified as the greatest hazard.

Dust may be looked upon as suspended solid contaminent in a state of minute subdivison present in the air. It is produced during various industrial activities like blasting, grinding, drilling and crushing or whenever any material used in industry undergoes disintegration. Such operations enhancing the occurance of dust are too common in coal mining industry. As the material undergoes progressive disintegration it acquires certain properties which has killer significance with regard to health of those exposed to its action. The very minute size (0.2-10.2 microns) itself confers it high reactivity both chemically and biologically and it becomes more toxic than its parent lump from which it has been disintegrated. These tiny particles once air borne can neither be swept off nor trapped by existing technical means. It is estimated that one cubic meter of a coal lump, after progressive disintegration may form 10^{19} particles and eventually spreads through 283 million cubic centimeter of the working environment.

Because of its small size these dust particles do not settle down and remain suspended in the air for quite long time.

It is quite natural, therefore that the various operations at the mechanised coal mines not only generate more dust but they reduce the size of the dust particles to a minimum. And these tiniest particles are more dangerous. Scientists have estimated that particles which are retained in the alveoli, the gas exchanging sacs of the lung – weigh 5 micrograms or below. These particle are termed as respirable dusts.

Generally the larger particles (nonrespirable dust) do not penetrate the alveoli and are not thought to cause pneumoconiosis. While the distinction between respirable and nonrespirable dust is scientifically valid, it is clear that both sizes can impair lung functions when inhaled in quantity over time. The larger particles are probably linked to bronchitis among the miners. Although these particles are generally not retained in the lung, continuous exposure to them during normal work year produce more or less constant irritation of the upper respiratory tract. Breathlessness has also been found to be significant among miners who do not show X-ray evidence of pneumoconiosis. Researchers believe the breathlessness is related to chronic non specific obstructive pulmonary disease. Some investigators have found, in addition to pneumoconiosis and broncho-pulmonary disease, a third as yet unidentified disease process that reduces the ability of the lungs to exchange gases.

Black lung disease has come to represent a broad definition of occupational respiratory disabilities in miners of which coal miners' pneumoconiosis (henceforth referred as CWP) is one major component. Respirable dust which is invisible to the unaided eye accounts for less than one percent of the dust in a mine. It is not clear how much nonrespirable dust is retained in the lungs when the standards for respirable dust (if they exist at all) are being met.

Along with CWP, coal miners will continue to experience other lung diseases — bronchitis, severe dyspnoea (shortnesses of breath) and airways obstruction. Many of these illness are work-related. Coal mine dusts contain a wide range of non-coal constituents including silica and naphtalenes. Researchers have found as many as 13 Polynuclear Aromatic Hydrocarbons (PAH) in the respirable mine dusts they had studied. (Shultz, Fridel and Sharkey, 1972). PAHs are tested carcinogens. Besides trace elements that are mentioned above there are a host of other elements listed as 'hazardous elements' which are liberated as dust or gas in the place where coal is cut from the working face. These hazardous elements are identified as Arsenic, Beryllium, Cadmium, Fluronine, Lead and Mercury. It is worthwhile to mention here that a mine producing one million tons of coal generates one ton of each element annually. These elements may have a role in producing black lung disability either alone or synergestically. They may also play a role in the excess lung and stomach cancer found among the coal miners.

Diesel powered equipments are commonly found in all the mechanised coal mines throughout this country. Diesel engines produce emissions that are known to be hazardous, unburnt hydrocarbons, oxides of nitrogen, particulates, PAH, phenols, aldehydes, oxides of sulpher, trace metals, Nitrogen compounds, smoke and light hydrocarbons many of which cause adverse respiratory effects.

Noise is a proven hazard to the miners working in a mechanised mine. Noise may cause temporary or permanent loss of hearing sensibility, physical and psychological disorder, interference with speech communication or the reception of other wanted sounds and disruption of job performance. Excessive noise may also cause changes in cardiovascular, endocrine, neurolgic and other psychological functions. Studies on the subject indicate that coal miners have miserably worse hearing than the average.

CWP and other work related disease in coal mines have been recognised as the subjects of large-scale investigations in countries like USA and UK and this recognition came through relentless struggle of the workers themselves. A physician Dr. Lorin Kerr who is also the representative of the coal miners of America voiced his alarm against CWP "At work, you (coal miners) are covered with dust. It is in your hair, your clothes and your skin. The rims of your eyes are coated with it. It gets between your teeth and you swallow it. You suck so much of it in your lungs that until you die you never stop spitting up coal dust. Some of you cough so hard that you wonder if you have a lung left. Slowly you notice you are getting short of breath, when you walk up a hill. On the job you stop more often to catch your breath. Finally just walking across the room at home is an affort because it makes you so short of breath. (Kess, 1968.)

We do not have any Dr Kerr to lament for our miners. Our miners are not even aware of such a fatal disease. As the detection of CWP is difficult in the initial stage without powerful X-ray examination (the facilities for which is non-existent in our colliery hospitals) the miners who suffer from shortness of breath or exhaustion are often wrongly treated.

The author has encountered several such cases in the Jharia coalfield. Kripal Chamar of Damoda Colliery has been treated as a TB patient because he has been suffering from shortness of breath. Kripal was told that TB is a curable disease but he wonders why in his case the medicine does not work. Another miner Chanari Beldar of Kenduadih Colliery died of TB(?) two years ago. When this trouble of breathlessness began Chanari used to abstain from his work once or twice a week. He received charge sheets and warning letters for negligence of duty. No one bothered to enquire about the real causes of his illness and consequent abstenteeism. We do not know the exact number of miners who suffer from breathlessness or other similar symptoms of CWP among Indian coalminers. But certainly the number is not small. Even in technologically advanced countries where more effective dust control methods are used and where people are more aware of such diseases, the number of miners affected by CWP is quite large. It was estimated that in USA between January 1970 and December 1977, 4,20,000 coal workers were awarded Federal Black Lung compensation because of total disablement due to CWP. In UK, National Coal Board had conducted a survey during 1974-77 and found that seven percent of the British coal miners were suffering from CWP. In India a small scale study conducted in 1960-66 by the Chief Advisor of factories revealed that 178 (18 percent) of 2754 coal miners who were radiologically examined were suffering from CWP. Another random representative survey done by Dr Viswanathan in 1964 showed the incidence of CWP varied between 6.0 to 16.8 percent. The situation here in India is certainly alarming.

Last decade witnessed a global energy crisis caused by price-hike of petroleum resources coupled with impending depletion of the same and this resulted in reemergence of coal as vital alternative. Eventually its scale of production was raised, mines were mechanised with borrowed technology associated with heavy over-head cost in terms of foreign exchange but a thing which was conveniently forgotten is the probable environmental impact.

Legislations, covering mines safety fail to address the problem related to miners' health and welfare. It appears that miners' health and welfare as an entity distinct from mines safety is yet to be recognised. It is equally distressing to note that established trade unions with commendable fighting spirit while realising economic demand are yet to recognise this invisible monster—the fugitive dust which slowly but steadily, surreptiously advances forward to collect its toll among the miners. Now the question is who will cry a halt?

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Table - 3 : People's knowledge of agencies for CHW selection and supervision

	Category I			Category II			Category III		
	1	2	3	1	2	3	1	2	3
				* SELECTION					
No. of house-holds	5	90	7	13	23	6	13	26	12
%	4.9	88.2	6.8	30.9	54.7	14.2	25.4	50.9	23.5
				** SUPERVISION					
No. of house-holds	18	84		9	33		25	26	
%	17.6	82.3		21.4	78.5		49.0	50.0	

*Code for Selection
1. By Sarpanch with or without other members.
2. Don't know
3. By hospital with or without Sarpanches.

**Code for Supervision
1. Supervised by Hosp/PHC
2. Don't know

Table - 4 : Social Background of CHWs

Tribe caste	No of HWCs	%of Total CHWs
Gonds	15	40.0
Baiga	4	10.8
Kol	1	2.7
Panika/Kangikar	2	5.4
Brahmin/Thakur	11	29.7
Gupta/Srivastav	2	5.4
Muslim	2	5.4

Table - 5

Relationship of CHWs with Sarpanch and other Elite in Pali Villages

(a) Relations with present Panchayat :

Himself a Sarpanch or Upsarpanch	Sarpanch or Upsarpanch a cousin/uncle/inlaw/ father	Panchayat members/ Mukhias as uncle/aunt/ cousin	Not related to Panchayat Members
1. Kannavahra 2. Paharia 3. Dhawrai (J) 4. Medhi 5. Kathai 6. Varmathola	1. Jamrhi 2. Bhautra 3. Vardhar 4. Makra 5. Khichkiri 6. Sarwahi 7 Bannoda 8. Karkati 9. Audhera 10. Malchua 11. Chaka 12. Gijri 13. Shahpur	1. Badwahi 2. Odri 3. Sans 4. Maliagoda 5. Barhai	1. Kanchodar 2. Jamuhai 3. Amiliha 4. Khalaund 5. Dhawrai (P) 6. Malaudu 7. Madaria 8. Manthar 9. Sunder Dadar 10. Sundri 11. Ghunghuti 12. Vadhvachhot
(b) Relations of above with previous Panchayat :			
None	4. Uncle was Sarpanch 5. Father was Sarpanch 8. Uncle was Mukhia 9. Aunt was member of Pali Zila Parishad 12. Uncle was Sarpanch 13. Father was Sarpanch	4. Father was panchayat member	2. Brother was Sarpanch 3. Uncle was Sarpanch 7. Father was Sarpanch 9. Father was Sarpanch 12. Father was Sarpanch
(c) CHWs who had relatives in other influential positions:			
	1. Father was a well-off Thekedar of the area, Brothers Revenue Inspector and Gram Sahayak 6. Father Patwari	6. Brother school teacher 13. Father Thekedar	4. Brothers as school teachers, railway clerks, railway khalasi father-railway gangman 5. Brothers Patwari and rationshop owner Father Ranger; brothers in army.

● ***Change of Address***

Radical Community Medicine, 14, Spring Crescent Southampton S02 IGA U.K.

Table - 6 : Land Holdings of the CHW's family and occupation of male members (fathers & brothers)

Relatives Occupation	2—5 acres		5—15 acres		over 15 acres	
	(1)	(2)	(1)	(2)	(1)	(2)
Farming	2	0	7	4	5	3
Farming with employment	0	0	0	3	3	6
Wage labour	1	0	2	0	0	0
Total households	3	0	9	7	8	9
%	15.0	—	45	43.7	40	56
No. of CHWs	3 (8.3)		16 (44.4)		17*(47.1)	

(1) Adivasi
(2) Non-Adivasi

*Out of 17 CHWs, 11 (30.5)% owned more than 20 acres of land

Table - 7 : Preferred action in Minor Illnesses in the intensive study villages

Category	CHW alone	CHW with traditional medicine	CHW with hospital	CHW with private practitioner	Hospital only	Hospital with traditional medicine	Private practitioner alone	Gunia	Home treatment	TOTALS
I Total	0	29	9	2	2	8	6	10	36	102
%	-	28.4	8.8	1.9	1.9	7.8	5.8	9.8	35.2	—
II Total	0	2	9	0	0	11	6	2	12	42
%	-	4.7	21.4	-	-	26.1	14.2	4.7	28.5	—
III Total	1	3	8	1	10	14	6	2	2	51
%	1.9	5.8	15.6	1.9	19.6	27.4	11.7	3.9	3.9	—

Table - 8 : Peoples awarness of Preventive activities of CHWs in intensive study villages and his Private Practice

	Activity house holds		Category I				Category II				Category III			
			1	2	3	4	1	2	3	4	1	2	3	4
I	Chlori-nation	Total	72	1	5	24	21	1	2	18	27	7	6	9
		%	70.5	0.9	4.9	23.5	49.9	2.3	4.6	42.8	56.8	13.7	11.7	17.6
II	MCH Services	Total	97	0	5	—	42	0	0	—	49	1	1	—
		%	95.0	—	4.9	—	100	—	—	—	100	—	—	—
III	Source of information regarding prevention	Total	67	5	30	—	32	0	10	—	22	2	27	—
		%	65.5	4.9	29.4	—	76.1	—	23.8	—	43.1	3.9	52.9	—
IV	Private practice	Total	43	29	30	—	30	7	15	—	37	2	—	12
		%	42.2	28.4	29.4	—	47.6	16.7	35.7	—	72.5	3.9	—	23.5

Codes :

I
1. Don't know/He does not chlorinate wells.
2. He chlorinates wells.
3. Ws use Jhiria/river
4. Chlorinates occassionally

II
1. No
2. Yes
3. Don't know

III
(1) Neighbours, friends and their own observation
(2) = CHW
(3) = Paramedical worker with or without others.

IV
(1) Give free medicine
(2) Charges for injections
(3) Don't know.

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This periodical is a collective effort of many individuals active or interested in the field of health or interested in health issues. The chief aim of the journal is to provide a forum for exchange of ideas and for generating a debate on practical and theoretical issues in health from a **radical or marxist** perspective. We believe that only through such interaction can a coherent radical and marxist critique of health and health care be evolved.

Each issue of the journal will focus on one theme, but it will also carry (i) Discussions on articles published in earlier issues (ii) Commentaries, reports, shorter contributions outside the main theme.

Our forthcoming issues will focus on : Systems of Medicine, Mental Health and Health Care in Post-Revolutionary Societies.

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The People
(Excerpts)

Pablo Neruda

That man I remember well, and at least two
centuries have passed since I saw him :
he travelled neither on horseback nor in a
carriage — purely on foot
he undid,
the distances,
carrying neither sword nor weapon
but nets on his shoulder,
axe or hammer or spade;
he never fought with another of his kind —
his struggle was with water or with earth,
with the wheat, for it to become bread,
with the towering tree, for it to yield wood,
with the walls, to open doors in them,
with the sand, constructing walls
and with the sea, to make it bear fruit.

I knew him and still he is there in me
. . . . . .
. . . . . .

Where he lived everything
a man touched would grow :
the hostile stones,
hewn
by his hands
took shape and form
and one by one took on
the sharp clarity of buildings
he made bread with his hands
set the trains running,
. . . . . .
. . . . . .

I think that those who made so many things
ought to be masters of everything.
And those who make bread ought to eat !

And those in the mine should have light !
Enough by now of grey man in chains !
Enough by now of the pale lost ones !
Not another man will go past except as a ruler
Not a single woman without her diadem
. . . . . .
. . . . . .

Someone is listening to me and although they
do not know it,
those I sing of, those who know
go on being born and will fill up the world.