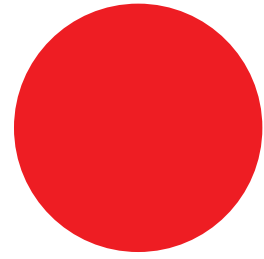


# 357-360

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*Concept Note for the 40<sup>th</sup> Annual Meet*

## **Social Discrimination in Health**

*(with reference to Caste, Class, Gender and Religious Minorities)*

*- E. Premdas Pinto and Manisha Gupte<sup>1</sup>*

### **Introduction**

The 40<sup>th</sup> Annual Meet of the Medico Friend Circle (MFC) being organised in Delhi from February 13-15, 2014, takes place at a very critical juncture in the public health history of India from the point of view of the socially disadvantaged communities. Medico Friend Circle was initiated four decades ago (in 1974) by visionaries of an alternative society, in the backdrop of the social ferment and social movements of the 1970's within the JP Movement (Movement led by Jay Prakash Narayan). This history has had an overwhelming influence on the thinking of MFC members in terms of envisioning a society based on equality, democracy and social justice, and with the understanding of health in its broadest sense – encompassing its social determinants, and as an indicator of human dignity, and individual as well as community well being. MFC has been a witness to the history of people's health in India through the last four decades (1974-2014) with uninterrupted Annual Meets, a bi-monthly bulletin, as well as in terms of taking principled positions offering critical responses to challenging issues to the health of the marginalised communities in India. In spite of MFC being a completely voluntary group, with expenses being shared by members who work country-wide in health-related organisations, it has been involved in campaigns, research, fact-finding and dissemination of crucial information to the public. At a time when the marketised, privatized, fragmented and reductionist understanding of health is promoted, the theme of 40<sup>th</sup> Annual Meet is *social discrimination in health with reference to caste, class, gender and religious minorities*. The

Theme will focus on the issues of social exclusion and discrimination which continue to haunt the lives of subordinated groups through societal structures and policies which favour the status-quo of such structures that have serious consequences to health of the disadvantaged and the marginalised. Experiences of communities that have been, and still are, discriminated and stigmatized on the basis of caste, class, gender orientation and religion. Such experiences are further aggravated through a combination of neo-liberal policies, by the practices of privatization, by the incidence of communal and ethnic conflicts, and by the continued violence on the basis of gender or sexual orientation.

### **Social Inequalities and Unequal Health Outcomes**

There has been a growing literature endorsing the hitherto known common sense understanding that socio-economic inequalities lead to unequal and adverse health outcomes. The Black Report in England, research by Michael Marmott conducted in fairly well-off societies such as United Kingdom, etc., have substantiated this argument (Marmott and Wilkinson 1999). The Report of the Commission on Social Determinants of Health (CSDH) of World Health Organisation (WHO – CSDH 2008) has articulated well that health is beyond clinical/medical/health care and that health care per se is influenced by various socio-political and cultural factors. These various determining factors influencing the health status of individuals and groups are summarized under the present day coinage of “social determinants of health”.

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The impact of social discrimination on health is studied by various scholars especially using the eco-social theoretical framework. Most of these studies are done keeping race as the axis of discrimination, especially in United States of America (USA) and Europe. According to this framework, racial discrimination, a form of social discrimination and societal injustice, becomes “embodied inequality” and manifests itself as health inequities. The eco-social theory is very pertinent to understand and conceptualise social discrimination in relation to health. This theory of disease distribution concerns who and what drive social inequalities in health. [A central focus of this framework is on how we literally and biologically embody exposures arising from our societal and ecological context. This is reflected in the distribution of health and illness among populations. The eco-social theoretical framework, inter alia, has relevance to the theme of social discrimination that MFC is discussing about. The axes of discrimination in such a discussion would be caste, class, gender and religion.

The core constructs and core propositions of this theory are well enunciated (Krieger 2012). Some of the core propositions of this theory include:

- *People literally and biologically embody* their lived experience, in societal and ecologic context, thereby creating population level patterns of health and disease;
- *epidemiological profiles of societies* are shaped by the ways of living afforded by their current and changing societal arrangements of power, property, and the production and reproduction of both social and biological life;
- *in societies exhibiting social divisions based on property and power*, the greater burden of disease is on those with lesser power and fewer resources,

Among the core constructs of this theory, two are of special significance to the theme of discrimination in health:

- (1) *embodiment* (we literally embody biologically, in societal and ecological context, the material and social world in which we live);
- (2) *diverse pathways of embodiment include a range of phenomena*: social and economic deprivation, exogenous hazards, hazardous conditions, social trauma, discrimination and other forms of mental, physical, and sexual trauma, inadequate or degrading health care, and degradation of

ecosystems, and in particular as linked to the alienation of indigenous populations from their lands.

### **Difference, Inequality, Inequity, Exclusion and Discrimination**

Differences, inequalities and some form of hierarchies seem to be part of the societal functioning. We also uphold the value of being different and diversity. Hence, sameness is not being advocated by us as a virtue for health, wellbeing and dignity. The key challenge is, however, to see when and how these differences, inequalities and hierarchies become institutionalized by a) restricting access to resources which are essential to a dignified living and b) giving rise to socio-politico-economic structures which exclude and discriminate communities without power and resources.

These structures give rise to social discrimination which is legitimized in the name of caste, race, religion, ethnicity, gender, etc., and, in turn becomes the media to perpetuate inequity. Discrimination - based on caste, class, religion and gender, identity in the community - is the outcome of a system that is infected with this structural malaise and play out in all spheres of life. The lower, one is in the power hierarchy, the more adverse the impact of health, dignity and wellbeing.

### **Political Economy of Social Discrimination in Health**

Discrimination is generally understood as “unfair treatment of a person or group on the basis of prejudice” (Webster’s Dictionary). Prejudice is embedded in social structures and institutions. Though social stratification is a given thing in the social processes, due to the unequal appropriation of resources and power, many individuals and communities are rendered vulnerable due to the lack of ownership over and access to resources. The injustice experienced by the poor this way ranges from exclusion from enjoying equal opportunities and resources to being targeted through expressed violence through stated or unstated societal sanctions. The data on anaemia, children dying of malnutrition and hunger, maternal mortality, infant and neonatal mortality, low literacy and inadequately paid labour, migration in search of livelihood, etc., point to communities who experience systemic and continuous discrimination through the inbuilt institutions of caste, class, gender constructs and religion. The adverse health outcomes, in a sense are not only an indicator of the public health delivery

system, but more so of the foundations of prejudice and discrimination within which the public health system is located. Dalit women who are brutalized, Muslim communities who are the constant targets of right wing religious hegemonies, manual scavengers who are unpaid and have no option but to do manual scavenging, sexual minorities who are criminalized due to their sexual orientation, tribal women and poor who become easy prey for clinical and medical experiments - they all tell stories of horror of indignity experienced due to the unjust social structures where privileges are reserved for a few.

### **Health and Disease are Socially Defined and Produced**

For long, the Western bio-medicine has concentrated on the individual as the locus of illness and has depended on medical technology and the chemicals as healing agents. The dominant Western allopathic medicine still defines health problems as technical problems. The research in the last few decades has provided sufficient argument for the social dimensions of health and disease. To accept that health and disease are socially defined and determined is one step ahead of the technological definitions. Health, however, is not only a socially defined, but also a socially produced, natural reality (Djurfeldt and Lindberg, 1975). Epidemiology alludes to this in a certain way by mentioning the distal, intermediate and proximal causes of disease, however it fails to recognize the structural roots of health and disease. The definition and production of health is embedded in the social-political-economic and cultural structures of the society which pay out the prejudices and discriminations that have adverse bearing on the health outcomes.

The societal positioning and the status enjoyed in the intersecting class, caste, gender and ethnic identities (religion, language, etc.) have a great bearing on the health and wellbeing enjoyed by persons. The Commission on Social Determinants of Health (2008) recognizes the social roots and causation of health and disease. The social discrimination in health refers to the factors and processes that deny access to resources that determine health is rooted in societal structures. This plays out in different ways, especially in the context of India. Dalits due to their lower caste status, women and sexual minorities due to their gender status and sexual orientations, tribals due to their vulnerability, and religious minorities due to their minority status often enjoy less power to determine their own control and ownership over the determinants of their health.

Link and Phelan (1995) described socioeconomic status, social networks, and stigmatization as “fundamental causes” of disease. Link and Phelan maintained that these factors shape access to significant salutary resources that ultimately influence health, such as money, knowledge, power, prestige, and social support. They suggested that fundamental causes can affect health through multiple mechanisms and are not disease-specific. Further, as root causes, these factors continue to influence health regardless of the effectiveness of individual treatment or therapy. Even as knowledge about healthy behaviour increases and as effective individual treatments improve, populations characterized by socioeconomic disadvantage will always lag behind in their adoption of these health-generating behaviours and resources, resulting in persistent socioeconomic disparities in health (Geronimus 2000).

### **Social Discrimination as a Driver of Ill-Health**

The social meaning of discrimination, as explained in depth by Aaron Antonovsky (1960), emphasizes on discrimination as a system of social relations; an institution with its own processes and not merely an issue of psychological prejudice or individual behaviour. A whole range of social arrangements create and perpetuate social discrimination. One of the serious consequences of discrimination is a pervasive and systematic inequality of “life-chances”. From the perspective of health, wellbeing and dignity, social discrimination can be construed as one of the prime drivers of ill-health. The embodiment of social discrimination can be exemplified by the life-experiences of Dalits, women, minorities who live in fear and the sexual minorities who are perpetually harassed. Social discrimination creates barriers to a life of dignity and is in itself a social barrier in accessing health care and good health. Embedded in the unjust social arrangements of the societal structures, it perpetuates the cycle of discrimination, marginalization and ill-health.

### **Inter-Sectionality and Axis of Social Discrimination**

Discrimination and exclusion are faced by various individuals and communities with various sexual orientations. People Living with HIV/AIDS, people with disability, women, children, various occupational groups (e.g. sex workers, agricultural labourers), groups in subaltern or segregated geographical settings such as relief camps, slums, etc., belong to various socially discriminated communities such as Dalits,

Adivasis/tribals, Muslims and other persecuted or discriminated minorities. Along with this multiple marginalizations is a reality of the groups that face social discrimination. This has serious implications to health and illness: for example, what happens to a Dalit woman who is disabled, anaemic and is a HIV positive person? What is the health condition of aged men and women in vulnerable communities? How does a poor Muslim woman who might be with disability or distress in least developed pockets in the country cope with ill-health? What kinds of suffering they experience faced with droughts, food insecurity, floods, debt, recession, unemployment? In a malfunctioning public health system and an over-privatised and marketised/commercialized healthcare system, how much more impoverished and marginalized they become?

#### Inter-Sectional Issues of Focus

**Caste:** United Nations refers Caste-based discrimination as the Discrimination based on Work and Descent. The Draft Principles and Guidelines for the Effective Elimination of Discrimination based on work and descent identifies it as “any distinction, exclusion, restriction, or preference based on inherited status such as caste, including present or ancestral occupation, family, community or social origin, name, birth place, place of residence, dialect and accent that has the purpose or effect of nullifying or impairing the recognition, enjoyment, or exercise, on an equal footing, of human rights and fundamental freedoms in the political, economic, social, cultural, or any other field of public life. This type of discrimination is typically associated with the notion of purity and pollution and practices of untouchability, and is deeply rooted in societies and cultures where this discrimination is practiced.” (ISDN).

In South Asia, “Dalits” (formerly known as untouchables) are traditionally people who fall outside the Hindu caste system. However caste systems and related caste discrimination are also found in Christian, Buddhist, Muslim and Sikh communities. Caste systems and discrimination based on work and descent are also found outside South Asia in countries such as Japan, Yemen and African countries. The conditions of the life of Dalits in the caste-hegemonic society of India and social, economic, political and cultural systems are detrimental to dignity and well-being and hence is a major concern for health. The social discrimination is practiced in various and all spheres of life, such as:

- extreme poverty
- degrading untouchability practices (e.g., denial of drinking water from upper caste water sources, denial of access to public and religious places)
- intergenerational bonded labour and child labour
- unemployment or dangerous/degrading employment (e.g., manual scavenging)
- restrictions on employment or forced occupations (e.g., trafficking and forced sex work)
- lack of access to justice, and discrimination and violence from the police and justice system
- lack of access to, control of, and benefit from resources - prohibition of ownership of land and property
- segregation in housing, school and burial/cremation grounds
- de-facto prohibition of inter-caste marriage
- abuse or discrimination against Dalit children in schools - high dropout rate from school due to poverty and discrimination
- lack of political power or genuine/independent political representation at all levels
- caste discrimination in humanitarian response to disasters or conflicts
- discrimination or lack of access to health care-related high maternal mortality

Dalit women, at the bottom of the caste, class and gender hierarchies, suffer multiple levels of caste discrimination. Violence and sexual assault are used to both maintain Dalit women’s subordinate position and to humiliate the wider Dalit community. Vulnerability of Dalit women is reinforced by their lack of economic independence, low education, poor health and nutrition, early marriage, limited (or no) access to land and often deeply conservative and patriarchal societies. Forced and ritual prostitution linked to the Devadasi system, trafficking and domestic violence is widespread. With the inter-sectionality of age, divorced, deserted or widows, Dalit women with physical disability or mental illness the adverse impact on health attains disproportionate measures. While seeking healthcare, the negligence and denial experienced faced by Dalit men and women again becomes an additional space of experiencing discrimination.

**Class:** According to the National Commission on Enterprises in the Unorganised Sector (NCEUS 2008), 90% of the workforce in India is in the informal sector. This is corroborated by the Economic Survey 2007-08 which estimates that 93% of India's workforce includes the self-employed and employed in unorganized sector. The informal sector is facing issues of social security which includes lack of health care. Due to the nature of their work and employment, the vulnerability to illness is very high.

The Ministry of Labour, Government of India, has categorized unorganized labour force under four groups in terms of occupation, nature of employment, especially distressed categories, and service categories. In addition to these, there exists a large section of unorganized labour force such as cobblers, hamals (head load carriers), handicraft artisans, handloom weavers, lady tailors, physically handicapped self-employed persons, rickshaw pullers, auto drivers, sericulture workers, carpenters, tannery workers, power loom workers and urban poor. The extent of unorganized workers is significantly high among agricultural workers, building and other construction workers and among home based workers. According to the Economic Survey 2007-08, agricultural workers constitute the largest segment of workers in the unorganized sector (i.e., 52% of the total workers).

The very nature of the unorganized sector results in adverse conditions of work and living which have adverse bearing on health. As per the National Sample Survey Organization (NSSO), 3 crore workers in India are constantly on the move (migrant labour) with 2.59 crore women being added to this labour market from the year 2000 onwards. The aged population among the unorganized labourers do not have any saving or social security. The existing social security legislations cover only 8% of the total work force of 45.9 crores in India.

Besides, due to the privatization and neo-liberal policies adopted by the Government of India, the labour market of India has been undergoing tremendous transformation, including growth of informal sector activities, deterioration in the quality of employment (in terms of job security, terms and conditions at work), weakening of worker organizations and collective bargaining institutions, marked decline in social security etc. The growing informalisation of labour market has been central to most of these transformations. Inflation, recession, price rise, and growth without employment creation,

have added to the swelling of informal sector and the onset of related insecurities making them highly vulnerable to illness.

Dalits and women form a substantial part of the informal workforce and their health conditions in already discriminated situations need to be a cause of concern. Various occupations which are considered "impure", and hard labour at that, becomes the only way of earning livelihood for them. Discrimination is experienced by people in life-events and processes. The accounts of people who are subjected to trafficking, or forced into sex-work, or bonded labour, or trapped in the cycle and conditions of manual scavenging, etc., would form another context of understanding discrimination. The substantial numbers of the work force of sanitation workers, manual scavengers, and sewerage workers come from Dalits.

**Gender:** In a patriarchal society, unequal power relations between men and women precipitate ill-health for women. Gendered expectations in terms of roles and responsibilities, the relegation of women to the private domain (with expectations of being good daughters, mothers and wives) and hierarchal pecking-orders within the family, affect health status as well as timely diagnosis and treatment. Disclosure of illness has different consequences for men and women, with the latter facing risk of violence and desertion, more so if the illness is debilitating, financially draining or stigmatising. This is especially true of reproductive, sexual or mental illnesses that may interfere with motherhood or sexual expectations from the husband. Added to the marginalisation within the family, women are further excluded through State policies related to population control. The artificial divide between the public and private domains results in families demanding sons from their daughters-in-law, and the State imposing the two-child norm. Social distortions such as pre-natal sex-selection are now evident as a consequence. The intersection of gender with caste and class further aggravates discrimination against women who have more than two children, resulting in reduced political access for poor and Dalit women, or shaming by health and development workers on a routine basis.

In India patriarchy is inseparable from caste. From ritual and food purity to endogamous arranged marriages, women suffer the brunt of the caste system more than men do. Since they embody family and caste tradition and honour, silence around violence keeps women away from health services at crucial times in their lives.

Insistence upon gender binaries also precipitate discrimination and violence upon people who do not fit into the strict categories of “man” and “woman”. Anyone who challenges heteronormativity is also vulnerable to marginalisation and exclusion, whether at home, in the clinic setting or in society at large. Unacceptable behaviour, or choices ranging from inter-caste or inter-religious marriage, same-sex preference, singlehood, transgender orientation or being in sex-work, “normalises” violence and discrimination against the individual or group.

Multiple axes of disadvantage create a complex web of discrimination – unless all these are taken into account while planning for inclusive health care delivery, the most subordinated are most likely to be left out. An intersectional approach that takes into account multiple discriminations is imperative if discrimination in health and health care delivery has to be addressed and eliminated.

**Religious Minorities:** The Sachar Committee Report of 2006, for the first time in India brought out the truth about the living conditions of the Muslim community. It revealed the extreme deprivation of Muslims in India and the low status the community has been relegated to, coupled with other exclusionary situations of violence, insecurity, identity crisis, discrimination in the public sphere, suspicion from other communities, and being branded “unpatriotic”. The social discrimination factors that affect the health of Muslims include exclusion from various development schemes, deep-rooted prejudice, ineffective National Commission for Minorities (NCM) and the Ministry of Minority Affairs. The repeated communal violence and conflicts that are engineered poses a constant threat to the physical and mental health of the Muslim community. The recent communal carnage in Muzaffarnagar in UP which displaced thousands of people leading to deaths during the riots and later infant deaths in the camps is a sad reminder of the living conditions of Muslims in India.

The Sachar Committee unfortunately found SC/STs as the nearest comparable demographic entity for Muslims. According to the Committee report, Muslims record the second highest incidence of poverty, with 31% of people below the poverty line, following SC/STs who are the most poor with a Head Count Ratio (HCR) of 35%. Not only was the literacy rate for Muslims far below the national average in 2001 but the rate of decline in illiteracy has also been much lower than among SC/STs. According

to the Sachar Committee’s findings, 25% of Muslim children in the 6-14 age-groups either never went to school or else dropped out at some stage. In no state of the country is the level of Muslim employment proportionate to their percentage in the population. Not only do Muslims have a considerably lower representation in Government jobs, including in public sector undertakings, compared to other excluded groups, Muslim participation in professional and management cadres in the private sector is also low. Their participation in security-related activities (for example in the police) is considerably lower than their population share - at 4% overall. Other figures on Muslim representation in civil services, State Public Service Commissions, railways, department of education, etc., are equally appalling.

### **Health Services System as the Expression of Socio-economic Inequalities**

The health services system in India is plural in terms of knowledge system and practice (Qadeer 2011). It is dominated by the allopathic (modern system of) medicine. However, one thing stands out is that barring a few indigenous or local health traditions which are practiced by people, in most of the systems of medicine the axis of discrimination that the MFC has discussed is prevalent. It is marked by hegemony of caste, class and patriarchy and the prevalence of the discrimination of Dalits, women, unorganized labourers and not infrequently even the discrimination of religious minorities. The low paid and most stressful health work, now is falling on the Accredited Social Health Activist (ASHA), who is a volunteer and a woman from the lower caste-class communities and is burdened with the public health activities while the medical officers are not available in the public health system and are generally engaged in private practice even while serving as medical officers. The discrimination faced by Dalits, women and minorities working within the system is known only anecdotal events and needs more in-depth research.

### **MFC’s Response so far and Present Challenges**

MFC has contributed significantly through writings and articulation the broadest understanding of health as wellbeing and dignity, beyond mere health and medical care. Firmly believing that such understanding of health is determined by the social structures has time again responded to the determinants and socio-political factors in their historical contexts. MFC has always believed in

people's movements and the struggle for health. A few selected illustrations of MFC's active engagement and responses, among others, include the following:

- Theme-based annual meets from 1974-2014 range from the relevance of present health services, role of doctors in society (1977), privatization of health care, alternative medical education, ethics, universal access to health care to the present - Social Discrimination in Health (2014)
- Range of critical publications include: In Search of Diagnosis: Analysis of the Present System of Health Care, 1977, Under the Lens: Health and Medicine, 1986, Medical Education Re-examined, etc.,
- *The Bhopal Disaster Aftermath - An Epidemiological and Socio-medical Survey* (1988) is one of the few scientifically investigated and publicly made available reports on the impact of the Bhopal Gas Tragedy. (The significance of the MFC report could be better gauged in the backdrop of the Indian Council for Medical Research - ICMR - study and the report which was never made available to the public). MFC's response to Gujarat Carnage 2002 was very engaging and critical.
- MFC's critical thought has always been ahead of times and is illustrated by the fact that in 2010 and 2011 MFC had already started the thought on Universal Access to Health Care much before Government of India constituted the High Level Expert Group (HLEG). MFC discussed the theme in two successive annual meets and made substantial contribution to the HLEG too. Besides, MFC members have provided critical inputs to National Rural Health Mission (NRHM), especially to the component of foregrounding community's stake in policy space through communitisation and community monitoring.

### Conclusion

A rigorous understanding and study on discrimination and health require conceptual clarity about the exploitative and oppressive realities of caste, class, gender and other multiple forms of adverse discrimination. It also requires careful attention to domains, pathways, level, and spatiotemporal scale, in politico-historical context; besides, structural-level and individual-level measures to gauge without relying solely on self-reported data or the

bureaucratic reports. An embodied or grounded analytic approach would help better understand and analyse realities of discrimination.

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## How to think of Discrimination?

*A review of 'Access to Health Care and Patterns of Discrimination'<sup>1</sup>*

*-R Srivatsan\**

**Abstract:** *This essay uses the form of a book review to propose a new way of looking at discrimination. What does the existence of caste discrimination in modern healthcare systems (and more broadly in education and society) mean? Is it simply the persistence of an archaic caste based social system, or is it an active reconfiguration of social structures of dominance. I argue in this essay that it is the latter: discrimination is reconfiguring itself in novel forms in modern social structures. This is one of the ways in which the older elite castes retain their dominance in the transition to capitalist society. Discrimination has two aspects: one, as a foundation of the caste structure it strongly discourages access to modern goods that invest the person with value – land, education, health care, jobs, etc. Two, within the class structure it 'disrespects' and devalues those who acquire these goods through state welfare programmes. This Janus (two) faced discrimination is an instrument to ensure that the ruling elite maintain and increase their dominance in the emerging form of capitalism in India.*

How is the concept of discrimination different from the concepts of inequity and lack of access? What is the relationship between the concept of stigma and that of discrimination? This is an essay on a contemporary understanding of caste discrimination. I would like to do this through a review of Sanghamitra Acharya's "Access to Health Care and Patterns of Discrimination" (see note 1 for reference). Given the report's focus and the lack of space, I haven't looked at discrimination with respect to community, but there will be similarities and differences.<sup>2</sup>

Acharya has conducted a sociological study of discrimination in Gujarat (6 villages) and Rajasthan (6 villages) against dalit children by health care professionals of PHCs, and sub-centres. She constructs 15 variables of discrimination based on sphere (or domain, e.g., visit to doctor, referral), form (e.g., refusal to touch), and provider (e.g., lab technician). She then finds ways to interpret responses of children and parents to understand how discrimination is experienced. The report comes to a conclusion that discrimination exists in India's villages today and is a hindrance to dalit children's health.

While the study was clearly conceived and executed with inventiveness in measuring discrimination, I felt it necessary to examine the paradigm of discrimination and the framework that the study adopted. I will now try to say what, in my first-cut opinion, is a next step,

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based on specific criticisms of the report.

1. The report tags specific variables of discrimination, covering locations of experience, acts, form and agents of discrimination (p 5). Though useful, this is limited because it simply points out that discrimination exists in India. It does not try to understand if there is a change in the structure of discrimination, expressed in different locations or agents. For example, how does one understand the difference between being prohibited from going to a temple, or drawing water from a well on the one hand, and being insulted by a doctor or technician on the other? What is the new issue that comes in when a modern/modernizing location discriminates?
2. It is important to see, as the report does, discrimination against dalits in terms of fixed acts, such as delay in treatment, unwillingness to touch, etc.(p 6), and to find the rationalizations (as the report does) for discrimination in terms described by the discriminators as 'these children are unclean'. However, when such routine 'ill-treatment' is coupled with the modern location in which it occurs, the humiliation in what is by Constitutional definition, normatively, an egalitarian space has an effect of disempowerment that may be internalized as low self worth and systematic lack of confidence among dalit children. What is the effect of this systematic humiliation in historical terms?
3. The report finds (table 6, p 18) that 596 out of 1045 doctors were seen as discriminatory by dalit children. This is the extreme manifestation and the report describes several experiences with respect to functionaries lower in the medical hierarchy. While drawing attention to the large percentage of doctors as agents who discriminate, the report stops at saying that the practice of discrimination is a widespread and pervasive sign of the backwardness of India. What is not explored is why a large proportion of doctors, who supposedly (by norm, given a modern education) have been educated against inequality, in a democratic country through a curriculum developed over 30 years at least, remain caste prejudiced. If this education has not done so, what then is crucially wrong with the planning, philosophy and the unstated assumptions of this education?



4. Here the concepts of a) lack of access or inequity and b) stigma come up against the concept of discrimination. The problem among these children is not the lack of access or inequity – they do have equitable access, since they have been able to approach the medical establishment. The problem is also not one of a stigma, which is classically understood as an uneducated response that will be erased by enlightenment. These are enlightened doctors, who are supposed to have had a liberal education. What is the education that would be necessary to erase their practice of stigmatizing dalits? Why has this not occurred? Discrimination in the context of this review of Acharya's report is a political concept that highlights a positive intent to treat a person differently, with less respect and insult if necessary. However, the presence of a large scale manifestation suggests that the intent is not individual – it is not a willed act in a simple individual sense. It is a structural effect of caste society. Yet, the changing locus, agents and forms of discrimination suggest that it is a historically changing structural effect. The way to understand discrimination is as an effect that depends on individual action, but exhibits a logic that is larger than an individual one.

**Example: Marxist notion of the 'action of a class'**

The Marxist notion of the action of a class is an effective resultant of class interest that is often the sum of, but sometimes differs from, individual actions. Action by a class is the manifestation of a class logic that is structurally distinct from and more powerful than an individual one. For example, both the BJP and the Congress have individually corrupt parliamentarians. They exhibit capitalism's basis in individual interest (and some other contradictory aspects too complex to go into here). However both parties support transparency and elimination of corruption pointing to the other's failing. Thus, both the parties also exhibit the class restraint of individual greed in the interests of the unfettered growth of capital through making the economy attractive to foreign investment. They are both speaking the political language of capital. While individual corruption is there, class action is more complex and different.

The novelty in our case is that we are speaking of caste discrimination against dalits, which is different from class oppression.

5. In the beginning of the report, there is a reference to Robert Putnam's notion of social capital (p 4). The report suggests (in my shorthand) that social capital among the haves is used to deny opportunity to have-nots so that they lose access to the goods of society. Putnam's argument about social capital was not about cornering access to social goods,

but about the importance of social networks of trust and reciprocity in the birth of a full fledged capitalism in Northern Italy (as opposed to the south). This crucial 'developmental' aspect of social capital (whatever its many drawbacks are) is not considered in the report's use of the term.

6. The report draws on the concept of a dalit identity that has some immutable, essential characteristics leading to docile conduct on the part of the dalit and discriminatory conduct on the part of the upper castes (p 5). While the notion of an identity is useful, it is important to see that there is a transformation of the dalit identity from one in relation to caste to one in relation to class in the transition to a capitalist society. The argument here is not that the dalit becomes a member of the working class in a transition that is historically a progressive, if painful, one in relation to the Marxist understanding of capital. At the level of detail, it is clear that there are several other backward castes and tribes in similar situations. More broadly however, without going into the different arguments regarding this transition, at the very least there seems to be no likelihood of this becoming a progressive transition in the near future. Rather my argument is that the growth of capitalism in the India sees the transformation of the hitherto existing caste elite into the broad capitalist ruling class formation. This includes its bureaucratic allies, and those undergoing formal professional education to undertake vital functions in modern Indian society. As this ruling class formation comes into being, it forces the evolution of new values, conduct and culture that fuse characteristics of class and castes; for the elite the advantages of both come together, while for the subaltern, the disadvantages of both come together to varying degrees based on caste.
7. Indices of discrimination are complex. Any given instance is not the operation of a simple stigma against a member of a scheduled caste in the act or process limiting access to specific spaces and facilities like class rooms and health care. It is also interpreted by all concerned according to an overall map and project. This interpretation has to be looked at. What do the specific signs of discrimination point to or signify? Discrimination has to be understood in relation to the project of development, modernization and democratic well being that are promised by health care and education.

**A Tentative Framework**

Discrimination in the Indian context should be seen as related to dynamic and active political exclusion first

of all – from access to property and from access to the goods of economic and social growth (including education, health and other forms of property that seem to constitute modern liberal thought and practice). This is in so far as ‘well being’ is imagined in these ways.

Secondly, discrimination is operationalized as disrespect for those who come to acquire property (goods, education, healthcare, well being) through mechanisms of welfare. Thus, in fields of education and health care, discrimination works through a lack of respect and status because the goods concerned are seen to be ‘given’ free of cost by the state. The ‘beneficiary’ is not a ‘property owner’ who has a right to that property and who should be respected as such. In health care, it is possible to see this in relation to the kinds of delay and disrespect experienced by Acharya’s dalit subjects in relation to healthcare. It is also possible to see this disrespect in the spontaneous eruption of Aarogyasri wards with poor infrastructure for poor patients in corporate hospitals in Hyderabad, *even though these poor patients’ costs are fully borne by government*. Disrespect and insult are also seen in government hospitals as described in the blog by Varun Patel<sup>3</sup> that was shared at the MFC website. The problem is not callousness here – it is a rationality that sees ‘free’ patients as not deserving of respect. This is a classic discrimination pattern in the neoliberal West in relation to the poor, and especially in relation to African Americans.

Thirdly, discrimination grafts this neoliberal disrespect for welfare on to caste disrespect for the dalit and to a lesser degree for other backward classes. The graft is not simply one in which disrespect has the same characteristic in caste and class. One must consider that in the transition to a modern capitalist society, a larger proportion of dalit, tribal and OBC populations are below the poverty line than that of the upper castes. This significant correlation between class and caste after Independence should be read to mean that in the process of economic growth, the upper castes maintain (if not increase) their social advantage in the transition in spite of Constitutional safeguards (the Directive Principles) against inequality and stigma. On the one hand, caste discrimination limits lower caste access to modern forms of property (e.g., education, jobs, good residential locations, and health care); on the other, when state welfare provides education, jobs, and health care, class discrimination disrespects those who access goods they are not seen to ‘own’. This double handicap results in some deadly manifestations of disrespect. Disrespect extends to active hostility, resentment and neglect that result in practical refusal of essential services needed to survive – e.g., health care, educational support and

guidance, etc. Modern Indian disrespect kills, and does so often with a casual unconcern.

Fourthly, economic discrimination often acts Constitutionally through ‘uniform’ ‘egalitarian’ measures across castes that entail differential results. How hard one is hit depends on how many generations of the family in question have had the privilege of education and formal employment. First generation literate families among the lower castes are hardest hit by the ‘uniform’ measures of deprivation (like withdrawal of scholarship, failure in exams, refusal to treat illnesses). For an example from a field of education, a university withdrew of a scholarship amount of Rs 500 across all students. The well-to-do therefore had to pay the mobile phone bill from their pockets. The less fortunate felt a pressure on food, survival and family saving. Those on the edge simply fall off.

Understanding the contradictory manifestations of discrimination in this changing context means maintaining the focus on untouchability at one end of the spectrum, and seeing how new class dimensions of discrimination come into being at the other end. This will be one aspect of the specific history of capitalism in the Indian context.

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#### Endnotes

<sup>1</sup>Sanghamitra Acharya, 2010. Access to Health Care and Patterns of Discrimination: A Study of Dalit Children in Selected Villages of Gujarat and Rajasthan. IIDS, Children, Social Exclusion and Development. Working Paper Series, Volume 1, No 2. Online: <http://www.dalitstudies.org.in/wp/wps0102.pdf> accessed on 9<sup>th</sup> January 2014.

<sup>2</sup>Drawing on discussions that took place in several informal discussions and two meetings of the Hyderabad Health Group (tentative name), consisting of Veena Shatrugna, Sheela Prasad, Rajan Shukla, Susie Tharu, A Suneetha, K Lalita, Jacob Tharu, Mithun Som, Lakshmi Kutty, Gogu Shyamala, Vasanta Duggirala and R Srivatsan I have also benefited from discussions with Jayasree Kalathil and Shubha Ranganathan in relation to mental health and discrimination.

<sup>3</sup>See: <http://www.indiamedicaltimes.com/2013/12/02/guest-article-a-year-as-a-doctors-apprentice-by-dr-varun-patel/> Accessed on 10<sup>th</sup> January 2014

<sup>4</sup>See for instance, Amit Thorat, 2010. “Ethnicity, Caste and Religion: Implications for Poverty Outcomes” *EPW*. December 18, Vol XLV, no. 51. pp 47-53. This study of NSS data 2004-5 shows that while 37% of the SCs, 48% of the STs and 43% of the OBCs are poor in rural India, only 15% of the other castes are. Table 2.

## Why Casteism Persists Even in the 21<sup>st</sup> Century?

-Anant Phadke\*

The theme of the 40<sup>th</sup> Annual Meet of MFC, to be held in Delhi on February 13-14, 2014 is 'Social Discrimination in Health'. In this Annual Meet, among other things we mean to explore in some detail, the role of casteism in health and health care. While there will be notes, papers on how casteism affects health and health care, this small piece is meant to explore in a simple and rather elementary manner, the issue of the role played by caste in pre-British era and in modern era in shaping the livelihood of people in daily life. Caste-hierarchy is not confined to social-cultural practices alone. Caste has been influencing this daily struggle to earn livelihood and this continues in a modified form and this explains why casteism persists even in 21<sup>st</sup> century. At the end are enlisted measures in the 'economic sphere' which are needed to abolish this basis of casteism. Sometimes simple considerations also help in clarifying certain basic issues. Hence this note.

From the viewpoint of liberal, democratic ideology, casteism is a pre-modern, obsolete ideology, which should not have any place in modern India. It is true that the older variety of feudal casteism has declined considerably. But however, casteism, the ideology which seeks to preserve the interests of particular groups of people as particular castes in a myriad of caste-based hierarchy, very much continues in its modern form. This note argues that this has happened because caste-system was and is not prevalent only in the form of caste-specific cultural-social practices, adoration of caste-specific deities, etc., but it was and is a crucial factor in shaping people's daily life in worldly matters. For example, caste decides which occupation would be undertaken by whom, that is caste-relations have a role in shaping the social division of labour, shaping social production. In every-day life, people experience that caste in which one is borne decides not only one's standing in cultural-social interactions but caste also decides one's social status in daily, worldly life. This every-day experience shapes the way people think. The hierarchical casteist values preached in the family and by social ideologues does influence the thinking of all people. But social ideology does not grip the minds of multitude of people for decades and centuries merely through preaching. Unless the daily experiences of people reinforce the values propagated through casteist preachings, casteism as an ideological system would not continue. The way and to the extent caste decides the daily life of ordinary people to that extent and manner people tend to believe in and act according to casteist-ideology.

There has been a tremendous difference in last 150 years, starting from the advent of British Raj, in how

caste shapes social division of labour and the power-structure in the society. Some activists and analysts focus on the disappearance or drastic dwindling down of certain casteist practices such as untouchability or ban on education of the non-Brahmins, of women and say that "caste-system is now only present in vestigial form." On the other hand, some people one-sidedly point to some of the casteist practices like intra-caste-marriages, caste-based housing, caste-based atrocities, etc., to say that "the changes are only skin-deep, in reality nothing has changed." Let us explore what has changed, what has not changed and why.

### Permanent Division of Labour and Labourers by Birth

*In pre-British India*, caste was an overwhelming, dominating, all pervasive reality.<sup>1</sup> It was not merely part of the cultural-social world. Who would or would not get access to which profession or means of livelihood was very much decided by the caste in which people were borne. For example, each and every person borne in the carpenter caste was compulsorily tied to carpentry all his/her life. Same was the case with people in the barber caste or the tailor caste and so on. This 'division of labour' was laid down juridically also and it was a crime to try to break the caste-based rigid boundaries of hereditary profession. Secondly, marriages and housing which are very much earthly affairs were totally and rigidly based on caste-system. It is this daily experience of the people of the role of the caste in earning their living and leading their worldly life that formed the basis of acceptance of the casteist ideology formulated and perpetuated by the Brahmins.

This feudal, Brahminical caste system was a mechanism to pump off, in a step-ladder fashion, wealth from the most down-trodden to the rulers. In this Indian variety of feudal system, the rigid casteist, hierarchical division of labour was also division of labourers as Dr. Ambedkar put it, and that too a life-long division. This 'by birth permanent division of labour' continued for generations and formed the basis of caste-based cultural-social norms.

It should however be noted that the pre-British India was not an entirely a caste system. It was a caste/class society. Leaving aside various details, variations and at the risk of simplifying the complex, varied reality across India, it can be said that in the immediate pre-British period, in India there were basically four classes, each one of these were made up of a group of castes

The lowermost class, the 'ati-shudras' was formed by the group of 'untouchable' castes whos' labour was exploited by the ruling class, composed of groups of

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castes. This was done through two routes. Firstly, it went directly to the exploiting class made up of the Brahmins and the royalty-castes. The 'untouchables' served the Brahmins and royalty-castes through forced, free/almost free labour on the farms of these ruling castes as well as by rendering them gratis, labour services of various kinds. Secondly, a part of their toil was funneled through the village system in which also they were exploited. In Maharashtra one form of this forced, unpaid labour was 'veth-bigaari'. Though there was some hierarchy within 'untouchable castes', they all belonged to a single class of the most exploited and oppressed toilers in India.

The Balutedar-castes, i.e., the artisan castes (barbers, carpenters, weavers, masons, etc.) together constituted the second exploited class of toilers. In social hierarchy balutedars were above the 'untouchables' but rendered various services to the peasants in exchange of whatever part of the produce the peasants would share with them at the end of harvesting. The social status and standard of living of balutedars was below that of the peasant class made up of peasant-castes because what they contributed to the peasants and the village system was more than what they received in exchange at the annual distribution of the agricultural produce. The balutedars also served the Brahmins and royalty-castes through rendering gratis, the respective services which these castes could provide. Though there was some hierarchy within 'balutedar castes', they all belonged to a single class of 'balutedars', the shudras.

The peasant castes together constituted the third class. The peasant castes on the one hand 'exploited' the balutedars and the 'untouchables' and functioned as a conduit for transferring part of the toil of the balutedars to Brahmins and the royalty-castes, the ruling class. On the other hand the peasants themselves were exploited; they had to pay the king taxes and also had to part with a portion of their produce to the local Brahmins and royalty castes or by tilting their farms through various unjust arrangements. The caste-hierarchy thus led to the siphoning of the surplus production (surplus beyond what is needed for mere existence at low level of consumption) in a step-wise fashion to the ruling class. Though there was some hierarchy within peasant castes and sub-castes, they all belonged to a single class of the 'peasantry'. The toiling peasants were also recognized as 'shudras.'

The ruling class was composed of the Brahmins and the royalty-castes. The non-Brahmin royalty-castes were different in different parts of India and in different periods whereas everywhere the Brahmins were part of the ruling class and in caste-hierarchy they were at the top. These ruling castes were appointed by the king as tax collectors and for this work they were allotted lands or were given a portion of the collected tax. In their own farms (given by the

king) they exploited the toilers by extracting from them land-rent and free labour/service.

In the caste hierarchy, the Brahmins were at the top and had an overwhelming ideological influence over the rest of the society. In this sense it was Brahminical feudalism. It should be noted that in the feudal society in India and also in Europe, the toilers had in their possession, means of livelihood (land, artisan-instruments). Some extra-economic force was therefore needed to ensure that despite this, they serve the rulers. This explains why in feudalism the acceptance by toilers of the openly hierarchical ideology that service must be rendered gratis to Brahmins and other higher ups. The openly hierarchical political structure which was openly based on the supposedly inherent superiority of Brahmins and other higher castes, was necessary for the exploitation to take place. In general the apparent overwhelming ideological domination of the Pope in Europe and of Brahmins in India, is explained by this peculiar fact of toilers being in possession of means of livelihood and yet being subservient to the rulers who were composed of Brahmins and royalty-castes. This is contrast to the modern commodity economy in which everybody is equal in the market, free to sell or not sell things in the market; there is no political or ideological compulsion that labourers have to work for and add to the profits of the employers yet they in fact do so 'voluntarily'. This is because in contrast to the erstwhile balutedars or peasants, they do not possess any means of self-employment, of livelihood and are forced to seek employment with the moneyed people.

I have outlined the pre-British caste-class relations in some detail because the point I want to make is – caste was not only a social-cultural entity, which it shaped how people could or could not earn their livelihood. Secondly, we need to grasp the inter-relation between caste and class. This is necessary if we want to understand why in pre-British India, certain group of people belonging to the same class had very different cultural-social practices or mythologies or if we want to understand why even if there were so many balutedar castes, why the relation of each balutedar caste was the same with the peasant castes. Thirdly, if we want to understand how surplus product was pumped off in a step-ladder fashion from the ati-shudras to the rulers this cannot be done without understanding the inter-relation between the Brahmin caste, the royalty and the toiling castes. Overall this complex Indian social structure cannot be grasped scientifically, adequately unless the importance caste-relations in shaping social division of labour is understood to be crucial in shaping this society.

Women were the most exploited, oppressed section of the society also because casteist hierarchy added additional dimension to her patriarchal exploitation

by strictly restricting marriages within castes. Strictly restricting women to marry within the caste was necessary to maintain the 'purity' of the caste. Brahmins and upper castes were obsessed with property and with purity of caste. That is why these sexual taboos were stricter in Brahmins and in other upper castes. Secondly, upper caste women were hardly involved in any social production; their role was mostly restricted to the reproduction in the family. Hence they were left with no role in this world if the husband died. That is why sati-practice was prevalent in some areas among some upper castes. But more often than not, widows were allowed to survive in exchange of a lot of domestic labour they must do. In addition in some areas Brahmin widows were tonsured and could wear only dark brown/white plain clothes to make them sexually unattractive; underscoring the value that woman's sexuality is totally tied to her husband. The tradition in certain lower castes of 'devoting' a girl-child to a particular 'deity' meant in practice that (upper caste) men would use her for their sexual gratification. These 'devoted' girls generally came from certain 'untouchable' castes. A mere 'class' analysis cannot explain these differences. This analysis of the caste-class relations in pre-British India is necessary to understand what has changed and not changed in the last 150 years.

### Modern Caste System

The commodity-based market economy induced by the colonial rule and after, has broken down this totally water-tight and totally rigid by birth casteist division of labour. However, due to the peculiar mode of development of the modern society in India, a new caste-based division of labour has come-about. In this new caste system, unskilled, hard, labour is done mostly by people borne in Dalit and tribal castes. Dirty jobs are done by people belonging to the Dalit castes. Shameful manual scavenging is all done by people borne in the bhangi caste. Majority of people born in middle castes are generally confined to blue collar industrial jobs and to non-remunerative, hard farming work in the fields whereas people borne in higher castes have mostly occupied the white collar and managerial jobs. After Independence, thanks to the rapid spread of education and due to the reservation-policy earned by the democratic movement, increasing proportion of Dalits have got employed in white-collar jobs, positions of power and have also entered elite professions. But only about 10% of Dalits have thus been benefited. This above mentioned broad casteist division of labour in modern India is being reproduced and it constitutes the new material basis of the modern caste system in which the place in the hierarchy of the market economy and in the society is broadly decided by the caste in which one is borne.

In feudal India each and every individual was rigidly controlled by the Brahminical caste system. In modern India not every individual is rigidly tied by the caste-system to the traditional occupation. What explains this change is commodification of social relations and the consequent separation of the economic sphere from the political sphere. In the commodity economy your worth is decided not mainly by what you are, but how much you have. Whosoever has more money and property is valued more. Everybody is 'free' to sell whatever s/he has and in the market-competition for money-making, whether to just eke out a living or to make mountains of money. We see so many Dalits, lower caste people becoming well to do and even rich. This was impossible in feudal society. But overwhelming majority of those borne in Dalit and other castes continue to lag far behind compared to those borne in upper castes. This is because in this market competition they have started from a starting point which is far behind and this is because of centuries of oppression. Secondly, their track in this competition is riddled with many obstacles created by continuing low economic, social status and continuing casteism. Wages for unorganised farm and non-farm labour are extremely low partly because these labourers come from Dalit, tribal castes. The caste system thus influences the wage-levels of the lower caste labourers.

Even 150 years after the British introduced modern market-based development in India and 60 years after Independence, not only that newer generations continue to be subjected to casteist division of labour, marriages continue to be largely intra-caste and housing colonies continue to be largely caste-based even in cities. This is despite the fact that on the one hand, the State's policy has been to promote inter-caste marriages and the quarters allotted to government, public sector employees are irrespective of caste and religion. Thus overall, the old, Brahminical caste-hierarchy has withered away, the modern caste-hierarchy, caste-based social division of labour has come about. It is this daily experience of caste angle to socio-economic hierarchy that continues to fuel casteist ideology.

This casteist ideology has its peculiar characteristic. It acts as vehicle to further narrow interests of upper layers in the competition for money and power. Even though money and power are supreme and more often than not over-ride caste-based identities, in all spheres, especially in politics, caste-based identities have strengthened. Caste-based social organisations continue to operate along with class-based social organisations and very strong influence of casteism in elections and other politics is a new phenomenon after Independence. Caste identity and caste-based organizations/alignments are now instruments to

further narrow, sectional interests in the market-competition or political competition. There was no such competition in the feudal society. In this competition only a few members of the caste benefit though the name of the caste and the support of the caste as a whole is assumed and used. This is despite the fact that in the modern class divided society, caste-identity politics inevitably benefits primarily the upper layers in various castes.

Overall one can say that pre-modern relations like caste- and gender-based hierarchy have been transformed into their new avatar and they continue to be reproduced as part of the social structure based on class, caste, gender inequality. The new casteist division of labour mentioned above has been integrated into modern economy. The new caste system is central and not peripheral part of the current social order.

Unless the material roots mentioned above of the casteist hierarchy are eliminated, this casteist hierarchy in all walks of life will not be eliminated. Secondly, so long as the society is divided into narrow commercial interests pitted against each other in market-competition and in power-struggle, all kinds of identities including caste-identities are bound to be used to gain or retain hegemony. Hence unless the society is built around co-operative entities, there will be breeding ground for casteist ideology as a weapon in the market-competition. Given all this, along with cultural-social transformation, which itself is a huge task, following economic measures are needed to abolish the material basis of the modern caste system. So long as in day to day life people experience caste-based socio-economic inequality, equality preached and practised in social and political sphere will continue undermine the former.

### **Economic Measures for Undermining the Modern Caste System**

- 1) Inclusion of the landless labourers in **redistribution of land and water in the agrarian transformation**. Majority of the landless labourers come from Dalit castes. Their conscious inclusion (as well as those of deserted women) in the redistribution of ownership/control over productive resources, would empower them and would lay the material foundation for progressive abolition of caste-based hierarchy along with class-exploitation. After this redistribution, agrarian transformation would have to rapidly move towards cooperative agriculture. Erstwhile Dalits would have to be equal partners in these new co-operative ventures which become part of a planned economy geared not to market but to satisfaction of human needs.

- 2) With the help of modern technology of **organic farming, specific training** (free or subsidised) to the erstwhile Dalits and tribals to enhance and to improve upon their traditional knowledge of agriculture. This is needed for the Dalit castes as they have been primarily used merely as labourers and hence their traditional knowledge and skill is limited compared to the peasant castes.
- 3) **Special concession** to erstwhile Dalit caste labourer to **access seeds, samplings, farm implementation, etc.** required for modern co-operative agriculture.
- 4) Toilers from erstwhile lower castes who were **artisan castes** (including those in Muslim community) would have to be given training to enhance with the help of modern appropriate technology, their traditional artisan knowledge, skills to move towards modern decentralised co-operative agro-industry.
- 5) Special **credits, encouragement packages** for these artisans will have to be designed and implemented. This policy would have to be applied also for majority of Muslims as majority of them belonged to Dalit castes and are part of the artisan community in India.
- 6) **Reservations policy and special encouragement policy in education and other spheres** will have to be continued so long as systemic, social differences exist, the reservation policy and special encouragement measures will have to continue in the framework of a planned socio-economic development.
- 7) **Inter-caste marriages** will have to be especially encouraged. Crimes against inter-caste marriages should be severely punished. Marriage and family relations are not merely cultural social relations. They are very much part of the material world in daily life and so long as inter-caste marriages are frowned upon, the daily experience of inequality would fuel casteist prejudices.
- 8) **Inter-caste housing colonies** will have to be created and caste-based segregation in housing colonies will have to be consciously broken down.

Opposing casteism in social, cultural, political sphere is absolutely essential. But to abolish casteism, the above mentioned measures are also necessary so that caste-based inequality in socio-economic life and casteism become a matter of history and preaching of humanist, egalitarian values is not contradicted by experience in the worldly life also.

#### **Endnote**

<sup>1</sup>It may be noted that the social relations in ancient India had their peculiar development spanning many centuries and took many forms in different periods in different areas. In this note we restrict ourselves to the immediate pre-British period in which a peculiar Indian variety of feudalism was prevailing in large parts of Indian subcontinent.

## Discrimination, Stigma and a Typology of Violence: Some Conceptual Reflections from HIV/AIDS Work

-Devaki Nambiar<sup>1</sup>

*...what's natural is the microbe. All the rest – health, integrity, purity (if you like) – is a product of human will, a vigilance that must never falter. (Camus, 1972)*

### Defining Stigma

In Delhi, where I conducted my dissertation fieldwork on the stigma associated with HIV/AIDS, I found no widely used Hindi word for stigma, nor a widely accepted definition.<sup>1</sup> Elsewhere, there has been a great deal of academic theorizing on stigma. Among the first stigma theorists is sociologist Erving Goffman, who categorized it as an individual “attribute that is deeply discrediting” focusing his attention on the management of social interactions of a discredited “spoiled identity” (Goffman, 1963: 13). Goffman emphasized that “stigma involves not so much a set of concrete individuals who can be separated into two piles, the stigmatized and the normal, but rather as a pervasive two-role social process in which every individual participates in both roles, at least in some connexions [sic] and in some phases of life. The normal and the stigmatized are not persons but perspectives” (Goffman, 1963:163-164). Notwithstanding Goffman’s emphasis on processes and perspectives, a focus on the individual has dominated understandings of stigma and discrimination in public health as well as human rights action for the past half century. In fact, researchers conducting HIV/AIDS-related research and interventions believe that individual-level conceptualizations of the construct in the HIV/AIDS context may in part be responsible for the limited success of efforts to reduce stigma (L. Brown, Macintyre, & Trujillo, 2003; Herek, 2002; A. P. Mahajan et al., 2008; Parker & Aggleton, 2003).

### Putting Stigma and Discrimination in Larger Context

Recent theorizing has emphasized the structural nature of stigma and discrimination, connected to ecological processes that establish and maintain social inequality (Keusch, Wilentz, & Kleinman, 2006; Nyblade & MacQuarrie, 2006; Parker & Aggleton, 2003). In my understanding of it based on fieldwork and experience, the processes of stigma manifest in ways that are different and must be apperceived accordingly. There are the **experiential** marking processes of stigma embodied in interactions and experience, specifically separation, status loss, and discrimination. Then there are forms of stigma that are **symbolic** (marked by labels and stereotypes) and **structural** (marked as power differences within institutions). While the subjective or experiential forms of stigma are those typically studied in public health, other forms of discrimination are connected to the concepts of symbolic violence and structural violence (see figure on next page).

Stigma is manifest as **experiential violence** in the processes of separation, status loss and discrimination. The bulk of stigma research in public health to date—particularly research employing quantitative methods - falls under this category.<sup>2</sup> **Symbolic violence** is “a process whereby symbolic systems (words, images, and practices) promote the interests and hierarchy of dominant groups in a manner perceived to be legitimate by dominated groups” (Bourdieu, 1990: 127). It is theorized that symbolic violence legitimizes stigma because dominated groups do not question the hegemonic words, images, and practices to which they are routinely subjected (Parker & Aggleton, 2003). In turn the symbolic forms of stigma are the basis for symbolic violence to occur: labels used to describe vulnerable groups – like people living HIV, minorities of gender, caste, or religion and the economically weaker. When dominant groups – including and sometimes especially public health institutions - normalize these labels (“high risk”), stigma becomes a form of symbolic violence (there has been some work on this in relation to targeted interventions and HIV).<sup>3</sup>

Experiential violence embodies and symbolic violence legitimizes **structural violence**, “preventable harm or damage... [that] emerges from the unequal distribution of power and resources or, in other words, is said to be built into the structure(s)” (Weigert, 1999: 431). Structural violence has been the subject of research in anthropological studies of stigma (Castro & Farmer, 2005; Farmer, 2004; Farmer, 2001). In this conceptualization, the distribution of power is a condition of stigma that closely relates to the workings of structural violence. Structural violence comprises social forces including racism, sexism, political violence and other social inequalities that are rooted in historical and economic processes (Castro & Farmer, 2005).<sup>4</sup> Critically, as these scholars note, structural violence is “not the result of accident or a *force majeure*; it is the direct or indirect consequence of human agency” (Farmer 2005: 40). The contradiction, of structural violence being intangible but at the same time social, requires that we re-socialise our understanding of stigma and violence (Castro & Farmer, 2005), which in turn links to Goffman’s (1963:13) submission that to understand the construct of stigma, “a language of relationships is needed.”

### Example of HIV/AIDS in India

In my recent attempt to understand stigma and discrimination in a larger context, I found that the use of the Targeted Intervention (TI) framework for HIV/AIDS prevention and control created labels that could be easily stereotyped by NGO practitioners in order to

<sup>1</sup>The following write-up is excerpted from research and analysis conducted as part of my dissertation (Nambiar, 2009) and ideas that I have been trying to build upon and think through since. The thinking here is still in ferment: apologies in advance for lapses in clarity, errors of commission and omission. Email: <devaki.nambiar@gmail.com>

legitimize their own role in the HIV/AIDS response (Nambiar, 2009). I saw this as a form of **adverse incorporation** where the involvement of NGOs in “peer outreach” work was endorsing the stigmatization of their peers (Nambiar & Rimal, 2012). Young people I spoke to who were unexposed to this nosology were less apt to stereotype PLWHA, suggesting that through adverse incorporation, symbolic forms of stigma were present among young people working in certain HIV/AIDS-related NGOs.

Further, I examined the HIV/AIDS response in India to see what power dependencies - structural elements of stigma - existed and how the presence of these structural elements might explain the higher stigmatization in the NGOs (Nambiar, 2011). I found disparities in the apparatus and level of funding allocated to HIV/AIDS in the late 1990s and early 2000s, relative to other diseases (with higher burden). This apparatus and funding support, almost exclusively dependent upon private donors and unchecked by the state apparatus, involved an uncritical and heavily financed endorsement of NGO participation. As a result, NGOs who already stigmatized TI groups became increasingly involved with HIV/AIDS program delivery to these populations. India’s apex HIV/AIDS control agency, NACO, itself constituted rather like an NGO is structured to ignore this weakness of NGO endorsement and instead perpetuate the hegemony of the NGO complex.

This stands in contrast to NGOs with a strong political perspective – like Naz Foundation - who have been involved with the response from the beginning of the epidemic and understand the intersections and forms of stigma and violence. I raised these alternatives as “realistic utopias” for the Indian HIV/AIDS response to re-structure itself, submitting that HIV/AIDS-related stigma could be reduced and HIV/AIDS control improved as a result. Having discovered the processes and relationships of stigmatization that are embedded (and ignored) within the apparatus of public health in India, we see how a globalized response to HIV/AIDS may play a role in legitimizing HIV/AIDS-related stigma locally.

**Larger Questions**

HIV/AIDS is a central trope for understanding the notions of stigma and discrimination and indeed, the ways in which activists, researchers and public health practitioners have responded to them. It also undergirds other tensions in movements and organizing for rights and justice. As Parker (2012: 168) outlines:

At precisely the time the global HIV/AIDS epidemic emerged, a growing neoliberal trend associated with an intensification of globalization had begun to spread across the globe, was a major step back for the principles

of social justice articulated only a decade earlier in the Alma Ata Declaration(27). Indeed, this context may have led many activists, researchers and policymakers to adopt the human rights approach rather than social justice as an ethical/political rallying cry in seeking to respond to the growing HIV/AIDS epidemic. Yet, as neoliberal policies and perspectives continued to shape global public health, the focus on the need to link public health with social justice underwent a resurgence. It is interesting to note that this process was motivated by the same concerns with the health consequences of social inequality and structural violence that have shaped much recent thinking on stigma, prejudice and discrimination.

There is a typical tendency of public health practitioners to “confuse the things of logic for the logic of things” (Bourdieu, 2003:19) through a formulaic and axiologically neutral replication of theories and interventions on a global (ized) scale. This allows us to move forward without reflection or reflexivity - dangerously.

There are some public health practitioners who argue that “there may be circumstances when public health efforts that unavoidably or even intentionally stigmatize [like smoking] are morally defensible” (Bayer, 2008: 471). However, conceptualizing stigma as connected to broader inequalities and power dynamics, unavoidably or intentionally stigmatizing is morally indefensible, unethical. Given the privileges of the discipline of public health and the power inherent in our role of promoting health, as Burris (2008) exhorts, the use of stigma as a tool of public health would be misuse.

Link and Phelan’s framework enables a reflexive vigilance to our own processes of marking others in our use of symbols, language, our acts and relationships, as well as our structural positions and access to power. There is a need for greater sensitivity to the hegemonic, reductive, and formulaic tendencies that sometimes arise in our discipline, for indeed, stigma is connected to the ethics of public health practice. As Camus put it, this requires a vigilance that must never falter.

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Stigma	1) Labelling			5) access to social, economic and political power
		2) Stereotyping		
		3) Separation of “us” from “them”		
		4) Discrimination & Status Loss		
comprises	Symbolic Violence (symbols and language)			Contingent on
		Experiential Violence (acts and experiences)		
		Structural Violence (Structures and Resources)		



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### Endnotes

<sup>1</sup>In my most recent of many conversations about the equivalent of "stigma" in Hindi/Sanskrit, the most recent contribution is of a renowned Sanskrit, Hindi and Tamil scholar, who feels that the best synonym is *laanchan*<sup>1</sup> (Jayaraman, personal communication, June

12, 2009). The word derives from classical Sanskrit and is related to the Sanskrit root *laks* referring to "mark" or "sign" (Whitney, 1945). The root *laanch* means "to mark" and the suffix *-an* refers to "a process of" (Jayaraman, personal communication, June 12 2009; Whitney, 1945). Stigma in this definition, therefore, is a process of marking.

<sup>2</sup>If we again take the example of HIV/AIDS, stigma as separation includes fear of contagion and avoidance of casual contact with PLWHA, as a way of distancing oneself from risk (See Nambiar 2009 for extensive literature on this). Human rights researchers have documented cases of police hampering HIV prevention efforts among injection drug users in the Ukraine (Human Rights Watch (HRW), 2006b), gender-based violence and HIV infection in a number of African countries (HRW, 2003), healthcare providers' refusal to treat HIV positive children in India (HRW, 2006a), and harassment faced by AIDS activists in China (HRW, 2005) and Jamaica (HRW, 2004). Moreover, HIV/AIDS-related NGOs have reported withholding, limiting, or lowering the quality of care, services, support and education for PLWHA (Hong, 2006; Kiwia, 2006).

<sup>3</sup>At the beginning of the epidemic, public health authorities' initial characterization of AIDS as Gay Related Immunodeficiency Disorder (GRID) brought with it a barrage of stereotypes about homosexuals (Farmer, 1992; McGough, 2005). Following this was the 4H categorization of risk (Hemophiliacs, Heroin addicts, Homosexuals and Haitians), which encouraged collectivized perceptions of PLWHA in terms of social groups and not in terms of individuals with unique and varying histories (Herek, 1990). These epidemiologic "risk" ontologies may have been introduced as apolitical and technocratic, but were intensely political and stigmatizing (Grover, 1996; Schiller, 1992; Treichler, 1996; Treichler, 1999).

<sup>4</sup>Structural violence in relation to HIV has been studied using ecological models: examples include housing and community disruption and increasing AIDS deaths in the US (Wallace & Fullilove, 1991), breakdown of the local agricultural economy leading to changing sexual patterns and heightened HIV risk in Haiti (Farmer, 1992), the disproportionate vulnerability of African Americans to HIV due to incarceration, residential segregation, and limited access to sexually transmitted disease services (Lane et al., 2004), and the lower quality of service provision to homosexual populations in the United States (Stockdill, 2003) such that more AIDS deaths occur among gay and bisexual men (across all races) than in any other group (CDC, 2004). The methods used here are typically institutional and community level ethnography, policy analysis, and multi-level modeling comparing populations. A qualitative study based on in depth interviews Indian men who have sex with men connected discrimination by law enforcement and the medical establishment to broader forces of structural violence (Chakrapani, Newman, Shunmugam, McLuckie & Melwin, 2007).

## **Anatomy of an Inhuman Form of Protest by Bhangis to Assert their Human Dignity against Social Discrimination**

*- E. Premdas Pinto and K. B. Obalesha<sup>1</sup>*

On July 20, 2010, several members of the Bhangi community in Savanur (Haveri District, Karnataka) smeared human excreta on themselves in front of the Municipal Administrator's office protesting against the Municipality's plan to evict them from their dwellings. They have been living there since eight decades. Bhangi, is a sub-caste of Madigas, the community which has been treated as untouchables and form part of the Safai Karmacharis who do manual scavenging cleaning the dry latrines. What seemed like a unique protest of inhuman form unravels various streams of indignity and inhumanity experienced by the Bhangis, one of the lowest even among Dalits. This case study is prepared on the basis of the fact-finding report that was done by a team of civil society organizations.

### **Background of the Bhangi Community and Incident**

Savanur is a small Municipality town located 24 km away from Haveri district headquarters about 300 km from Bangalore. Savanur was ruled by Nawab Abdul Majid Khan II till Independence who granted land to the Bhangi community on which they could build their houses. From the days of the Nawab, these families have been working as manual scavengers in the town of Savanur. Post-independence, the Government did not issue land rights to this community, but never interfered with their enjoyment of this property. Savanur has grown over the years, and the place where Bhangi families live has now become the centre of the town and is a prime property.

The Town Municipality in a special meeting on Nov 23, 2009 decided to construct a commercial complex on the property where the Bhangi families lived declaring the Bhangis as unauthorized occupants. Even those Bhangis who worked as sweepers were kept in the dark about the decision of the Municipality. Soon the officials and councilors began harassing the community in order to vacate the place. The last attempt in this sequence of events was stopping water supply to the colony.

The panic-stricken Bhangi families, on the advice of Dalit organizations and other well-wishers, gave a written memorandum to the Regional Commissioner, Belgaum Revenue Division, on Jan 8, 2010, complaining against the unilateral and deliberate decision of the Municipality to dislocate their families. He sent direction to the officers in-charge to look into the issues mentioned in the memorandum and take action as per law, with an instruction to inform the complainants about the action. The Bhangi families did not receive any letter nor any instruction and the harassment continued in different forms.

On July 17, 2010, the Municipality disconnected the water connection to the Bhangi colony without giving any notice in writing. The Bhangis met the Assistant Commissioner with a memorandum giving details of the nature and the extent of threats, atrocities and discrimination. The memorandum specially pointed out that there was no other source of water as they were not allowed to draw water from public taps because of being untouchables. The Assistant Commissioner was impatient and he rather insisted that they pay Rs. 2000/- to restore the water connections.

***On 20<sup>th</sup> July 2010 members of the Bhangi colony gathered in front of the Municipality office bringing with them buckets of human excreta which they clean every day. In front of the media and the public they smeared human excreta on themselves as a protest against the inhuman treatment and atrocity meted out to them.***

Officials of the Municipality were indifferent and refused to receive their memorandum, which was later submitted to the Tahsildar. The protest was covered extensively by both State and national electronic/print media and exposed the inhuman treatment given to the Bhangi community.

Resorting to an extreme form of inhuman and non-violent (?) protest had its impact as it shamed the Government which has denied the existence of any form of manual scavenging in the State of Karnataka. The protest against the exploitation of Dalits, manual scavengers and Safai Karmacharis took place all over the State with many thinkers and writers denouncing the apathy of the State Government. The enormous amount of public pressure that was built up soon after the event forced the Government to do something – to save their face immediately.

### **Major Post-Protest Socio-Political Developments**

A small community of powerless Bhangis, the voiceless even among Dalits caught the imagination of the national media due to the nature of their protest. The State Government filed an affidavit in the Supreme Court and also issued a statement in the Parliament that there is no manual scavenging in Karnataka. As part of the face-saving measures, two emergency meetings were held chaired by the local MLA to defuse the tension: it was decided not to evict Bhangis from the present place till alternative arrangements were made, and allot sites and construct houses in already formulated Ashraya plots for all 13 families; to provide basic amenities in the area; to provide employment to recruit nine persons from the Bhangi community in the existing 13 vacant permanent sanitation worker positions in

<sup>1</sup>The authors were part of the process of fact-finding and follow up. K. B. Obalesha is a Dalit Human Rights activist who has been involved with the Safai Karmachari Andolan over a long period. Email for contact: <e.premdas@gmail.com>

the Municipality; to provide scholarship to all school-going children with assurance of two acres of land for each of these families along with access to loans.

The Government officials and ruling party leaders were trying to “manage” the issue in order to cover up the injustice done by taking the Bhangis to hospital, pressuring them not to give negative statements, providing food, enticing them with various letters of assurance, arranging a special meeting for them with the Minister. The Municipality President called the incident as an unfortunate one, he suspected the Bhangis were influenced and were misguided by political conspiracy to bring a bad name to his Municipality. He and other elected representatives expressed their concern and commitment to the cause of Bhangis and gave copies of the resolution passed, and the decisions made to rehabilitate them.

Interestingly, the right wing Sriram Sene leader Mr. Pramod Muthalik who visited the members of the Bhangi families posed before press persons and TV channels simultaneously; his followers shouted slogans “Bharath Maatha Ki Jai” till he left the place. Sangh Parivar, through its Sriram Sene chief, entered the scene using the Bhangi incident to pursue its communal agenda in the constituency which has a predominant Muslims population (60%).

A local Dalit leader complained that the Social Welfare Office is generally indifferent and apathetic towards Dalits. Despite innumerable social welfare schemes for the welfare of Dalits and a Special Component Plan which mandates compulsory allocation of 15% of all development funds for the SCs, most of the Bhangi families continued in manual scavenging, their health conditions were appalling and they did not have ration cards.

### **Tokenism to Bury Larger Issue of Manual Scavengers**

The tokenism resulted in erosion of the real issue. Under pressure, nine families opted for the posts of sweepers in the Municipality, four asked for loans to start petty business, and old age pension for one. Chandru Bangi, a disabled person, and the only ITI diploma holder, had not got any disability pension or assistance so far and he asked for financial assistance to set up a welding shop. In their deprivation and option-less situation, many of them considered a sweeper’s post as a symbol of enhanced status and a respectable position and opted for it. The systematic caste discrimination encoded in the very working of the Municipal Council was very visible. The series of documents accessed and information gathered endorse the fact of systemic prejudice against the Bhangis, the Dalits among Dalits. Various schemes which are meant for the welfare of the SC/ST community just lapse or is siphoned off, the Administration making no proactive attempt to reach them to the needy community.

Following the incident of July 20, the Social Welfare Office took three immediate actions purportedly for Bhangi welfare: conducting survey of manual scavenging families, issuance of ration card and sanction of incentive money of Rs. 50,000 per couple for inter-caste marriages. None of the 14 families have been able to access any Government scheme so far. It is evident that the Social Welfare Office has not undertaken any rehabilitation program under the Prohibition of Dry Latrines Act 1993, even after a lapse of 17 years. Food grains for a month were issued to 11 families by the Social Welfare office as immediate assistance - however the food grains reached the families only after nine long days! Departments responsible for the education of children in the community, the enumeration of children and enrolling them in the school register began only after the protest!

One of the important issues that got buried in the whole drama of appeasing the seven protesting families was the actual number of manual scavengers in the Municipality area. The Dalit households engaged in menial work were 41 with a total population of 202. Further, the larger issue that has not been raised and got buried in the damage control action to protect the ‘honour’ is that of manual scavengers in general and the issues of their livelihood and dignity. In Savanur town there are 4,977 latrines with 50% being open latrines and complete absence of underground sewage. This indicates that only seven families cannot maintain them and there are large number of Dalits who are working either on contract basis or on daily wage whose issues are not taken up. The Government which denies the existence of manual scavenging was in a hurry to see that this issue did not surface as manual scavenging is *“legally eradicated and that technically there were no manual scavengers”!*

### **Whither Violation of Dalit’s Right to Life and Dignity?**

The act depicts exploitation of the vulnerability of Bhangis and the violation of the rights of Dalits. The actions of threats, disconnecting water supply, barging into and dumping waste in front of their homes, insulting women and threatening them, clearly amounts to violation under various sections of the SC/ST Prevention of Atrocities Act 1989 and the Protection of Civil Liberties Act. The families were not allowed to draw water from other public sources of water, and the Municipality made them collect drain water near public taps, resulting in children falling sick. The Assistant Commissioner asked them to pay for reconnection and denied water. Despite the enactment of free and compulsory primary education, a 13-year old boy, Yesu Bhangi, was engaged in manual scavenging and had discontinued his education till 3rd standard. Hence the larger issue of the rights of manual scavengers, their human dignity got buried in the swift action that followed the protest. The systemic prejudice against Dalits, combined with the

apathy and arrogance of the bureaucrats who collude with the interests of the local power wielders, is very evident.

When the neglected peripheries and shanties in growing small towns become the centre of economic activities as their settlements become visible due to the land that they dwell on, a process sets in with the connivance of all the others who have developed “stake” in the land. The people supposedly without human dignity now become a blot for “development”. Though wanting to clean up human dirt, the prejudice and practice of untouchability continues. The incident highlights the perpetual arrogance, abuse, threats and subjugation that they have to face.

The imbued arrogance of the ruling class and the practice of discrimination express itself through ways which denies the very existence of Dalits! In the year 2013, as the writ petition of the Safai Karmacharis was being heard in the Supreme Court, Government of India and the National Human Rights Commission undertook a joint operation to enumerate the manual scavengers in about 3500 small and big towns. However, the officials of Karnataka have denied the presence of manual scavengers thus again denying them of every opportunity of being counted or rehabilitated. The new legislation “The Prohibition of Employment as Manual Scavengers and their Rehabilitation Act, 2013 (No.25 of 2013)” recognizes only the registered manual scavengers and thus defeating the very purpose of this legislation! Though in principle a self-declaration (affidavit) is sufficient for this recognition, it has been a great struggle with the officials to accept these affidavits. The bureaucracy is doing its best to thwart this very process.

The manipulation of land records, passing of resolutions, disconnecting water supplies while doing nothing to rehabilitate the community in total violation of the legislation of Prohibition of Dry Latrines Act 1993, SC/ST Prohibition of Atrocities Act 1989, etc., is the oft-repeated story of social discrimination against Dalits in any given place in the country. The incident which happened in a very small town far away from the Capital of the State typifies such incidents in rural India where the gap between the policy statements, programmes and its ACTUAL reach to the last and the most powerless where the social discrimination is experienced in its totality of punch and might.

Manual scavenging is a caste-based occupation ridden with the complexities of poverty, subjugation and powerlessness. Gita Ramaswamy (2005) vividly describes the plight of those who are in this occupation. The deaths of manual scavengers trapped

in the man-holes, or in the underground drainages, is rarely covered by the media. Their nature of the occupation keeps them closer to the townships where sanitation is a huge problem and the places that they occupy over a period of time are seen as valuable commodities. The incident and the dynamics around the issue shows the process of nexus of various people in burying the truth with tokenistic gestures and their ability to evade the real issue – the dignity and well-being of Dalits.

What followed in Karnataka was a hopeful but forceful campaign to expose the lies of the Government by evidence-gathering and fact-finding on the existence of manual scavenging and the practice of night soil carrying – they became strong evidence in the Supreme Court which culminated in the new Act for the prohibition of the employment of manual scavengers. However, the Act and such legal enactments, more often than not, become a tool for the bureaucracy to deny the existence of manual scavengers rather than recognizing and rehabilitating them! So, a prejudiced mind-set invents newer methods to continue the practice of social discrimination, irrespective of any law or regulation. The new Act is only half the battle won. But the further battle is to see that Bhangis and manual scavengers get identity cards which will recognise them manual scavengers thus making them eligible for rehabilitation under the new Act. In many states the bureaucrats are busy guarding the ‘honour’ of the State by saying that there are no manual scavengers.

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## Why did Satyam die?

-Mithun Som<sup>1</sup>

Satyam, a 43-year old worker died while cleaning one of the manholes in Serilingampally (Circle 11), which comes under Greater Hyderabad Municipal Corporation (GHMC) on May 11, 2013. This particular manhole was one of the few manholes in this circle which has a depth of about 30 ft. The normal manholes are 3-5 ft in depth. His daughter, who also works with him, was present near the opening when he entered to clean the manhole. She saw Satyam going down using the steps and was just a few feet away from the bottom when, probably weakened by the lack of oxygen and presence of poisonous gases, he could not grasp the stairs with his hand. He fell. The daughter called for help and a passerby, Anjaneyulu, age 18 years, went inside the manhole to help Satyam. Both died.

### What do the GHMC Management and Union Say?

The management says that they do not know why Satyam went in to clean the manhole as they had not instructed him to do so. Even though there have been complaints for two months regarding this manhole, it could not be cleaned as the machines available with GHMC was not able to clean this 30 ft manhole. The executive engineer claimed that he had visited that manhole, declared it dangerous and had clarified that it was only to be cleaned by the machines they were planning to get from Water Supply and Sewerage Board Department. The management says there were clear instructions given to the supervisor and the workers not to try cleaning the manhole even if there is pressure from the people. Satyam had cleaned another two manholes the same morning before going into this one. The supervisor denies having given any instructions. The Union (general secretary, Babji) agrees with the management saying he does not know why Satyam went to clean the manhole even when there was clear instruction not to clean it. He further says that Satyam ought to have known how dangerous this manhole was by looking at it, even if no one has told him so. The health officer, who is the officer in charge, said that this was an off day as it was second Saturday and also the work was done after 11 am, generally by which time the workers have done their drainage work. In other words, Satyam was supposed to be off duty at that time.

### What Does the Family Say?

The family clarified that they do not get any leave, no weekly off and no holidays. They are supposed to work on all the days in a month. The shift timing for Satyam was 4.00 am to 2.00 pm, so the question of his being off duty on that particular day does not arise at all. He told his daughter who was with him when he went in to the manhole that 'Sir' has asked him to clean it. She could not identify which 'Sir' but she

was confident that he was working under instructions. He did not know the depth of the manhole and was unaware of the dangers. The family feels that if the group leader had been there she would have warned him and would have told him about the danger and his death could have been prevented. The workers have their own techniques of minimizing some dangers like this, e.g., they open the adjacent manholes when cleaning a particular one as this releases the fumes and lessens the toxicity in the manhole which needs to be cleaned. On this day his partner was not there, he was working alone and so this process was not followed.

### What Makes a Worker Get into this Kind of Work?

This section explores as to who are these people who get into this kind of work of cleaning manholes which no one would take up by choice.

#### Caste

The workers cleaning the manholes are from backward castes, Dalit s and tribals. There are no general category workers. On a rough estimate, about 80% of the GHMC workers including workers for cleaning and sweeping are of Madiga caste (SC). Others are mostly SCs, with 1-2% OBC (Mudiraj, Chakali, Yadav) and a negligible number of members of the ST. This is a job open to all yet it is predominantly taken up by the lower castes throughout India. There have also been cases of upper castes holding on the job and subcontracting the job to the lower caste (Tripathi, 2012). As this work is considered dirty and polluting, a person will chose it when no other opportunity is available. A majority of these workers in Hyderabad are from Madiga caste (SC). The Madiga and other castes in India like Valmiki, Bhangi, etc., have been associated with this work "traditionally" and they have moved only from manual scavenging to manhole cleaning. Once a worker or community is associated with this kind of work, it is a like a trap, he would get the same kind of work but find it difficult to get other kinds of work. Thus it is important to see the manhole workers not as a professional class but rather as a caste group. Satyam however belonged to the Mudiraj community (BC) who traditionally do not do this kind of work.

So what forced him to take up a work which is below his "caste profession".

#### Livelihood and Debt

The Mudiraj is primarily a non-agricultural BC community. They do seasonal gathering (fruit and forest produce), fishing and farm labour. Traditionally one family from this community in a village function as "muskoor" that is peons or couriers between the village authority and the residents. Satyam

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belonged to Mahbubnagar district. With the general desertification of the environment in Mahbubnagar, the Mudiraj community lost its livelihood and agriculture labour also became scarce. The added issue here is that the politics of irrigation and dams in the past fifty years has accelerated the desertification of Mahbubnagar (Satyam's district) and benefiting Guntur district. Thus most forms of traditional occupation for Satyam's community had dwindled. So have many other traditional occupations like pottery, basket weaving, mat making etc., over the years with the advent of modernization.

The low public spending in agriculture, changes in farming technology, resulting in high input cost and unavailability of credit at reasonable rates, is making it difficult for the marginal farmers and farm labourers to sustain themselves (Reddy, 2009). The situation is worse in Andhra Pradesh with systematic cuts in agricultural and allied activities budget (Reddy, 2006). The NSS figures show there is an increasing trend towards the more insecure casual labour rather than self employment or regular employment in rural labour (Chowdhury, 2011). Casual labour is at its highest for rural male since 1970s (Chowdhury, 2011).

Mahbubnagar district is considered the hub of migration, the migrants renowned as "Palamur labours". Satyam was from Achampet Mandal of this district. This district has a history of drought especially seen in last few decades, and the net sown area has decreased in the last couple of decades and all these factors combined provides cheap migrant labour (Olsen, Ramana Murthy, 2000). Some people migrate by themselves and others are brought by middlemen or contractors (*maistries*) to the city. Satyam's family, consisting of his wife, four daughters and one son did not have any land. They survived working as farm labourers. However, with the poor state of agriculture, and the seasonality and insecurity of the work, they found it difficult and therefore decided to move to the city.

Debt in many poor households is another major reason which leads to migration as migration becomes a defensive coping strategy. Debts incurred due to marriage, death, ill-health, bad agricultural season, or any other catastrophic expenditure pushes the people out to the urban areas. Debts from formal sources in rural areas have declined after 1992 and the debt from formal sources as percentage of total debt have seen more decline in Dalit households (16% from 1992 to 2002) as compared to non Dalit households (5% from 1992 to 2002) (Chavan, 2012). By 2002, moneylenders replaced commercial banks as the largest source of debt for Dalit households. And the share of debt taken at an interest rate of above 20% saw an increase for the same period (Chavan, 2012). Andhra Pradesh has the highest indebtedness in farmer household (82%) and the institutional sources in the state account for the lowest (30%) percent of loans in the country (Reddy, 2006).

Satyam had also incurred a debt on account of his elder daughter's marriage. It seems that the Mudiraj community did not have the dowry system earlier but now for the elder daughter's wedding, Satyam had given one lakh rupees in cash and five tolas of gold. There is an increasing trend of dowry in the lower castes which can be attributed to a complex set of factors which merit a separate investigation. He had three more daughters to marry off and with every daughter he would have to take a loan to pay for the dowry. A study in rural Tamil Nadu shows that "low caste, landless households and labourers more often borrow to cover daily survival costs and ceremonies, while middle castes, landowners and producers more often borrow for economic investment" (Guerin et al, 2011).

### **Education**

People from the lower castes face double hardship due to their caste status and poverty, especially in rural areas. The children often have to help their parents due to which they are not able to continue their education provided of course the schools are accessible to them. Many have never attended schools. When they come to the city, these people with little or no education are left to work in the informal, unorganized sectors in low paying jobs, barely able to sustain, which makes them again economically vulnerable. Thus the next generation is no way better off and the cycle continues unless someone is able to escape (Singla, 2013). Satyam had studied till class four and was able to read, his elder three daughters have dropped out in class tenth, ninth and fourth respectively, his fourth daughter in class 7th and his son in class 4th are the only ones continuing their studies.

### **Limited Choice after Migration to City**

When people come to the city in search of work, with almost no education, with no capital, and skills not suited to urban labour, they have very limited scope of work. As in Satyam's case, the family had a choice of entering into construction work or be a part of the self help group (SHG) and work in GHMC. But with Satyam's wife's poor health condition, she would not have been able to take the heavy load and strenuous work in a construction site. Satyam's individual income would not have been enough for the family to survive. In GHMC they had a chance where three members of the family could work and so they opted for this work and later on stuck on to this work. Most workers migrate by chain migration (Banerjee, 1983) where migrants come to the city and then other migrants from their village or community mostly follow to the same kind of jobs. Thus a lower caste worker in informal work will introduce his/her kin to do the same kind of work. When SHGs become the medium of employment like in GHMC, then it becomes another facilitator for migration. And since it is generally seen that the same or equal caste people form a group, this facilitates their entering into same occupations.

For the first two months after joining the GHMC, Satyam used to clean roads and it was only after two months that he was instructed to clean manholes. At that time, Satyam did not have an option; he had to take it up or else risk losing his job. His youngest daughter said, "if we don't do it when we are told we will lose the job".

This shows the desperate need of the family and is a particularly severe blow to a non-Dalit caste. The politicization of the Dalit caste permits them to take these jobs with an understanding of caste politics involved, and in any case their doing these jobs is public knowledge. For these reasons, they do not face isolation. Being an OBC, lacking the necessary politicization and facing stigmatization due to doing work below their caste, it is not surprising that people like Satyam would quietly accept these jobs without complaint and in addition keep it secret. This leads to isolation from the larger community they belong to (G Shyamala in personal discussions).

### Work Conditions

**Weekly offs:** Officially they are a seven member group and everyday one member takes leave. This would be based on their internal arrangement and six members would be working on any given day. Satyam's family said that they have to work on all the days in a month without a single leave. In case they take any leave, Rs.230 per day is deducted from their pay. These are flagrant violations of labour laws, yet the family reported that this has been going on. This reduces the workers as daily wagers, the only difference being they do not have to look for work every day.

**Shifts:** For drainage cleaning, they work in the first shift from 4.00 am. Some three groups on an average have a common sanitary field assistant (or supervisor) who has the muster roll, who marks their attendance, assigns them work and also oversees their work. The workers need to have a good relation with the supervisor as he marks their attendance according to which they get their pay.

**Pay:** About a year back the money was given in the name of the group and the group leader withdrew the money and gave it to the workers. But now GHMC pays the workers by direct transfers into their accounts and even now, the group leader like in Satyam's group helps them in withdrawing the money from the bank. The workers do not receive money on any fixed day or at the beginning of the month. For example, Satyam's wife's Narramma's account from 2011 showed that she has been receiving money in her account on different dates and even at the fag end of the month. It was only after November 12, that they have got money within the first 10 days of the month. The period before one year was even worse as she invariably got her money almost at the end of the month. This is because the system of calculating salary based on attendance and verifying it is a complicated process which passes from head office, a contract agency, zonal office, audit and finally bank.

The amount has also varied from Rs.3500 (till May 2012) to Rs.5540 being the maximum.

The Union General Secretary (Babji) said the workers do not get enough money to support the family. They have to manage the entire family's expenses and that includes rent, food, clothing, health and education for their children with what they get. Another Union official, also said that the single worker's salary is certainly not enough to cover the family's expenses. The Union person also adds that these workers, many times cannot send their children to school and the children also have to work to support the family. Children in many households earn about Rs. 1000-2000 in some other jobs to help the family.

**Contract Status:** The earlier system had 18 workers who formed a unit under the contractor, but there were reports of widespread corruption by the contractors. So the contractor system has been replaced by the seven member sanitary workers group for the sweepers. This is technically different from the Self Help Group which requires a minimum of ten members. The drainage workers are all part of these groups in the peripheral circles, which includes Serilingampally circle where Satyam worked. In the main city area, the sweeping and drainage groups are different. In these areas, the drainage groups are still under contractor and come under Hyderabad Metropolitan Water Supply and Sewerage Board (HMWSSB).

The drainage workers in the peripheral circles of the city do not fall under the permanent employees nor are they under any contractor. They are part of groups registered with GHMC which puts them in a unique position. They are better off than contract labourers. The informal group leader is the link who negotiates between the management and the members. There would be a general tendency for the leader to move closer to the management rather than the group members and perhaps in the long run she becomes more of a "middleman". So on the face of it, the group may look democratic and group together capable of taking care of its members but the reality could be quite different. This would be more so in groups where there is marked difference between the literacy and numeracy skills of the leader and other members.

These workers do not get anything like a paper contract or appointment letter. Since they do not have a paper contract, there is no proof of prior work experience on the basis of which they can command better pay or other advantages. This handicap remains even though they are not contract workers in strict sense.

**Drinking and Work:** One of the points raised by the health officer and also surprisingly the Union was that Satyam was drunk on that day. Satyam's family said that he used to drink only during the night after work. We do not know what the autopsy has revealed. But even if we accept that he was drunk, we need to question why do workers like him drink while on work. Is it the nature of the work that they do, a



work which no one would like, but they have to do to earn a living? Getting into a manhole blocked and overflowing with stinking feces and rotting refuse would need one to numb his senses to deal with the experience. Drinking helps them to deal with both the experience and the physical labour.

### **Why Does a Manhole Need Cleaning by the Workers?**

With so much progress in technology in today's world, why does a human being still need to go down in the manhole, totally unequipped, without any safety gear, to clean it? Why is the state not investing money in technology and rather leaving it to the workers to enter in the manholes to clean it, when the task is such a basic necessity of urban life. The only answer that suggests itself is that there is a lack of will to do it, to think with humanity about the workers who are cleaning the manholes, and without whom the health and sanitation of the whole city will collapse. Even though some high courts like the Gujarat high court has banned manual cleaning of manholes, there are instances of manual cleaning of manholes even there (*Indian Express*, 2009). There is also a danger that total ban of entering manholes may lead to the continuance of the work but in more difficult circumstances, in a more invisible way.

Even now, all the circles do not have the machines. Yadaiah says that of the total budget of Rs 3,800 crores of GHMC, they surely can budget for the machines. The circle where Satyam was working (as neighboring two circles) does not have their own Airtech machine for cleaning manholes. So the three circles have to depend on circle 14, Kukatpally, for the machines. In the present arrangement, this circle gets the machine once a week on a Wednesday. This particular manhole where Satyam died had a complaint since the last two months. The GHMC attended to it, bought machines from neighbouring circle and tried resolving it but after few days, the drainage would again get blocked. They were trying to get a more powerful machine from the HMWSSB department.

In most developed countries, the workers who enter the manholes are equipped with protective clothing, respiratory apparatus, safety harness, manhole mechanically aerated with huge fans, the atmosphere of the manhole tested at three different levels for oxygen, explosive gases and hydrogen sulphide and a person is always outside the manhole when someone goes in.

Here, when a person is going inside the manhole, there is no effort or equipment to assess the level of poisonous gas inside the manhole. These are simple techniques which can easily be developed at very low cost. (Interestingly, in rural areas, when a person needs to enter a deep well for further digging, they have their own indigenous technique to assess the level of danger. For example they send a live hen or a burning lamp inside the well to assess the level of

oxygen. If the hen dies or the lamp goes out, the area lacks oxygen. (*Andhra Jyoti*, July 9, 2013, article by Jeevan Kumar). The workers develop their own small prevention measures like keeping the cover open for some time, opening the adjacent manhole covers, burning a candle to assess the oxygen content etc. But these are not full proof measures of security. The state or the municipality does not provide any protective or security measures.

The health officer of Serilingampally circle says that safety gear is provided by GHMC like hand gloves, leather boots, masks to the garbage collector and drainage cleaners. For the permanent employees, the GHMC provides clothes, chappals, soap, oil, etc. There certainly seem to be divergent accounts because two of the supervisors from the same circle said that no masks are provided to the sweepers nor any safety gear provided to the drainage cleaners. Satyam's family said that they have never received any kind of safety gear.

This can only happen when the workers are considered dispensable. There are scores of people waiting to take up this work who are in a similar situation of desperation and would not consider the dangers because their primary need is the money for survival. In failing these workers, the state is abandoning its responsibility for their life and safety.

### **Health, Accidents and Deaths**

A number of toxic and non-toxic gases are present at varying levels in the manholes depending on the source. The most common and hazardous gases are hydrogen sulphide, methane and carbon monoxide. In addition, oxygen deficiency is another major cause of illness and fatalities. Hydrogen sulphide has a rotten smell but at levels over 100ppm, it has paralyzing effect on the sense of smell (OSHB, 2007). So it is very dangerous to rely on smell for the presence of this gas. All of these gases in a higher concentration has a paralyzing effect and causes immediate death. A study done by Centre for Education and Communication on the Health and Safety Status of Sewage Workers in Delhi has shown that the majority of workers have had eye irritation, skin rash and cuts. More than 50% of the pulmonary test results were abnormal. None of the workers have been formally instructed about the hazards in their workplace. There have been different estimates of deaths of manhole workers across the country. Data obtained from Mumbai under RTI shows that 2039 Safai Karmacharis between 1996 to 2006 have died in 14 of the 24 wards of the city. Another estimate shows at least 22,327 Dalits die every year cleaning sewage (Anand, 2007). In GHMC, the Union leader said that there have been at least 20 deaths in Under Ground Drainage (UGD).

Yadaiah said that the contract workers (in some circles) do not get coverage as their contractors do not pay their share to the ESI. Other workers who form self-help groups like Satyam have ESI coverage and their contribution is cut from their salary. But the

Union leader in the head office insists that many of the workers do not get the cards and many are still not aware about the services that they are supposed to get. Satyam's family has never used the ESI card. They had a temporary card that was valid only till October 2011. They never got a new card and never bothered. After hearing about the negative experiences of others accessing ESI, they never gave it a try. In addition, for going to ESI OPD, they do not get any leave and are asked to go after their work gets over in the afternoon. So they instead go to the private provider in their area who charges them 100-150 rupees for a visit. In these circumstances a worker would not access health services unless and until they are incapable of doing their work, thereby ignoring their health till it becomes a crisis. The situation will be even worse for the women in the family. A study of Sanitation workers in Ahmedabad shows that about 25% of the income is spent on medical expenses (Mishra et al, 2012). Satyam's family has not got any compensation due to his death from ESI either.

### Whose Responsibility is Satyam's Death Ultimately?

There is no separate law to protect the health and safety of these workers, even though they have a very high morbidity and mortality rate. Even though there are so many accidents and deaths, there is no official mechanism by which they are compensated. Every time the Union has to fight for it and only then the GHMC compensates. Here the money looks like more of a charity and not as a right of the worker's family who have lost their earning member due to lack of adequate precautions by the GHMC.

It is the Government's responsibility to clean the manholes using machines. By bringing in first the contract system and next this new system of self help groups, the Government is distancing itself from the workers and their welfare. Where use of machines should have been a priority instead of workers cleaning the manholes, presently four circles are sharing one machine to do what the workers cannot do, and with fatal results. The compensation is also not seen even by the Union as the right of the worker, but rather something that needs to be fought for.

This is not an individual case of accident as the management is trying to portray. Rather this comes across as a worker who came to the city forced by the political, economic and social forces and which also shepherded his work toward this menial and ultimately fatal task. This kind of work is banned and yet many like him are doing it with full cognizance of the Government. Further, due to the callousness of the state towards his work and work condition, he died cleaning a manhole.

In the absence of the Government's commitment to these workers, it is the passerby Anjaneyulu who acted with compassion and in that act gave his life up alongside Satyam. It is not difficult to see that

Anjaneyulu too was from an untouchable caste – nobody else would have entered a manhole!

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## Caste Background of Health Professionals in India

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It is well known that there is inequitable distribution of healthcare professionals across social groups, especially for physicians. The census publishes this data every ten years and the NSSO also collects data on occupations (but does not publish disaggregated data listing various health professionals) but a literature search shows that this subject of caste background of health professionals is inadequately researched and discussed. Human power statistics published by the Institute for Applied Manpower Research provides information only for those in public services but does not disaggregate by caste. The SC

**Table 1: Caste Profile of Health Professionals and Paramedics for all Non-Agricultural Workforce**  
Source: 2001 Census India Economic Tables B-25, B-25SC and B-25ST

Occup.	Category of Worker	ALL Persons	Caste Category			Variance from Population		
			%SC	%ST	%Other	SC	ST	Others
2220	Health Professionals (except	947433	7.49	1.87	90.63	-42.65	-53.20	9.29
2221	Physicians and Surgeons,	617619	7.49	1.50	91.01	-42.68	-62.46	9.74
2222	Physicians and Surgeons,	107346	5.49	1.23	93.28	-58.01	-69.19	12.48
2223	Physicians and Surgeons,	64567	5.42	0.54	94.03	-58.50	-86.42	13.39
2224	Physicians and Surgeons, Unani	10020	3.96	0.49	95.55	-69.67	-87.78	15.21
2225	Dental Specialists	21261	6.00	1.17	92.83	-54.06	-70.86	11.94
2226	Veterinarians	81584	11.25	5.66	83.09	-13.86	41.27	0.19
2229	Health Professionals (Except	45036	9.98	4.18	85.84	-23.59	4.38	3.50
2230	Nursing Professionals	14343	14.03	8.40	77.56	7.43	109.86	-6.47
2230	Nursing Professionals	14343	14.03	8.40	77.56	7.43	109.86	-6.47
	<b>B. Paramedic/Associate Professionals</b>							
3220	Modern Health Associate	545579	11.62	4.11	84.27	-11.06	2.66	1.61
3221	Medical Assistants	91676	8.78	3.64	87.58	-32.78	-9.16	5.61
3222	Sanitarians	164955	14.43	4.84	80.73	10.49	20.87	-2.66
3223	Dieticians and Nutritionists	3321	10.42	2.68	86.90	-20.25	-33.06	4.79
3224	Optometrists and Opticians	12665	6.52	0.81	92.66	-50.08	-79.69	11.74
3225	Dental Assistants	2461	7.07	1.67	91.26	-45.88	-58.39	10.05
3226	Physiotherapists and Related	6727	7.63	1.14	91.23	-41.63	-71.41	10.00
3227	Veterinary Assistants	27966	10.55	4.16	85.29	-19.26	3.97	2.84
3228	Pharmaceutical Assistants	221552	11.24	3.24	85.52	-13.95	-19.09	3.12
3229	Modern Health Associate	14256	12.71	17.23	70.06	-2.71	330.33	-15.52
3230	Nursing and Midwifery Associate	583284	12.90	5.87	81.23	-1.28	46.67	-2.05
3231	Nursing Associate Professionals	491151	11.54	5.13	83.33	-11.69	28.20	0.48
3232	Midwifery Associate Professionals	92133	20.15	9.81	70.04	54.23	145.15	-15.55
3240	Traditional Medicine Practitioners	11488	9.48	2.99	87.53	-27.44	-25.42	5.55
3241	Traditional Medicine Practitioners	10885	9.55	3.01	87.44	-26.94	-24.73	5.44
3242	Faith Healers	603	8.29	2.49	89.22	-36.53	-37.86	7.58
0000	TOTAL Non Agricultural	145509200	13.06	4.00	82.93			

*Note: The variance has been calculated using the total non-agricultural workers, and within that the proportion of respective social group as the universe. \*Negative figure means that the proportion is lower by that much percentage as per their population proportion for the concerned social group and a positive figure reflects that it is that much higher.*

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and ST Commissions who should have a keen interest in such a profile too do not collate and provide any data/statistics about SC / ST occupational data. So generally there is very little information about caste and professions/occupations and this lack of information is indeed surprising given that there exists education and job quotas / reservations for the SC and ST, and now also for OBCs and Muslims.

In 2003, the World Health Survey by WHO and IIPS (2006) on Health Systems Performance Assessment provided an excellent profile of the health system in India but failed to record caste. However they classified households into income quintiles and this data shows some interesting patterns of health human resources. Bottom THREE quintiles did

Wealth Quintile percent	SC	ST	OBC	Other	All
Bottom	27.9	49.9	18.1	9.8	20
Second	24.6	23.6	22.1	13.6	20
Middle	20.8	13.4	23.2	17.1	20
Fourth	16.6	8	21.1	23.9	20
Highest	10.2	5.2	15.6	35.6	20

Child Mortality per 1000	SC	ST	OBC	Other	All
NNM	46.3	39.9	38.3	34.5	39
PNNM	20.1	22.3	18.3	14.5	18
IMR	66.4	62.1	56.6	48.9	57
CM	23.2	35.8	17.3	10.8	18.4
U5M	88.1	95.7	72.8	59.2	74.3

Child Health %	SC	ST	OBC	Other	All
All Vaccines	39.7	31.3	40.7	53.8	43.5
ICDS any service	36.1	49.9	30.3	28.3	32.9
No food at ICDS	69.6	56.1	77.6	76.8	73.5

Maternal Health %	SC	ST	OBC	Other	All
No ANC	25.9	29.4	25.5	15.2	22.8
atleast 90 days IFA	17.4	17.6	22.1	30.1	23.1
atleast 2 TT Inj	73.6	61.9	76.5	82.3	76.3
USG	16.6	9.9	22.7	33.8	23.5
Institution Delivery of above in public facility	32.9	17.7	37.7	51	38.7
Delivery by skilled provider	59	65	43	43	46
of above by doctor	40.6	25.4	46.7	57.8	46.6
No PNC	72	67	72	82	75
	62.9	68.6	59.8	47.4	57.6

Child Nutrition %	SC	ST	OBC	Other	All
Stunting -2SD	53.9	53.9	48.8	40.7	48
Wasting -2SD	21	27.6	20	16.3	19.8
Underweight - 2SD	47.9	54.5	43.2	33.7	42.5
U5 any anemia	72.2	76.8	70.3	63.8	69.5

Adult malnutrition %	SC	ST	OBC	Other	All
Women height <145cm	15	12.7	11.4	8.9	11.4
Women BMI < 18.5	41.1	46.6	35.7	29.4	39.1
Men BMI < 18.5	39.1	41.3	34.6	28.9	34.2
Women any anemia	58.3	68.5	54.4	51.3	55.3
Men any anemia	26.6	29.6	22.3	20.9	24.2

Health Insurance/Access %	SC	ST	OBC	Other	All
Any health insurance cover	3.3	2.6	3.8	7.8	4.9
of above private purchase	15.5	23.5	25.8	31.9	27.5
Financial barrier for women to seeking healthcare	20.4	31.2	16.4	12.9	17.3
Distance as barrier to seeking healthcare	27.3	44	26	18.5	25.2

Select Diseases prevalence per lakh	SC	ST	OBC	Other	All
Women Diabetes	798	349	774	1189	881
Asthma	1494	1749	1498	2035	1696
Goitre/Thyroid	754	753	819	1240	949
Men Diabetes	991	477	955	1336	1051
Asthma	1688	1973	1276	1919	1627
Goitre/Thyroid	348	567	328	424	383

<b>NSS 60th Round 2004 select health indicators</b>	<b>SC</b>	<b>ST</b>	<b>OBC</b>	<b>Other</b>	<b>All</b>
15 day morbidity per 1000	88	58	88	106	91
Percent above treated	81	78	84	87	84
Percent using public facility	21	25	17	16	18
Financial reason for no treatment %	36	31	25	20	27
Tap/Tube -well water %	88	72	83	88	84
Expenditure per OPD ailment in Rupees	184	149	203	258	218
% OPD paid by borrowing/sale of assets	23	23	21	17	20

not have a single physician whereas the top quintile accounted for 83 percent of all physicians – not unexpected as doctors have a clear class character and generally class and caste go together so we can deduce that most physicians would also be from the upper caste groups. The 2001 census data in Table 1 below provides the evidence of the caste character of physicians.

With regard to nursing and midwifery too there was some concentration in the top 2 quintiles in the WHO survey – 61 percent of nurses. The bottom two quintiles had only 19 percent nurses. But for the support health staff the contribution of the bottom quintile was as much as 37 percent.

The 2001 census data in Table 1 gives a snapshot of the caste character of various healthcare professionals and the distribution patterns are not very dissimilar to what we see in the class distribution from the WHS 2003. The last three columns in the table tell the real story for each social group, Scheduled Caste (SC), Scheduled Tribe (ST) and Others. For the health professional groups the variances

from the proportion in the population (non-agricultural workers as universe) for each social group is highly negatively skewed for the SCs and STs, the deficits being between 50 and 80 percent, but for the “Others” group it is in excess between 10 to 15 percent. As we move down the hierarchy to nurses and paramedics the variances become narrower and one sees a few excess ratios for SC and ST, notably for the category of sanitarians and nursing/midwifery. For the ST, the nursing and midwifery categories surprisingly show a huge excess of over 100 percent. Thus despite affirmative action policies the SC and ST have been unable to break the glass ceiling of the upper caste control over the health professions, especially physicians of all types.

Further, the “Others“ is a very varied group and includes a number of underprivileged categories like OBCs and Muslims. If further disaggregation for this category was available the upper caste domination, similar to upper class (top quintile) would have come out more sharply. Historical evidence from Gazetteers, Indian Medical Service Reports and writings on colonial medicine suggest that the Brahmins, Parsis and Christians were the first to take advantage of modern medical education and hence they got a head start. Their domination continued in early Independent India but soon other upper caste Hindus, initially Kshatriyas and later Baniyas entered the medical profession in large numbers. With reservations for Dalits and Adivasis they too

got an opportunity to enter medical schools. As medicine got commodified, especially post-1980s, and private medical education and private health insurance entered the scene upper caste domination (being coterminous with upper and middle classes), especially of banyas got consolidated further.

While the above data is only for a single year, the trend over time would show similar adversity for SCs and STs if not worse, assuming that the affirmative action policy has had some impact in accessing jobs and education enrolment by them in atleast public institutions. In Table 2, an abstract profile of health professionals for Maharashtra for 1991 is compiled. This shows that even in a developed state like Maharashtra which has seen many reform movements and has a politically strong dalit movement the deficit among SCs and STs as health professionals is very high – similar to the 2001 India average.

So it is clear that the impact of affirmative action for becoming a health professional is very limited and the predominance in this profession of upper castes continues to rule.

To conclude, the adverse experience of dalit and adivasi doctors, nurses and other health workers is reported regularly by the media. An excellent documentation of the personal experience of a dalit cardiac surgeon from Maharashtra reveals how difficult it is for dalits to get into the profession and when they get in, to survive. (Dr. Ashok Bhoyar, *My Encounter with Dronacharya*, Sugava Prakashan, Pune, 2001). The dalits and adivasis suffer a double adversity of their social disadvantage as well as their class position and unless there is radical transformation in the structure of medical education and the healthcare system on one hand and the social discrimination based on caste on the other we will not witness any progressive change.

**Table 2: Caste Profile of Health Professionals and Paramedics in Maharashtra for all non-agricultural Workforce**

Source: Maharashtra Census 1991 Economic Tables B-21 and SC & ST Special Tables

Maharashtra Census	1991 Persons				Variance from population proportion		
		%SC	%ST	% Other	SC	ST	Other
Physician & Surgeons*	92419	5.27	1.59	93.14	-49.57	-62.75	9.21
Nurses, Midwives & Paramedics	131178	14.32	3.33	82.35	37.11	-22.06	-3.44
Medical Scientists	8535	4.93	1.58	93.48	-52.77	-62.93	9.61

\* Includes pharmacists and nutritionists, who in 2001 census are part of paramedics

## Invisibility of Caste in Nutrition Perspective

-Veena Shatrugna<sup>1</sup>

Caste, and gender came knocking on the doors of disciplines like nutrition ever so often, but sadly no one saw or heard these pleas, or even tried to make space for a different thinking. Science with all its limitations arrogated to itself the responsibility of planning for a nation, in the area of food and nutrition.

My first exposure to caste and nutrition, which occurred in the 1970s, is still etched in my mind ... it was a meeting of the Nutrition Society of India at NIN in 1977. I think it was a meeting of top notch experts from India and from abroad. The ICDS program had been launched in some parts of the country with much fanfare; after all it was going to provide 300 kcal and 10 gm of protein to pre-school children, based on a meticulous scientific calculation of the calorie deficit, and a formula called the Hyderabad mix had been prepared to address child malnutrition. (Hyderabad mix contained cereal, pulse, ground nut, sugar, milk powder, with nutrition advice about adding carrots, and greens to the preparation.) It had been successfully tried out in some rural areas around Hyderabad. Milk powder was withdrawn very soon because of its expense. The meeting had reports on the ICDS program, but there was an unease, in speaker after speaker who reported the 'small' problem that the upper caste children refused to eat with the Dalit children, or that the cooks were Dalit, and not acceptable to the majority of the village population. At the other end Dalit children were also barred from entering the ICDS centres located in the main village.

There was irritation, and disbelief - no one had foreseen this. They protested that these were not scientific questions. No one had a solution to this insurmountable problem either.

For the well-meaning scientists the worst was yet to come. The very next year a new problem had arisen,

beneficiaries (as the children were called) were seen carrying the ICDS food home to share it with their siblings. This had the potential of completely derailing a national program. There was talk in hushed tones that this ICDS food was proving to be a substitute for home food and not a children's diet supplement as planned by nutritionists.

A scientific construction of a food supplement based on calories and proteins for a child, in the age group of 1-6 years did not factor in the culture among Dalits, and among others in the villages, which encourages children to 'share food with others present' and definitely with siblings. It is perhaps this sharing which helped the rural population survive the ravages of repeated famines over many years; but this very practice had the potential of ruining the careers of nutrition scientists. Food sharing did not last very long, because over time the food became inedible and fit for animals.

The other fact, which came as a shock to the scientists was that children 'preferred' eggs to the insipid fare doled out to them. The demand for eggs was often dismissed by state governments as illegitimate and against Indian culture. Another proposal to introduce eggs and milk in the ICDS based on the UNICEF Reports which recommended that children be provided with milk and other sources of animal protein for growth, was seen as 'not feasible'. The confidence in science which did not see beyond 300 kcal helped authorities ignore the recommendations of UNICEF too. An earlier attempt at investigating the vegetarian RDA constructed for a nation where over 70% eat flesh, fish and eggs was seen as an attack on the Scientists who put India on the map of Nutrition Research (mfc bulletin, No. 355-356, Mar-June 2013).

No one thought it fit to investigate the eating cultures and desires of the poor. No pilot survey was done to

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find an acceptable food for one of the largest feeding programs in the world. Even the timing of the ICDS was proving to be a problem because women had to go out to work early, and there was no one to bring the child to the feeding centres. Instead a whole nation was held to ransom by the rigid rules and of course in the name of our vegetarian culture, even if that meant over 40-60% of our children would continue to be classified as malnourished (< - 2SD weight for age and height for age).

The scientists attending the review meetings appeared helpless in the face of what they believed were assaults by the community, largely drawn from the poorest Dalit and BC backgrounds. This continued year after year, stories of 'subversion' by a caste and class who should have actually behaved like thankful recipients of this program. It was a shame that they (recipients) did not recognize the benefits of a Government supplementation program, and nothing could be done about it. No one had a solution to this problem nor did anyone suggest that they should talk to the people for whom the programs had been prepared.

A program like the ICDS was sacrificed because the Nutritionists, bureaucrats and planners did not see the role of caste, class, eating culture and other social variables impacting nutrition in India. This symptomatic refusal to consult the poor either about their eating cultures and desires, or about how to make the program succeed, points to a larger problem: the scientists felt that it was unimportant to give credence to the opinions of the poor because a) they had no say in the matter because they were beneficiaries of a welfare program; and b) because given the caste/class correlation, most of them belonged to the 'lower castes', whose lives and cultures were not worth investigating anyway. Thus, while the social problem of discrimination existed in relation to interdining among Dalit and non-Dalit children, an administrative problem of discrimination comes into view against asking 'beneficiaries of state charity' what they actually needed.

Over the next 10-15 years (during the 1980s and

1990s) "feeding programs" had lost their charm – and not only because children shared the supplement (by now it was made of some rancid soya bean, cereal and little sugar, and in any case less than 25% of kids ever came to the ICDS centre, and most of the time this inedible supplement was fed to the cows.). There was the larger problem that anthropometric indices reflecting under nutrition were proving to be an embarrassment for India. For example,

- a) Mean Birth Weights in the country were stationary at 2.7 kg with 30% of the babies Small for Gestational Age
- b) Anaemia prevalence was at 60-80% in children, men and women.
- c) Percentage of children who were underweight and stunted hovered around 45-50% in the <6year group.
- d) About 30% of adults, men and women, had BMIs <18.5.
- e) And a new 'index' called wasting was rearing its head.

Around 75% of the population could be classified under any one or more of the above categories. That left very few 'normal' children.

However, one of the main reasons for loss of interest in the program was that the nutrition data generated by the NFHS and the NNMB was proving to be an embarrassment. It was used largely to rank state governments, and even countries on different scales of hunger and deprivation by the World Bank and other international agencies like the WHO, UNICEF FAO, and India ranked among the last few countries.

Nutrition had also lost its sheen because the country was euphoric with the arrival of the corporate health care due to liberalization at one end, and the working of the DOTS Program, Pulse Polio and newer techniques in Family Planning at the other. In other words, privatized clinical care and public health modeled as selective intervention removed the emphasis from building the population's health



through sustained comprehensive care.

The social questions like caste and gender continued to create havoc, and remained invisible to the scientific eye. Most of the scientists were still unwilling to accept that the Dalitwada was located outside the main village, or the fact that upper caste children were not allowed to eat with the Dalits, or that the ICDS centres and government schools were located in the main village, near the Panchayat President's (PP) house, or that the ANM visited the village only to camp outside the PP's house expecting the pregnant mothers to come to her for their check ups and tablets. No one dare ask her to come to the Dalitwada! As expected Dalit women who were pregnant did not seek the ANMs help at the PP's house. It was but 'natural' that the main village inhabited by the privileged upper castes, had access to public services like roads, water, electricity, schools, Anganwadi centres, etc.

It was true that sciences like nutrition and health did not include a study of caste, gender, rural urban divide, and other social variables. Nor was the medical profession ready to soil their hands with these issues. They were convinced that caste did not operate in the sciences, in any case it had become illegal, and therefore non-existent with Independence and the Constitution of India. They could not see its new forms. The failure of the ICDS was a non-issue; it was seen as a failure of the implementation agencies. The scientists from NIN, Baroda, Delhi and other centres were convinced that implementation of nutrition programs was not their job. (This stand is evident in the minutes of the NSI meetings in the 70s and 80s). It did not occur to them that even space scientists do not rest till the rocket takes off and starts sending back data! Perhaps it is easier to work with inanimate materials like alloys, rocket fuel, and even gravity than with caste in India.

Meanwhile caste was reluctantly introduced as one of the social variables in the NNMB survey reports of 1994-95, after the Mandal Commission Report. But there was nothing to cheer about. Nutrition data which was caste blind till the 1980s and 1990s,

does appears for the first time in 1994 but in a new avatar. The data presents figures for undernutrition in relation to socio-economic variables, because the new software makes it possible to generate 2x2 tables which show linear relationships of caste and other socio-economic indicators like land holding, occupation of the head of the household, literacy of the mother/father, availability of toilets, piped water supply, electricity, etc., with severe malnutrition in children, or BMI in men and women or any other index of malnutrition. But the whole exercise exposes the uneasy relationship with these social categories, and ends up paying lip service to the task of mapping caste-wise data. As one tries to understand table after table, caste becomes hazy and eventually disappears, and you remain no wiser.

#### Example

Some details from the latest Report of the NNMB\* are given below (2012, see Appendix, given below). The sample consists of the following-

The results show that a) 48.1% of Tribals and 39.5% of SC women have BMIs <18.5; and then from the same sample b) 40.9% of those in Kutcha houses, 40.2% of landless agricultural labour, 40.7% of non-literate, and 46.7% of those with per capita incomes less than Rs. 300 all also have BMIs <18.5,

No. of Households	23,889
Total Population	86,898
Number of Women	32,295
Number of Men	24,130
Total no. of Children <6 years of age	9038
Girls	4437
Boys	4601
Total number Girls and Boys 6-17 yrs	21,037

you are left wondering. How many Dalits, are landless agricultural labour, are landless, and/or have incomes less than Rs.300/month, and/or are non-literate and simultaneously have a BMI below 18.5? Surely Dalits must be the majority among those with no land, or the agriculture labour, or with no toilets or no piped water. The correlation of BMI with

these multiple variables would focus administrative understanding (and action) on the process of caste based structural discrimination that leads to poor health status. Instead, the correlation tables are like magic - caste is there, but is erased immediately by leaving it disconnected to other indicators, in order to help the nutritionists get on with life and forget the inconvenient problem. The solution is convenient in two ways: one, it avoids any commitment to focused effort to undo caste disadvantage. Two, it avoids the ideologically taboo intersectoral solution to the problem of low BMI: that is, to educate, give proper housing, provide nutrition, and distribute land to take care of the issue in a comprehensive manner.

Thus, my attempt to sift through caste-based data from the latest NNMB 2012 Report has been a learning experience on how the report shirks the responsibility for providing any kind of complete explanation for the nutritional status of the SC and STs.

In conclusion, I would like to reiterate my argument briefly. In the first part of the essay I traced the manner in which caste was never recognized as a variable affecting the ICDS program, leading to its utter failure. This example served to indicate the manner in which nutrition scientists and administrators refused to look at caste in that period. In the second part of the paper, I look at the situation after the Mandal Commission, where administrative data begins to look at caste. Here my example is the NNMB data (2012), where I demonstrate the lack of a grounded and meaningful analysis of the relationship between caste, housing, sanitation, literacy and BMI. It is a shallow analysis, which while paying lip service to addressing the problem of caste, carefully avoids solutions that run against neoliberal norms of minimal state intervention.

## Appendix

### Women's BMI Status in Relation to Social variables

(Source: National Nutrition Monitoring Bureau (NNMB), National Institute of Nutrition, Hyderabad, 2012)

Total Women in the sample: 32,295

Total no of Women who have BMIs <18.5: 11,238

Community	Total number of women in each Category	% women with BMI <18.5
ST	4233	48.1 (2036)
SC	7300	39.5 (2883)
BC	11437	32.4 (3705)
Others	9325	27.8 (2592)
<b>Total</b>	<b>32,295</b>	<b>34.8 (11,238)</b>

Type of House	Total number of women in each category	% women with BMI <18.5
Kutcha	5617	40.9
Semi Pucca	18,440	37.3
Pucca	8238	24.9
<b>Pooled</b>	<b>32,295</b>	<b>34.8 (11,238)</b>

Literacy Status of Women	Total number of women in each category	% women with BMI <18.5
Non Literate	15,001	40.7
Read & Write-up to College	17,294	28.5-31.5
<b>Pooled</b>	<b>32,295</b>	<b>34.8 (11,238)</b>

Per Capita income (Rs./month)	Total number of women in each category	% women with BMI <18.5
<300	2937	46.7
300-600	7459	42.8
600-900	5910	38.8
>900	15,989	27.3
<b>Pooled</b>	<b>32,295</b>	<b>34.8</b>

Electrification	Total number of women in each category	% women with BMI <18.5
Present	26,233	32.0
Absent	6062	46.8
<b>Pooled</b>	<b>32,295</b>	<b>34.8 (11,238)</b>

Sanitary Latrine	Total number of women in each category	% women with BMI <18.5
Present and in use	12,004	23.5
Present but not in use	664	37.7
Absent	19627	41.5
<b>Pooled</b>	<b>32,295</b>	<b>34.8 (11,238)</b>

## Caste and Medical Education and Reservation

*-Sanjay Nagral<sup>1</sup>*

The inevitable intersection of caste and health care in India could be dissected at various levels. One of the areas that has been and continues to be a matter of vitriolic public debate is caste-based reservation in medical education. The issue of ‘merit’ being compromised has been raised several times. In a situation of relative scarcity of medical seats the reservation policy is perceived as eating into the opportunities available to those from the open category. Even today there are huge tensions in the process of medical college admissions on issue. This debate is of course complex and the terms ‘merit’ ‘opportunity’ in the Indian context are superfluous if viewed in isolation as they often are. But it is an issue that will continue to occupy the minds of young doctors in the making.

Based on my personal experience let me try and present some information which could add an additional element to the discourse. I joined medicine in the year 1979, in a batch of around 180 students in Mumbai’s Seth GS Medical College. At that time the proportion of reserved seats was around thirty five percent. So we had around sixty students from the reserved category. Although I do not have claims of knowing the precise detail on the career trajectory of each and every batch mate of mine, thanks to a spate of recent reunions I have a sense of what most of them are currently doing. From amongst the open category a large number (around 50% to 60% ) are abroad mainly in the US and some in the UK. Many of them have done very well in their chosen fields including in academic medicine. It seems to me that perhaps not more than two or three from the reserved category migrated. Amongst those who are practicing in India a majority from the open category are working in speciality and superspeciality areas in the private sector. On the other hand a majority from the reserved category is into family practice and many have gone back to their local areas to work amongst their communities. Of course as I have already stated

these figures are not based on methodical research, but I believe are fairly accurate. Of course there are exceptions but they are the outliers. So what it means is that if one were to do some kind of social analysis of my batches contribution to the local community here students from the reserved category score over the open category. In other words public investment in medical education has perhaps been better justified by those from the reserved category.

Although it is not my intention to do so, it does not take great analytical skills to explain this phenomenon. I can remember at least five of my batch mates who came from families of textile workers and fishermen. For them their career paths were probably determined by the need to start earning early so as to support their families. On the other hand for many of us the luxury of spending years in post graduate and super speciality training with funding from our parents was a viable option. And for the large number of my friends who migrated to the USA , this was a natural destination determined partly by tradition and partly by ability to take the costly entry level exams. Many of them had family, friends in the USA who helped them in their early days facilitating the process.

So whilst we continue to debate the merits of the reservation policy we could do well to remember that payback to society is one of the parameters that should logically be used to assess its impact. Although I am not aware of any large scale studies on this issue but studies on urban-rural location, migration, etc., could do well to look at this detail. My experience though small and anecdotal is likely to be representative of the larger reality. Whilst we must be willing to debate the role of the reservation policy in fundamentally changing the nature of health care or the social contribution of doctors , the all so common attempt to project a vacuous concept of “ merit” needs to be challenged. On that count the career trajectories of the GS Medical batch of 79 seem to give a small albeit significant message.

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## Medical Education and Rural India: Reflections of a Recent Graduate

- *Abhijit Gadewar*<sup>1</sup>

Medical Education and Rural India - it is a paradox to use these words together. Young doctors are increasingly motivated to move or are forced to move towards our so-called 'civilized cities'. You will be considered a fool if you willingly go to villages. Only 26% of doctors are serving 73% of the rural population. I may not be the right person to criticize the medical education system but these figures are not an illusion. Something is going wrong.

I finished my internship two years back. I got my MCI registration within 3-4 months of completion. Legally I was a doctor but socially and skillfully I was not. Everybody in my batch was studying for PG (post-graduate) entrance. It is a considered self-evident, a dogma, that if you do not do a PG (in any subject whether you like the specialty or not), you are incomplete. I was not convinced. I was confused. I thought and decided to work at least 2-3 years in a rural area. I wanted to explore various places myself. I came to know about JSS and joined within 3 months of my internship. I did it quickly because I was suffocating within the four walls of medical education.

I had some real education at JSS. Preventive and Social Medicine is a subject we hated most in medical college. At JSS, I actually realized what 'social' means. To make aware and to implement the 'prevention' is more difficult than reading Harrison. Tuberculosis is not just HRZE or DOTs. PEM is not just the lack of protein and energy. Malaria is not just giving Artesunate. I realized disease is the manifestation of socially unfair situations and inequity and poverty.

Baba Amte used to say "in relationship with suffering". When I saw a 33 kg woman with TB, I was trying to imagine myself in her place but I could not even imagine. I learnt the calorific value of various food materials at medical college but I learnt the significance of nutrition at JSS. A woman with TB is left by her husband along with three children. There is no source of earning, what will she do? I asked this question to myself and I was baffled. How could you learn this face of TB just by reading it as 'social stigma'? There is a major difference between 'reading' and 'seeing'. Increase in 11 kg of weight after AKT is neither written in books nor taught in colleges. It tells you how much the patient was starved of food. They do not teach Empathy and Approach towards a rural patient. You have to see villages first.

Investigation is one of the most abused parts of patient management. I never came across a thing like rational investigations in medical college. We always used to advise a battery of tests like liver function test, renal function test, etc. Most of the time you do not need those investigations. I learn that a significant amount of expenditure of the patient can be saved and it

stimulates us to improve our clinical skills.

Same with medicines - we learn generic medicines in colleges and while prescribing we use brand names. In college, we would talk among friends, which MR (medical representative) was giving more money or gifts. We see from residents to professors each one is hankering for those gifts. Much of the time they do not even think about the patient. I learnt the importance of cost effectiveness and how it is important to cut the cost of treatment of a poor patient as much as possible. This is why this rational approach is necessary.

I argued with one of my friends who is doing his PG. He blamed the rural folks for not coming on time. I would have done the same thing were I doing PG without experiencing the rural conditions. You never realized the woes of rural people sitting in a tertiary care hospital. A daily wage laborer cannot come on time without making arrangements for money for him and his family. A seven-day stay at a tertiary hospital snatches so much from him. I saw this because I chose to witness it.

Many rural areas in India are still lacking in primary health care. There is no accessibility to hospitals. Many die while coming to the hospital. Many of them become worse on the way to the hospital because of poor roads, poor vehicles and/or no ambulance.

Once I was travelling from one of our mobile clinics to the main hospital. There was an 8-months pregnant woman travelling with us. She was in severe discomfort because of the bad road. Yes I know that I cannot understand her pain but next time when I see in the clinic a pregnant woman coming from a long distance, I will surely show some sympathy for her.

About 2-3 years back students used to prepare for PG from internship, but nowadays it is from the second year. You will be considered incompetent if you have not done PG. During my last year in school, we used to say, "I will be settled once I get admission to MBBS," then during MBBS we say, "I will be settled after PG," and now during PG some say, "there is no point in doing plain PG, you have to do superspecialty." I am confused, do we decide our skills or the degrees will decide our skills? Is this the kind of education that we are getting or are we greedy? Students are 'interested' to work in rural areas when they were plain MBBS but then there is sudden change of attitude when they become PG. At the time of internship some of my teachers used to say "why don't you go and study for PG instead of doing the internship." I am not opposing PG but I surely refuse to do PG without having rural exposure in a country like India.

I do not know whether I have succeeded in explaining the topic very well but the attitude which reflects through my article is what I have learnt. I would not have got it if I had not come to JSS.

<sup>1</sup>Volunteer, Jan Swasthya Sahyog, Bilaspur, Chhattisgarh

## Reservations...a boon?

-Dr. Kunal Mhapankar, SMO, WHO

Reservation...a word that shapes the futures of many individuals...a word that has the strength to play with the ambitions and dreams of many innocent individuals and modify the path of their lives.

Before we analyze the positive and negative aspects of reservations, it is imperative that we understand the basis as to why this was made an integral part of our constitution. However, this would be impossible until we untangle the threads of our vast history. The varna system which was predominant in Hindu India from the medieval ages divided all human beings into four "varnas". Though it is a common notion to believe that a man's varna was decided solely by his birth, one can find innumerable examples demonstrating that a person could achieve whatever he desired based on his abilities and merit. To cite one of them, Vidura, who was born to the lady in waiting to the queen of Hastinapur was appointed prime-minister of the same kingdom as he possessed.

I would like to mention a few examples of my personal experiences during the course of my medical education. I am amazed by the fact that even after thirteen long years of going through the ordeal of securing admission in medical college, the memories continue to be an integral part of my consciousness. The basic concept behind implementing the concept of reservation was to bring an equality in the social fabric of India. However, what comes across in medical colleges is just the opposite. The fact the child of a rich landowner secures a free seat with a moderate rank against a middle class individual with a good score is very difficult to erase from the minds of individuals who face these circumstances. To add to the discontent is the fact that individuals securing admissions in the reserved quota are also entitled to free usage of medical books for a whole year at the cost of the college! When I sit back and go down memory lane, incidents such as clicking photos of "SC" group and "ST" group and "Brahmin" group during traditional day celebrations always succeed in amazing me. It compels me to think about how this whole reservation process has managed to further increase the divide between the different "castes". It may sound funny today and probably unbelievable too, but to my utter surprise, the first question asked to me by my seniors in medical college was my caste! And lo and behold...there began my quest to search the sole identity of my personality!

A recent episode at a medical college in north India should serve as a wakeup call for our policy makers. A large number of students belonging to the SC/ST category were failed deliberately by the department of physiology. Indeed it was a cruel deed and it does portray the professors and other staff in bad light. But has anyone tried to figure out as to why did this happen? Why were the professors against a certain section of students? Was it anger? Was it jealousy? This is just one of many examples which emphasize the fact that reservations have not only managed to bring about a divide among medical college students but this though process has started to haunt the faculty as well.

Article 15(4) of the constitution of India mentions about providing equal opportunities of receiving education to all the citizens whereby stating that nothing shall preclude the state from providing facilities to the educationally backward "sections". While analyzing this statement, it is natural for us to think that after the long history of reservations both, pre and post-independence, the earlier oppressed castes must be educationally more potent with all the facilities and benefits provided to them over the years. Then what should be the next step? Should the reservations be reversed for the earlier "upper castes" now? And then what should be the agenda fifty years down the line? The entire cycle be repeated? Does this sound logical? If yes, then what have we achieved over the years with the reservation system? And if no, then why should only ones section continue to benefit from the provisions of the constitution?

It is the call of the hour to change our policies; change our policies in such a way that the true and just meaning of the constitution is implemented. There is enough documented evidence demonstrating the marginalization of certain sections of the Indian society in the past. The cruel history of untouchability cannot be erased from the pages of Indian history. But does the current generation have any role to play in this? Is it necessary that innocent individuals of the present pay for something that their ancestors may or may not have done? Do we have to give in to the vote bank politics played by certain political leaders to their own advantage? I am sure that most of the young mind would say no to this.

To address the problem at the grass root level itself, the government needs to pay attention to the state of public schools in the country, which along with free education should provide quality education as well. This would go a long way in ensuring that a student from a village will feel confident enough to take the entrance exam as that of a city student having access to schools providing all the facilities. Wouldn't it be nice that an independent body be appointed to assess the economic status of individuals applying to medical colleges. Or for that matter any educational institution and provide the needy ones with funds and grants rather than reserving seats for them without paying heed to merit at all? Many students falling within the "reserved caste" category start taking things for granted when they feel assured that seats are reserved for them no matter what their score is. At the same time many students who don't fall within the reservation criteria get demotivated at the beginning itself thinking about their bleak chances of securing a seat in medical colleges.

To summarize, reservation is a very crucial issue that needs to be tackled urgently and in a very sensitive manner in order to prevent the possible negative effects it may lead to in the near future. A merit based system with adequate emphasis on economic background would ensure that deserving candidates secure a seat in medical colleges and the batch passing out each year would be charged with motivation and dedication to serve the Indian society.

## A Snapshot of Health and Nutrition of the Ageing/Elderly Poor

*Survey of 102 Participants of Pension Parishad Dharna, December 2013, New Delhi*

### **-Public Health Resource Network and Pension Parishad<sup>1</sup>**

#### **Pension Parishad**

The Pension Parishad comprises over 200 organisations and groups from across India who are in agreement that how we treat the elderly speaks about the kind of society that we live in and that the rights of the elderly to live with dignity must be recognised and ensured. The elderly constitute 8.2% of the total population. About 10 crore people live either alone or with their husband/wife. Working class people migrate in search of work. Others struggle to eke out a living. The elderly are often left behind in the villages. They often do not have the physical and financial support of younger family members. Since as they have contributed to India's growth during their working lives, Pension Parishad believes they should be entitled to a pension from the Government.

#### **The Elderly and their Demand for Pension**

According to a Government of India 2011 report<sup>1</sup> about 65% of the aged and elderly<sup>2</sup> depend on others for their day-to-day maintenance. Less than 20% of elderly women and majority of elderly men are economically independent and nearly 40% of persons aged 60 years and above (60% of men and 19% of women) are still having to work. In rural areas 66% of elderly men and above 23% of aged women are still participating in economic activity, while in urban areas only 39% of elderly men and about 7% of elderly women are economically active.

Under these types of circumstances, the demand for universal old age pension is one of the key demands of the Pension Parishad. The demand also developed from the experiences and needs of various marginalized communities indigenous communities, internally displaced, Dalits, cycle rickshaw pullers, forest dwellers, agricultural workers, construction workers, waste pickers, re-cycling workers, daily wage workers, NREGA workers, rural artisans, saltpan workers, domestic workers, sex workers, transgender, disabled, MSMs, street vendors, fish workers people living with HIV and innumerable other workers in insecure and precarious employments who live a hand to mouth existence.

Various Government of India reports acknowledge that informal unprotected workers constitute 93 per cent of the workforce. The National Commission of Enterprises in the Unorganised Sector estimated the contribution of the unorganised sector to be 50 per cent of the country's GDP (NCEUS, 2008). Humanitarian considerations apart, it stands to reason that unorganised, informal workers in often precarious

livelihoods and occupations who have contributed to India's growth during their working lives should be entitled to a pension and health care from the Government. The Government of India provides a measly pension of Rs.200 per month only to those who are listed as being below the poverty line. Some states supplement this through state resources. The combined expenditure of the states and centre on old age social pensions was Rs.14,370 cr in 2011-12. Compare this with Rs.1,66,169 crores which is what the centre and states combined spend on pension and benefits of retired government employees. The inequity needs no further elaboration and really has no justification.

#### **Health Survey**

Pension Parishad organised a basic health camp as part of the dharna at Delhi on Dec 16-18, 2013. The purpose of the health camp was to understand the health and nutritional status of the participants who had spent more than 20 days during dharna in the bitter Delhi cold. The health checkups was conducted by teams from various fraternal organisations and networks; the Mobile Clinic from HelpAge India and a doctor from Public Health Resource Network. Investigations were carried out free of cost by Fortis and conducted by Super Religare Laboratories (SRL) Diagnostics as part of their Corporate Social Responsibility. Public Health Resource Network and Pension Parishad were responsible for overall coordination, documentation and analysis.

The health checkups mainly included a general checkup, recording of weights and heights, Blood Pressure, estimation of Total Serum Cholesterol, Haemoglobin and Blood Sugar Random. Body Mass Index (BMI) was calculated for each individual based on height and weight, which reflects their nutritional status. Medicines for common symptoms such as chest congestion, cough, influenza, head ache and body ache not exceeding a week were dispensed by the HelpAge mobile clinic. HelpAge also provided a fortnights iron supplements to those with low haemoglobin. A report of the checkups were made available to the participants so that required follow up and further investigation could be assisted when they got back home.

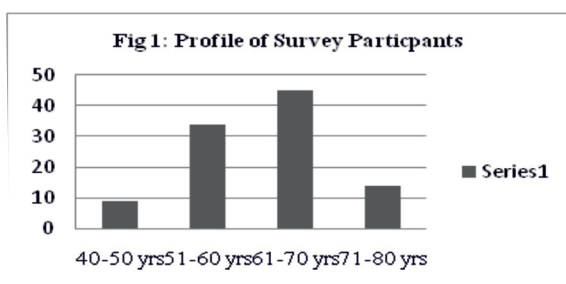
#### **The Sample**

At the outset, it must be clarified that since this was a convenience sample of people attending a dharna of over 2 weeks; in bitter cold, living on a pavement, following substantial travel, the sample is biased

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by the fact that only the relatively well elderly are participants. Results must be interpreted keeping this fact in mind.

A total of 102 participants in the age group of 40 – 80 years consented for the health checkups, with participants from four different States across the country. Sixty two participants were from Rajasthan, 35 from Bihar, 3 from Maharashtra and 1 from Gujarat. The sample comprised of 48 men (47%) and 54 (53%) women. Out of these a majority of participants (81%) were elderly persons belonging to the age group of 60-80 years. Figure 1 provides an age wise distribution of the participants.



## Findings of the Health Survey

### 1. Nutritional Status: Weight

The findings on weight were dramatic with the average weight being only 46.7 kg (avg wt men 49.4 kg and women 44.2 kg). The weights ranged from as low as 28 kg to 80 kg. the distribution of weight by age and sex is further described in the table below. Altogether, 3/4<sup>ths</sup> of the people weighed less than 50 kg and nearly 1/4<sup>th</sup> less than even 40 kg.

Since stunting due to chronic undernutrition is also common in India, BMIs were calculated as a finer measure of thinness.

### 2. Nutritional Status: Body Mass Index

Classification of nutritional status was done based on BMI, as per World Health Organisation (WHO) standards. BMI classification is provided in Table 1.

The average BMI in this group is 19.1 and ranges from 11.8 to 31.2.

**Table 1: Distribution of Participants According to BMI**

Detail	Total	M	F	40-50 yrs		51-60 yrs.		61-70 yrs		71-80 yrs	
				M	F	M	F	M	F	M	F
Normal	59	25	34	2	3	11	13	8	12	4	6
Underweight	25	16	9	0	0	3	5	12	2	1	2
Severely underweight	14	6	8	0	3	0	2	6	2	0	1
Overweight	2	0	2	0	1	0	0	0	1	0	0
Obese	1	1	0	-	-	-	-	1	-	-	-

The data shows that 40 (39%) persons, comprised of 22 men and 18 women, are underweight. Out of these 40 underweight persons 14 (35% of underweight and 13.7% of total), comprising of 6 men and 8 women, are severely underweight (severe thinness). **The average BMI in this group is as low as 14.8.**

### 3. Anaemia

Anaemia is a common haematological abnormality in the aging population. It should never be considered a normal physiological response to ageing. The causes of anaemia are diverse. Nutritional anaemia and the anaemia of chronic disease is probably the commonest in old age. The WHO criteria for diagnosing anaemia are a hemoglobin (Hb) level of less than 13 g/dl in men and 12 g/dl in women.<sup>3</sup>

The Hb level of 95 participants was estimated and classification was done based on WHO standard. The result shows that 71% of the women were normal, whereas 29% were anaemic and 61% men were normal and 39% were anaemic.

Hb ranged widely from 7 gm/dl to 16.8 gm/dl. However, most values; nearly 70%, were clustered between 10 and 14 gm/dl with nearly 50% lying between 10 and 13 gm/dl, as the lined scatter below demonstrates.

The average Hb level of all participants was 12.8 g/dl and 12.5 for women and 13.2 for men participants. Out of the total 51 women, 15 (29%) were anaemic with an average Hb level of 10.78 g/dl. One woman had an Hb level as low as 7g/dl and 4 women below 10g/dl. Similarly out of 48 men, 17 (39%) were anaemic with average Hb level 11.44 g/dl, with as low as 8.3 g/dl.

Surprisingly the haemoglobin level of the 14 persons with lowest BMIs ranged between 11.9 and 16.8 gm/dl (the highest Hb of the sample!), with an average of 13.8 gm/dl.

### 4. Total Cholesterol Serum

Out of total 102 participants, cholesterol estimation was done for 94 participants. Of these, 23 (24.5%) were found to have high cholesterol (over 200 gm/dl).

### 5. Blood Sugar Random

A random blood sugar checkups was also carried out for 94 elderly persons.

Out of these 94 participants one person was a known diabetic and a further two persons (1 male of 60 yrs. and female of 45 yrs.) had high random blood sugars (higher than 200 gm/dl).

### 6. Blood Pressure

Blood Pressure was recorded for 93 persons, of whom only 9 (9.6% were detected to have high blood pressure).

### Discussion

To do a health survey in the settings of a noisy, overcrowded dharna has obvious limitations and challenges. Those notwithstanding, and considering the fact that the sample comprised of a population of ageing/ elderly poor people who were fit enough to participate in the physically demanding event, the findings are quite dramatic in their pointer to a drastic situation of food insecurity.

Of these relatively well people, 13.7 % had BMIs less than 16 – a situation that is classified as one of not mere “thinness” but starvation.<sup>4</sup> Starvation demands from the administration immediate action and the implementation of “mandatory protocols for intervention for relief, prevention and accountability” as per the Supreme Court Commissioners for the Right to Food,<sup>5</sup> whereas these vulnerable people have been found living on the pavements of the capital demonstrating for the right to live with dignity.

In all, 39% were significantly underweight with BMIs less than 18.5. Considering the fact that the elderly are dependent upon others for their expenditures on food and health (ref status report), this is hardly surprising.

The findings on anemia, with 34% being anemic are consistent with other studies<sup>6</sup> and tend to corroborate the general findings of nutritional and health insufficiency. However, there appears to be an overestimation in terms of actual hemoglobin levels with averages which are higher than expected from previous experience even while it is understood that hemoglobin levels tend to be higher and anemia milder amongst the elderly. There is also a remarkably poor correlation with underweight which cannot easily be explained even while it is understood that many non-nutritional causes of anemia exist in the elderly.

None of these underweight people seemed to be suffering from any acute illness from the records of their health check during the survey and past history. Thus their nutritional status is unlikely to be the

result of some acute medical condition. However, TB and other chronic diseases cannot be rule out as underlying conditions, which further raises the issue of the access to health care by the elderly and the outreach to them by the public health system.

The screening for hypertension and diabetes revealed a low incidence amongst this sample as compared with other studies<sup>7,8</sup> the experience and reports of others working with poor rural elderly in a hospital setting such as Jan Swasthya Sahyog, which can be explained by the nature of the sample itself. However, hypercholesterolemia was significant at 24.5%.

While this survey offers only a snapshot of the nutritional status of the ageing and elderly it reinforces the demand for greater focus on the food security and health care of the elderly, both of which depend on economic sufficiency as well as a policy environment that specifically links public programmes to this vulnerable population.

### Endnotes

<sup>1</sup>*Situational Analysis of the Elderly in India*, Central Statistics Office, Ministry of Statistics and Programme Implementation Government of India, June 2011.

<sup>2</sup>The National Policy on “Older Persons” (January, 1999) defines “senior citizen” or “elderly” as a person who is of age 60 years or above.

<sup>3</sup> Iron deficiency anaemia in older people: investigation, management and treatment. Commentary in *Age and Ageing*, 31:87-91, 2002.

<sup>4</sup>Jan Swasthya Abhiyan, Hunger Watch Group. Guidelines for Investigating Suspected Starvation Deaths. Available online at [http://www.righttofoodindia.org/data/guidelines\\_starvation.pdf](http://www.righttofoodindia.org/data/guidelines_starvation.pdf)

<sup>5</sup><http://www.sccommissioners.org/Starvation/investigationprotocol.html>

<sup>6</sup>Saurabh R Shrivastava et al.. Patterns of Anemia in Geriatric Age Group. *JKIMSU*, Vol. 2, No. 1, Jan-June 2013. Available <http://www.jkimsu.com/jkimsu-vol2no1/jkimsu,%20vol%202,%20no%201,%20jan%20-%20june%202013,%2077-81.pdf>

<sup>7</sup>Arvind Kumar Singh et al. (2012). Prevalence, Awareness, Treatment and Control of Diabetes Among Elderly Persons in an Urban Slum of Delhi. *Indian J Community Med.* Oct-Dec; 37(4): 236–239. Available <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3531017/>

<sup>8</sup>Hypertension Study Group (2001). Prevalence, Awareness, Treatment and Control of Hypertension Among the Elderly in Bangladesh and India: a Multicentre Study. *Bull World Health Organ.* 79(6):490-500. Available <http://www.ncbi.nlm.nih.gov/pubmed/11436469>



## Discrimination in Health Care and the Structure of Medical Knowledge

- Anand Zachariah<sup>1</sup>

How does one understand discrimination in medicine from the point of view of the structure of knowledge?

It is easy to understand discrimination in medicine from the point of view of gender, sexual minority, caste, social category or economically disadvantaged groups. Such forms of discrimination are based on socially exclusionary practices of individual practitioners who fall back on age old prejudices in treating (or not) their patients. However there are discriminations that emerge from the very structure of our medical knowledge. These arise from an insufficient understanding of the disease in the local setting, due to the lack of access to an expensively designed treatment, or due to a treatment inappropriate to the patient profile. This article attempts to explore how developments in our knowledge have led to such structured discriminations in provision of health care in India.

### Historical Approach to the Structure of Medical Knowledge

Knowledge is the way we know and understand ourselves. And Western medical knowledge is the way medical people see the patient and understand disease. When we refer to “Western medicine”, we mean modern medicine that was born in Europe and strengthened in Europe and America. It is the mainstream medicine that has been dominant in the West, and now across the world, born of European and Western science in general, its epistemological base, technology, administrative system and overall form.

It is easy to see the evolution of Western medical knowledge, in a progressive manner towards a perfect knowledge or a perfect treatment. However we know that Western medicine or clinico-pathological medicine in the 19<sup>th</sup> century had its birth within certain historical circumstances in Europe, linked to the development of modern Government. These historical circumstances have shaped the nature of medicine. Studies of the sociology of medical knowledge suggest that specific medical and administrative conditions, constraints and facilitations of research, treatment and policy led to the structure of nineteenth century medicine. These are studies that show how broader social and cultural factors of that time shape our present knowledge of medicine.

Immediately after the World war II, the Labour Government in England established the National

Health system and within a decade all the other European Government s followed suit. The right to health and health care became a commitment that no Western Government could refuse. The substantial state funding of health care in US, UK and Europe led to hitherto unimaginable therapeutic advances and resulted in what is today tertiary care or specialty medicine. A large number of specialties came into being with different diagnostic and invasive treatment technologies: cardiology is associated with the development of angiography in the 1950s, pulmonology with pulmonary function tests and bronchoscopies and gastroenterology with endoscopy in the 1960s, nephrology with dialysis in the 1970s, haematology with bone marrow transplantation in the 1980s, and so on. These treatments were designed for the health system in the West, for their patients and at a cost that they could afford. However they became the world standard scientific practice. (However, today these treatments are becoming too expensive even in the countries within which they were designed).

Allopathic doctors in India today are trained in a form of medicine that arose in another culture and context [the West]. The model of medicine that doctors are trained in encompasses both technical knowledge (knowledge of physiology, biochemistry, clinical signs, etc.) and social knowledge. It assumes a social context and a health care context of the West. When these practices were transferred to contexts such as India, they carried with them problems of both cost and appropriateness.<sup>1</sup> So the question is, which bits of Western medicine are generalisable and which not? How much of that is relevant to a local culture and context? So there is a problem of translation - translation of a Western medical knowledge to another social context.

### Development of Specialty Medicine in India and the Profile of Medical Practitioners

From the 1950s onward in India, we have witnessed the development of medical superspecialisation originating from and mirroring similar trends that occurred in US and Europe. During the period 1950-70, the specializations of Cardiology, Cardiothoracic surgery, Neurosurgery, Urology and Nephrology, Gastroenterology became established in medical colleges, with their associated training programmes. In the 1980s and 90s, Haematology, Hepatology, Endocrinology, Medical Oncology, Medical Genetics, Pulmonology and Rheumatology

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became separate disciplines. Doctors who were trained in Western settings, came back to develop these specialties in premier teaching institutions in Governmental and nonGovernmental sector such as Christian Medical College, Vellore and All India Institute of Medical Sciences, New Delhi.<sup>2,3</sup> Today, there are 33 medical and 12 surgical superspecialty training programmes - the most prominent of which are Cardiology, Neurology, Gastroenterology, Nephrology, Neurosurgery, Urology, Plastic surgery, Cardiothoracic surgery and Paediatric surgery. The growth of the academic specialization has been important for training sufficient specialists in India. However the development of these specialties in India has duplicated Western origin specialties without being fully cognizant of the realities of the local context and local problems (as we will argue in a later section of this article, "The development of specialty medicine and inappropriate treatments: example of cardiovascular medicine"). The development of these specialties however has provided a large number of specialists to allow for growth of multi-specialty private hospitals.

The development of corporate sector hospitals in the 1980s gave fillip to this specialist orientation, with the development of multi-specialty private hospitals. Till the 1970s, the majority of hospital beds were in Government hospitals. Middle and upper class patients would access hospital treatment in Government hospitals. The scene changed in the next decade, with the arrival of corporate hospitals. The impetus for this seems to be related to the growing number of Indian doctors practising and doing well in the US and the West in general, developing the economic resources, the desire for business and the technical competence to invest in the newly emerging medical industry in India. The neoliberal policies of the Government which provided loans, land, tax rebates, and other subsidies encouraged the development of multi-specialty and corporate hospitals. Starting with Apollo in Chennai, corporate hospitals have grown in leaps and bounds accounting for 70% of the urban health care market with an estimated financial turnover of \$ 20 billion industry in 2010.<sup>4,5</sup> The growth of specialty medicine has been primarily in the private sector which has 75% of specialists and 85% of technology in their facilities.<sup>6</sup> At this time of the beginnings of privatization of the hospital based sector, there appears to be a shift in ethical framework of Medicine from a service orientation to provide medicine to common people, to that of a market orientation for accumulating profit through the provision of health care. In the last 30 years, the Government has shifted from being the main provider of hospital based care, to providing

"basic treatment" for those who cannot afford private hospital treatment. And modern medicine in India has become synonymous with specialty medicine and superspecialty hospitals, for those who can afford private health care.

There are two parallel movements here. One, specialist medicine in India becomes *sine qua non* to good medicine. The second, market forces in India take rein of specialty medicine to expand it into a business mode. As a consequence of specialty medicine in India over the last 50 years, our cities are over populated by super specialists. And the desired aim of young medical graduates today is to become superspecialists.

### **Lack of Emergence of Family Medicine and General Practice**

Simultaneous to and in contradistinction with the evolution of specialty medicine in India, has been the sheer underdevelopment of "primary care" or "family medicine". In most countries of the world there have been significant attempts to develop a large corps of multi-competent primary care physicians known as "family physicians" or "family practitioners". In a move away from the specialist orientation of tertiary care, family medicine in most countries has developed as an important specialty. Underlying this move has been the acknowledgement that primary care requires a different kind of expertise from tertiary care – one that is as specialized in handling a range of clinical problems, with understanding of the patient and the context.

In the UK, the first country to provide universal health care, the National Health System was based on the concept of the Family Physician who provides primary care to the entire population. The specialty of family medicine in this country was developed to train sufficient and appropriately trained Family Physicians for the health service. In all 50% of the students in the medical schools become Family Physicians for the health service. Family medicine consultants have equal status and remuneration as any other consultant. Even as specialty medicine developed in this country, the health system has been able to provide universal health care through the family medicine model.

In India, the discipline of "Social and Preventive Medicine" was renamed "Community Medicine" in the early 1970s. In some medical colleges, community medicine departments had their own service areas, where they delivered primary and secondary health care and performed developmental health activities. However in most medical colleges the community medicine departments had only nominal links with urban and rural health centres and faculty and PGs

had little involvement in clinical care. The average MD Community Medicine postgraduate today has little clinical competence and could scarcely be called a Family Physician. However the proponents of the discipline of Community Medicine continue to maintain that Community Medicine encompasses Family Medicine.

Family medicine or the discipline of primary care is yet to develop as a discipline in India with its own training programmes and career opportunities in the health system as the box on the following page explains. The point being made is that Medical Council of India, the Ministry of Health and the health universities have expanded the disciplines of specialty medicine without planning the development of the discipline of primary care. The health system within the country has not developed a good model of primary care, with sufficient career opportunities for trained primary care physicians. Both these together have led to the underdevelopment of primary care in our country. [References for box below.<sup>7,8,9</sup>]

#### **How does Lack of Development of Primary Care Constitute an Active Discrimination?**

Today there are 49,919 MBBS seats and 24,201 PG seats in 381 medical colleges. Today there are 633,000 medical doctors who are registered with the state medical councils. The doctor to population ratio in India is skewed towards urban locations and against rural, tribal and hilly areas and better performing states have thrice the number of doctors compared to poorly performing ones.<sup>10</sup>

There is a lacunae of doctors working at the primary and secondary level (in primary health centres, 6.5% of doctor's posts are vacant and in secondary health centres, 49.9% of specialist posts are vacant).<sup>11</sup> In a health system, 95% of illnesses should be taken care of by a primary care physician who would form the majority of the doctors. Patients should be referred to specialists where the primary care physician cannot take care of the problem. The lack of doctors in rural areas and at the primary and secondary level is resulting in lack of access to and poor provision of health care.

Two examples of discriminatory effect of specialization on health care in rural areas are related to blood transfusions and ultrasound examination.

With the HIV epidemic and legislation to regulate blood banks, transfusion therapy requires registered blood banks and qualified clinical pathologists. In small rural hospitals without blood banks, women are dying of antepartum haemorrhage, as the hospitals are not able to cross match and transfuse without an authorized blood bank. The regulation has simply made this vital life support in distant locations scarce.<sup>12,13</sup>

Ultrasound has become a vital and inexpensive tool particularly in obstetric care. With laws on sex selection, a trained sonologist is required perform ultrasound examinations.<sup>14,15</sup> Radiology is the most lucrative specialty and it is hardly likely that a radiologist would want to work in a rural hospital. The world over ultrasound machines are being seen as an

#### **What is the need for Family Physicians in India?**

It is estimated that there are 250,000 doctors who are in general practice either in the Government or private sector, though they have received no specific training in this discipline.

There is a critical lacuna in the specialist availability at the district and sub-district hospitals as well as CHC and PHCs. The current position of specialists manpower at CHCs reveal that out of the sanctioned posts, about 51.9% of Surgeons, 43.6% of Obstetricians & Gynaecologists, 56.6% of Physicians and about 56% of Paediatricians are vacant. Overall about 49.9% of the sanctioned posts of specialists at CHCs were vacant and there is a shortfall of 6110 specialists at this level. It is arguably true that a well trained MD Family Medicine postgraduate will be able to function in the place of these 4 specialists at the CHC level.

Based on the number of community health centres (3222) in the country, we estimate that the total number of Family Physicians to man all the CHCs should be approximately 3000. In addition there should be one Family physician for every district hospital, which would require an additional 640 MD Family Medicine graduates. Since the size of the private sector is 4 times that of the public sector, we estimate the private sector would require 3-4 times the number in the public sector (approximately 10,000) family physicians. In total we estimate that the total requirement of trained MD family physicians should be 14,000.

Today, there is only one medical college in the country which offers two seats for MD post-graduate degree in Family Medicine. The Diplomate of the National Board offers a 3 year postgraduate course in the specialty with 108 seats. The institutions running DNB in Family Medicine are non-teaching hospitals in the private sector. Currently there are about 400 DNB postgraduates who are in the pipeline. This contrasts to a total of 18,414 MD/MS seats, 3935 Diploma seats and 1852 DM/MCh seats.

extension of the examination hand, and will become an essential tool for every practicing physician. The inability to perform ultrasound examinations in rural hospitals can affect critical decision making in obstetric care.

Both these examples, which are doubtless standardization measures, make it impossible for a doctor to function without a level of sophisticated support found only in specialty hospitals. Overall, these steps worsen the lack of a functioning health system and result in poor patients accessing tertiary care in private hospitals leading in substantial indebtedness (12 million or approximately 1% of India's population falls below the poverty line as a result of catastrophic health expenditure). Hence this is not simply isn't a passive matter of doctors not willing to go to rural area or 'inequity' or inability to pay, but of a conscious and active development of the field of medicine in India in a way that creates more specialists and less generalists. It also results in health set ups in rural areas with work conditions that are less than conducive. In the end, it makes for a health care that is inaccessible to the poor. This is a problem not of Western medicine per se, but the problem of transfer of specialty medicine into India, without proper translation.

#### **Development of Specialty Medicine and Inappropriate Treatments: Example of Cardiovascular Medicine**

India is in the midst of a twin cardiovascular epidemic, one epidemic among the rich reflecting the epidemic in the West, and another among poor. The epidemic among the poor is actually larger than among the rich, reflecting increase in slum population, high rates of hypertension, smoking, poor diet and high stress. Today cardiovascular deaths are the most important killer in the adult population.<sup>16</sup>

Substantial treatment research in the Western countries over the last 40 years has led to development of effective treatment for coronary artery disease. These include drug treatments, coronary artery bypass grafting (CABG), stenting and thrombolysis. The treatment of coronary artery disease is premised on the availability of cardiologists, cardiac surgeons, coronary angiography facilities and a health system that can purchase drugs for treatment of coronary artery disease.

When Western guidelines are translated into the Indian setting they result in the problem of lack of access and inappropriate care. Today there over 500 cardiac catheterization labs in nearly every metropolitan city predominantly in the private sector, performing more than 70,000 cardiac procedures every year.<sup>17</sup> Very few

Government medical colleges have these facilities. To provide personnel to these centres medical colleges admit 265 DM students in Cardiology every year, the largest superspecialty training programme in India. In contrast, there are negligible number of cardiologists in rural locations as evidenced by a study of 8 middle size districts across the country.<sup>18</sup> The management of patients with drugs, bypass surgery and stenting is extremely expensive. Hence this Western form of treatment for coronary artery disease is unavailable for the vast majority of patients with coronary artery disease in this country. When poor patients land up in private hospitals, debt due to the high cost treatment can lead to immiseration of families. In some states in a bid to provide universal access health care, state insurance is paying private hospitals for stenting and CABG.

The development of the knowledge of cardiovascular medicine in India has not occurred in a manner that takes account of the epidemic in India. The unreflective transfer of knowledge developed in a Western population and for the Western health systems to the Indian setting has led to a mismatch between the structure of the health problem and that of the knowledge that is being used to address it. These have led to lack of access and inappropriate care of coronary artery disease. In effect, the lack of access and inappropriateness are discriminatory because the profit orientation of super-specialty cardiovascular medicine that does not consider the accessibility and affordability of this treatment for those falling prey to the epidemic of cardiovascular disease among the poor.

Let us contrast this to Rheumatic heart disease (RHD) which is the other main cardiovascular disease in India. Rheumatic heart disease declined in Western countries even before Cardiology became a specialty. Hence the Western discipline of Cardiology has not focused equal attention on Rheumatic fever and Rheumatic heart disease as it has on coronary artery disease. Today we should be in a situation where our wards and OPDs should be free of chronic rheumatic heart disease. It is true that Rheumatic fever is declining and that improved treatments are available for mitral stenosis in the form of Balloon mitral valvotomy.<sup>19</sup> However cardiac surgery centres are still full of cases of RHD requiring valve replacement and RHD is still the cardiovascular case for the final MBBS examination reflecting its clinical importance. It is our argument that a more sustained academic focus on prevention and treatment of Rheumatic fever, could have led to a virtual eradication of the Rheumatic heart disease today in India. The absence of focus on RHD is a clear indication of the

discriminatory structure of medical knowledge and education in India that do not consider it necessary to develop treatments for diseases that have not yet been eradicated in our population.

#### **Lack of Development of Knowledge or Specialization for Significant Public Health Problems: Examples of Poisoning and Snakebite**

Today suicide by poisoning is a major and recent public health problem in young adults.<sup>20,21</sup> The main causes of death in such instances are organophosphate poisoning and aluminium phosphide poisoning. We know that the rates of serious psychopathology such as depression or psychoses underlying deliberate self-harm are low.<sup>22</sup> There is an epidemic of suicide among farmers due to risky agriculture, with high cost of seeds and fertilizer requiring loans, and as a result of debt due to crop failure. There are also large numbers of young people who are attempting suicide due to acute stress, or acute stress on the background of chronic stress, such as love failure, in-law problems, failure in examinations, parents scolding their children -- typically impulsive suicidal behavior. The suicide/parasuicide epidemic in India has to be understood as a developmental disease, a stressed society in the throes of rapid social change.<sup>23</sup>

What are the treatments that are available for poisonings in India? The only known effective treatment in OP is atropine, respiratory support and ICU care. The only effective treatments for Oleander poisoning are charcoal, FAB antibodies treatment and transvenous cardiac pacing which are expensive. Endosulphan and aluminium phosphide poisoning which are causes of large scale death have no effective treatment.

Snake bite on the other hand is an ancient problem. The million death study has shown that about 50,000 deaths occur due to snake bite every year, three fourths of them before patients reach the hospital.<sup>24</sup> Today we do not have a single laboratory test to identify the species of snake that has bitten the patient. While we know that the big four (Indian Cobra, Common Krait, Russell's Viper and Saw Scale Viper) are the main cause of venomous bite, there are snakes outside the big four that cause venomous bites in different regions (for example the Pit Viper of Malabar),<sup>25</sup> that are not covered by the polyvalent anti-venom (ASV). The technology of anti-venom production in India is about 100 years old and outdated when compared to other antibody treatments such as Rabies or Tetanus immunoglobulin.<sup>26</sup> Each of the 8 RCTs conducted on antivenom therapy for snake bite in India have their limitations. It is unclear what the appropriate dose of ASV should be for an individual patient, as

proper dose findings studies are yet to be conducted in the Indian setting. The rates of allergy with ASV are the highest known for any drug in the Western pharmacopeia. The treatment of snake bite is literally from a century ago and does not qualify as a modern treatment.

In the last 10 years there have been only 14 RCTs for OP poisoning, 2 for Oleander poisoning, 8 for snake envenomations and 4 for scorpion envenomation in the region of the Indian subcontinent. Endosulphan poisoning and Aluminium phosphide poisoning have not had a single trial.<sup>27</sup> The body of research on poisonings in India has been miniscule, specially when contrasted to high profile areas such as cardiovascular disease.

All these are indicative of the orphan nature of the problems of suicide, poisonings and snake bite in India. Medical doctors treat them, the media reports them, patients live and die of them. But these diseases do not have respectability for the scientific community, they do not have the moral or cultural force, that demands that a treatment be found. These are clear cases of discrimination against important bodies of knowledge of medicine in India needed to treat a large number of people who suffer and die each year.

The discipline of medical toxicology developed in Western countries around drug overdoses and poisons for the Western setting. However the toxicology of the developing world is one of mega dose pesticide ingestion, plant poisoning with high lethality and snake envenomation.<sup>28,29</sup> If the problem of poisonings that we are seeing is a developmental problem, then we have to develop a science/discipline of toxicology and toxinology appropriate to the problems that we are seeing, and accountable to the people whom we service. This requires the development of evidence base, the rewriting of textbooks and the development of appropriate training. To do this we have to focus our efforts in directing the development of this discipline in a manner that is able to address our local issues in a contextual manner.

#### **Decline of TB, Leprosy, Tropical Diseases as Specialisations and Rise of Super-Specialty Clinical Infectious Diseases and Travel Medicine**

Parallel to the ascent of modern specializations, has been the decline of certain India specific specializations: TB, Leprosy and Tropical Medicine.

#### **TB MEDICINE**

During the period 1950-80, TB developed as a specialty area in chest and TB hospitals with the

postgraduate training programme of Diploma in TB and Chest Diseases. The National Institute of Tuberculosis was created to develop the National TB control programme and the academic discipline of tuberculosis in India. A body of research was developed around TB epidemiology, laboratory diagnosis, treatment and prevention. The Tambaram study in the 1950s which showed the equal efficacy of domiciliary treatment to sanatorium treatment led to the world wide closing down of TB sanatoria and shift to the outpatient TB treatment programmes. The Chinglepet BCG vaccination trial, is still the basis of world-wide BCG vaccination of children.

The WHO struck the note of alarm regarding the resurgence of TB across the world and advocated DOTS as the universal TB control strategy advocating it in every member country. India too took on the DOTS strategy with the conversion of its home grown National TB control programme to the Revised National TB control programme (RNTCP) in the 1990s. The RNTCP enabled country wide coverage with programme data showing 83% rates of sputum conversion and cure. However independent scientific evaluation of the efficacy of RNTCP is not available. There are serious concerns about the RNTCP regimens such as lack of rationale for category 3 regimens and increased rates of relapse and drug resistance with intermittent chemotherapy.<sup>30</sup> Because of these concerns, WHO has recommended daily TB treatment regimens particularly in HIV positive individuals. However the RNTCP guidelines continue to use intermittent treatment regimens. There is no evidence to show that RNTCP has led to a decline in TB incidence in India. We are now faced with the increasing problem of MDR-TB, XDR-TB and that of TB among health workers.<sup>31,32</sup>

With the promotion of universal DOTS strategy, there appears to have been a decline of TB research in our country. Two recent papers have emphasised the significance of undernutrition as a risk factor for the development of TB and for increased TB mortality and the potential benefit of nutritional therapy in TB treatment.<sup>33,34</sup> Nutritional therapy was an important part of sanatorium treatment, and became obsolete in modern evidence based treatment guidelines due to the lack of RCT evidence. There has been no well designed RCT on nutritional therapy in TB.<sup>35</sup> This lacuna in TB research is indicative of our inability to pursue medical research in a manner appropriate to our context.

## LEPROSY

Research centres for Leprosy established the discipline of Leprosy in India. For instance the Schieffelin

Leprosy Research & Training Centre, Karigiri in Vellore District ran training programmes for doctors, ophthalmologists and orthotists in Leprosy.<sup>36</sup> This was the centre where reconstructive surgery in Leprosy was started, the team approach to Leprosy treatment and early trials of Multi-drug treatment (MDT) for Leprosy. With the dismantling of the Leprosy control programme and the disappearance of Leprosy cases from Government statistics, academic and research capacity in Leprosy have also declined. The Karigiri hospital has become a general hospital while retaining its focus on Leprosy to ensure future sustainability.<sup>37</sup> While Leprosy has declined, there is still ongoing transmission and significant number of clinical cases are being reported with delayed diagnosis.<sup>38,39</sup> There is little emphasis on Leprosy in the current MBBS curriculum. Students do not see this as an important disease and do not have the requisite skills to diagnose and treat it.

## TROPICAL MEDICINE AND KALAAZAR/ VISCERAL LEISHMANIASIS

The Kolkata School of Tropical Medicine was established in 1914 to study and treat tropical disease<sup>40</sup> and is known for several pioneering discoveries such as the laboratory cultivation of *Leishmania donovani* by Rogers and the synthesis and use of urea stibamine for treatment of Leishmaniasis by Brahmachari.<sup>41</sup> The Tropical Institute is the only centre offering the MD and Diploma in Tropical Medicine within the whole country. In the post-independence period this institute has not been able to develop and popularize the discipline to address the specific health problems of the Indian setting.

An example of this inability of premier health institutes to deal with local tropical health problems is that of visceral Leishmaniasis or Kalaazar—which is still a public health problem in Bihar, Jharkhand, West Bengal and parts of Uttar Pradesh. With increasing antimonial resistance, parenteral amphotericin therapy, which is expensive and toxic, is the treatment of choice. Liposomal amphotericin which is the standard of care in Western countries is unaffordable by common people and the health system. This is despite extensive laboratory research, clinical trials and development of cheaper version of liposomal amphotericin in India!<sup>42</sup> It is a tragic irony that the Government does not have an effective prevention strategy for Kalaazar. Although it is a public health problem, Kalaazar is not a “must know” topic in the MBBS curriculum and the majority of students would not have seen or taken care of a case with this condition.

### **Re-emergence of the Discipline of Infectious Disease in the Tertiary Care Mode**

Infectious diseases are the most important cause of morbidity in adults and children in India. However Infectious disease has not developed as a specialty in an India specific manner. Clinical Infectious Disease developed as a specialty in Western Countries around HIV Medicine, Transplant medicine, Oncology, cancer chemotherapy and Hospital acquired infections in the setting of large hospitals. Indian doctors trained in Clinical Infectious Disease in Western countries are returning to develop this specialty in India.<sup>43</sup> They have formed the Clinical Infectious Disease Society and a DM programme is due to begin soon.<sup>44</sup> The primary concerns of this new specialty are on the infectious problems of large specialty hospitals and secondarily on the common infectious diseases at the primary and secondary level.

While there is need for competence in handling specialty infectious disease problems in large hospitals, a crying need is development of competence in management of common infectious disease problems at the primary and secondary level.

### **Conclusion**

It is the argument of this paper that modern medicine in India has not been creative enough to tackle the health problems that it confronts. The blind transfer of the technical knowledge of medicine with a Western epistemological framework to a non-Western setting has led to problems of translation, resulting in high costs of care, lack of access and inappropriate care. There has been transfer of high profiles specializations from the Western countries such as Cardiology, Cardiothoracic surgery, Neurosurgery, Gastroenterology without sufficient re-reading and re-interpretation for the Indian setting. The market through private hospital chains such as Apollo and neoliberal policies of the Government have played a key role in the development of these specializations in a private mode, and in shifting the ethical stance of medicine from a commitment to serve common people to that of "for profit business orientation". Even as Western oriented specialties have found root and a nurturing environment, the development of disciplines which are required to handle priority health problems in India has not taken place. Most importantly the discipline of primary care, and that of Family Medicine, has not developed as has happened in the UK. Disciplines which are required to handle priority health problems such as Infectious disease, Toxicology, Snake envenomation are yet to receive attention. In fact disciplines that were previously initiated to deal with local problems such

as Tuberculosis, Leprosy and Tropical Diseases are now becoming extinct.

Discrimination is not only about how we perceive other people due to past prejudices. The argument of this paper considers discrimination as an active process that arises from the structure and emphases of medical knowledge originating from the West and mismatches between a universal Western knowledge and the local setting. When this medical knowledge originating from the West, loses focus on specific diseases and morbidities of the local setting, those trained in medicine in India lose the interest and ability to treat those diseases or morbidities. This effectively results in improperly understood, inappropriate and therefore discriminatory treatment against those who suffer from diseases that fall out of medical fashion. When such forms of exclusion affect large populations in our country, the great extent of structural discrimination becomes apparent. On the other hand, the positive stress on specific specializations also mesh with preferences for urban clinical locations where the wealthy reside, thus resulting in the absence of medical care for those who need it most in rural areas, and in addition cannot afford it. This is another aspect of structural discrimination that is as invisible as it is pervasive. The crisis of medical care today arises in the manner in which marketized medicine, in the name of liberalization and corporate medicine's ability to develop advanced medical care, actually reshapes medicine in India in a way that is inaccessible to, and therefore discriminatory against, the poor. If this crisis is an active process that arises from our inability to translate Western medical knowledge to our social context, then it our responsibility as academics, teachers and producers of this knowledge in our country to address this structural problem.

### **Appendix**

#### ***A Future Knowledge of Medicine in India: A Way Forward***

This paper is not trying to make an anti-specialization argument. From a historical view point, specializations in the mid and late 19<sup>th</sup> century in French medicine were crucial to the birth of clinico-pathological medicine. We recognize the importance of research and specialization in the development of academic medicine. The argument rather is that the forces of knowledge formation, large hospitals, Government funding, pharmaceutical industry, private health care, insurance, academic bodies, professional societies, evidence based medicine are creating knowledge objects, disciplinary bodies of knowledge that are quickly universalized, without grappling with the local contexts within which they are applied.

In developing our knowledge disciplines we need to ask ourselves, what are our health problems, who are the people we want to service, what is culture of medicine that we want to practice? We need an active struggle and negotiation of academic disciplines with the problems of health of the local setting. An active counter force which works against the grain of the universal assumption of Western knowledge to assert the “local” as frame against which an academic discipline should develop. As an activist counter force it may need to take on the forces that are asserting the universal, funding agencies, international bodies, pharmaceutical, business and evidence based medicine.

Such is the task of development of medicine for India. This medicine cannot be a specialization for the tertiary. Rather it is a *specialization* with a small ‘s’, to provide an appropriate medicine for the common problems. It should not be a primary medicine against the binary of tertiary medicine, against which it will always be compared as third rate. But rather it should be a critical, responsible and thinking medicine. This argument could apply to Cardiology or Nephrology or General Surgery or Family Medicine. A specialization of context, a specialization for and of the subject, a specialization of practice.

This article makes two propositions towards developing a critical practice of medicine in India. The first is pedagogical task and second is the task of research agenda setting.

### Teaching a Contextual Knowledge of Medicine

In pedagogy, the teacher’s role is not just to transmit a body of knowledge related to a medical subject but provide a critical view of the subject. In teaching a topic of medicine it would be useful for a teacher to consider what may be a contextual knowledge, a contextual syllabus and contextual curriculum.<sup>45</sup>

### Contextual Knowledge, Syllabus and Curriculum

**Foregrounding Questions:** What are the mismatches between universal or standard knowledge and cases that present to the local setting and why do these differences take place?

How is the disease and practice of medicine different in the local context?

**Disease definition:** What are the difficulties of the disease definition in the local setting?

**Epidemiology:** How is the local epidemiology different?

**Causation:** Are there local differences in causative factors and pathogenesis?

**Clinical features:** What are the differences between local presentations and the textbook descriptions?

**Lab diagnosis:** What are the locally appropriate tests? How should tests be used in the local setting?

**Treatment:** What is the evidence for applicability of standard treatments in the local setting; what are the problems in using standard treatments in the local setting?

**Prevention:** What are issues of prevention in the local setting?

**Contextual issues:** Cost issues, patient perceptions, access issues, health seeking behavior, guidelines for care at different levels, health system issues

As the diagram below highlights, this critical perspective of knowledge will influence the syllabus, the sites of teaching, the cases that are chosen, who should be teachers, the teaching methods and assessment. (See Diagram 1 below)

### Research Agenda Setting for Local Health Problems

The following is a mapping approach that we undertook towards developing a research agenda setting in toxicology and toxinology for the South Asian setting. We did a mapping exercise as a collaboration between the Department of Medicine at Christian Medical College and the South Asia Cochrane Centre and Network using the following approach (See diagram 2 below).

#### A. Knowledge mapping exercise and defining research priorities

1. Which are the priority health problems in this field?
2. What are the management strategies that are recommended for each of these conditions?
3. What is the evidence to support each of these management strategies?

We did this by preparing systematic reviews compiling and summarizing evidence in relation to each these questions.

- Which are the problems for which we have good treatments?
- Which are the interventions for which more research needs to be done?
- Mapping the areas where there is no good treatment or inadequate treatment. What are potential treatments that may be of benefit?



4. Based on this what are the research priorities?

**B. Consultation of experts:**

Following this mapping exercise we held a consultation of experts from an interdisciplinary background to discuss the evidence summaries and define research priorities, collaborations and research advocacy.

Such an approach could be taken in relation to research agenda setting for other priority health problems,

Workshop documents and recommendations available at: <http://cochrane-sacn.org/toxicology/index.html>

**Endnotes:**

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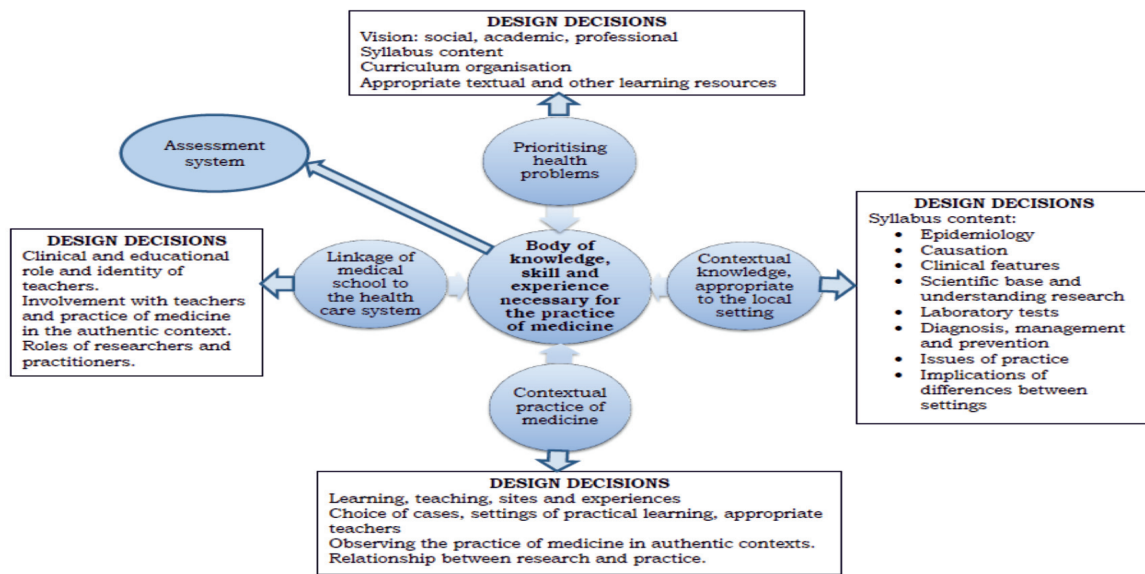
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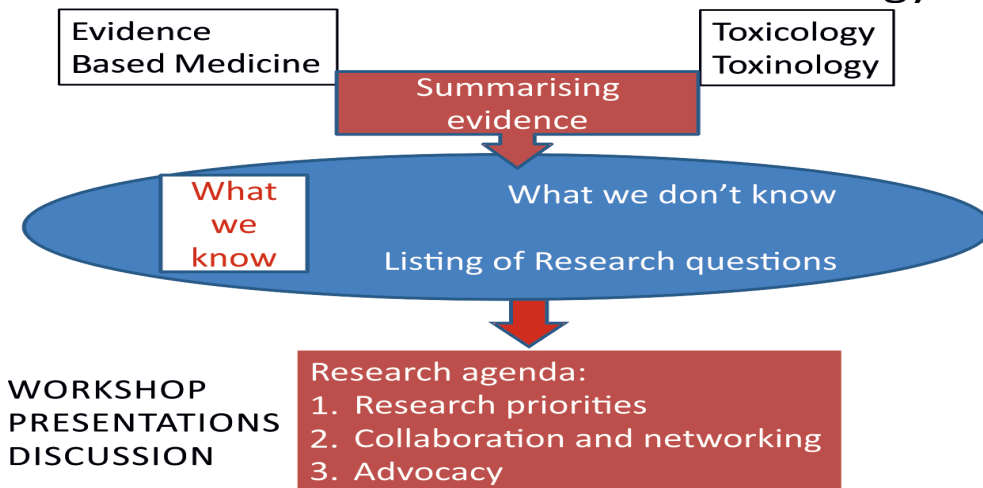
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**Diagram 1: Designing a contextual curriculum (from Curriculum Design in Context in Oxford Textbook of Medicine 2013, Janet Grant, Anand Zachariah and Mohammed YH Abdelrahman)**



**Diagram 2**

**Workshop - a collaboration between Evidence Based Medicine and Clinical Toxicology**



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## Ayush Medical Education: Reflections from History, Policy and the Field

-Devaki Nambiar<sup>i</sup> & Venkatesh V. Narayan

### Introduction

In the 1989 issue of the *mfc bulletin*, Ravi Narayan and Dhruv Mankad carefully laid out a range of theoretical, empirical, and ethical issues related to the notion of medical pluralism, integration and related concepts.<sup>1</sup> Usefully, they also took us through 148 MFC bulletins with an aim to demonstrate ‘open-ended scientificity’ regarding various non-allopathic systems of medicine, raising the work of Banerji, Phadke, Bang, Kelkar, Priya and many others, who elaborated upon the rationales of health culture, the power of ‘indigenous medicine’, the notion of polypathy emerging from a regional MFC seminar in 1977, among other critical contributions.

In most of these explorations, the issue of medical education and training itself is given passing attention, the focus largely being on compatibility and legitimacy (of systems and drugs). This paper seeks to open a discussion on contemporary medical syllabi of non-allopathic systems of medicine – admittedly in a limited fashion – that in part sheds light on these larger issues, but also proposes this as an independent domain of inquiry.

Our motivations extend in part from the Twelfth Five Year planning process, in which a number of critical recommendations were made by a separate Steering Group on AYUSH,<sup>2</sup> and some mention was given to AYUSH integration by the High Level Expert Group on Universal Health Coverage.<sup>3</sup> Drawing selectively from these inputs, the Health Chapter of the final Five Year Plan document encourages, inter alia, greater involvement of recognized non-allopathic systems of medicine (AYUSH specifically) in preventive and promotive health. It also proposes cross-disciplinary learning between modern and AYUSH systems at the post-graduate level, calling, additionally, for a *better understanding of syllabi at the undergraduate level so that collaboration between AYUSH teaching colleges and medical colleges may be facilitated*.<sup>4</sup>

Collaborative medical education pedagogy across allopathy and other systems of medicine is an intriguing prospect, but neither new nor as straightforward as it may seem (though it likely does not!). In the following sections, we provide some context to this proposition by tracing this theme in India’s history, followed by summary findings from a rapid review of course syllabi. We also present interview data from a larger three state study we are conducting on integration of systems of medicine in health services delivery.<sup>5</sup> Finally, we link this to recent research on AYUSH faculty and student perspectives on medical education, concluding with certain provocations

and questions that must be addressed in considering “integrative” medical education in India.

### Historical Perspectives

Medical education in India can be traced as far back as the 7<sup>th</sup> century in the writings of Chinese explorer Yuan Chwang/Hiuen Tang, who described *chikitsavidya* as one of the five subjects compulsorily taught at the primary level and that medical science then went on to be the most developed science of the Hindu civilisation.<sup>6</sup> Ionian medicine or Unani, finds its origins in the third century, entering India by the 12<sup>th</sup> century and thriving in the following years with sovereign patronage, which encouraged collaborative practice and pedagogy of Ayurvedic vaidas and Unani hakims.<sup>7</sup>

With reference to the colonial period, Sujatha and Abraham point out that the integrated medical classes across systems of medicine were discontinued upon the introduction of Macaulay’s Minute on Education in 1835, and further deligitimised by an overemphasis on English pedagogy and a wide assumption that non-allopathic systems of medicine were “closed” and opposed to ‘scientific methods.’<sup>8</sup> They go on to say “The facts that anatomy and dissection as epistemic tools were neither entirely new to indigenous systems such as Ayurveda and that during this period several vaidas and hakims learnt modern anatomy and surgery from Indian or British surgeons and some of them chose to incorporate it into the curriculum in the new Ayurveda and Unani colleges that they established are ignored...”<sup>8(p.7)</sup> Rare historical analysis suggests that ‘Reformists’ in this period explored this “admixture” of medical education across systems of medicine, spurring many debates in the All India Ayurvedic and Unani Tibbi conference, and the inclusion of Urdu translation of terms used in the modern sciences as part of the Unani curriculum.<sup>7</sup> Indeed in the 1960s and 1970s, as pointed out by Sujatha, at least in the Ayurvedic curriculum, the extent of biomedical subjects covered ranged from 50 to 75% in regional academic institutions.<sup>9</sup>

Around this period, the Indian Medicine Central Council Act, 1970 (IMCC Act, for Ayurveda, Siddha and Unani Systems) and the Homoeopathy Central Council Act, 1973 (HCC Act) introduced provisions for the setting up of autonomous regulatory Central Councils [(Central Council for Indian Medicine (CCIM); Central Council of Homoeopathy (CCH)].<sup>ii</sup> These Councils had wide ranging powers to prescribe the courses of study and their duration and the conduct of examinations in medical colleges.<sup>10</sup> As

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<sup>ii</sup> No such central governing body exists for medical education in Yoga & Naturopathy, or Sowa Rigap (Amchi), to our knowledge.

raised by Chandra<sup>11</sup> and elaborated by Abraham,<sup>12</sup> the formation of the Central Council for Indian Medicine was heavily resisted by Shudh Ayurveda proponents, and further, the wide inclusion of biomedical subjects like anatomy, physiology and pathology in Ayurvedic curricula was viewed objectionably by the allopathic fraternity.

Concern over the content of curricula and their revision for quality has been inflected by the mushroom growth of teaching institutions during India's economic liberalisation (for current figures, see Box 1). Under its Tenth Five Year Plan, the Government of India implemented a Centrally Sponsored Scheme "Development of Institutions", under which financial assistance was provided for the development of model colleges, which would exhibit a high quality standard of education. Around the same time, in 2003, the Central Council Acts were amended to require prior permission from the Central Government for establishing new colleges, starting new and advanced courses, and increasing the admission capacity in AYUSH colleges.<sup>13</sup> CCIM and CCH retained control over the setting and revision of curricula and course content: universities' roles were restricted to the conduct of examinations.

In 2006, the Planning Commission convened a Task Force for AYUSH Education, which found the curriculum and course content across systems unsatisfactory, calling for significant improvement.<sup>14</sup> The Task Force concluded further that most AYUSH educational institutions do not provide quality medical education, a feature compounded by poor infrastructure and lack of qualified and committed faculty. This yielded ill trained AYUSH practitioners who lacked knowledge of the fundamentals of the concerned system of medicine, and were unable to practice in accordance with the best traditions of their systems. Specifically, both Under Graduate and Post Graduate courses were described as "blindly imitative of the corresponding courses in Allopathic medicine... to the extent that the very character of the AYUSH systems gets compromised. The load on undergraduate students in terms of subjects and papers at Degree level appears to be excessive and unnecessary when compared to the load for MBBS students. The Allopathic medicine component at Degree level appears to be disproportionately large for no apparent reason."<sup>14(p. 16)</sup>

Under the Eleventh Five Year Plan, apart from supporting 120 proposals of AYUSH teaching institutions (mainly for infrastructural development), financial grants were given to the Regulatory Bodies

CCIM & CCH for activities supporting revision of course curricula with attention to quality.<sup>15</sup> However, gross violations of the IMCC & HCC act regarding issues pertaining to colleges & regulation continue, as pointed out in several letters that have been sent to the CCIM and CCH from the office of the secretary, AYUSH department.<sup>16</sup>

### Rapid Review of Course Syllabi

In a rapid analysis of graduate and post-graduate courses in Ayurveda, Siddha, Unani, and Homoeopathy earlier this year, we found high levels of parity with allopathic medical training, echoing the findings of the 2006 Task Force. For one, there is a uniform five and a half year Degree course which includes one year of internship training. Further, there are three year Post Graduate courses in 22 specialties of Ayurveda, 6 specialties each of Unani and Siddha and 7 specialties of Homoeopathy offered by various colleges. Admission to these post-graduate courses is generally on the basis of a qualifying test, as in allopathy. We did not find any post-graduate courses for Yoga and Naturopathy.

This pattern continued in our review<sup>iii</sup> of web-

#### Box 1. A Snapshot of the size of the AYUSH Education Sector in India

As of 2012, there were 508 colleges conducting undergraduate AYUSH education with an admission capacity of 25,586 students in India. Out of which, approximately a fifth of the intake capacity is in the Government Sector. Across systems, about 41% of the admission capacity comprises Ayurveda and 48% belongs to Homoeopathy. Maharashtra had the greatest number of AYUSH colleges (22.8%), and the highest number of Ayurveda (23.8%) and Homoeopathy (25.9%) colleges in the country. The states of Uttar Pradesh and Tamil Nadu had the most number of Unani (26.8%) and Naturopathy (28.6%) colleges respectively. This report also states that there were in 2012, 117 colleges imparting post graduate education in India, catering to an admission capacity of 2,493 students (over a third of this is in the government sector). Here, again, Ayurveda (60%) and Homeopathy (33%) dominate admission capacity.

**Source:** Department of AYUSH, Ministry of Health & Family Welfare, Government of India. (2012). AYUSH in 2012. Section 4: Medical Education. Available at: <http://indianmedicine.nic.in/writereaddata/linkimages/0208546249-Medical%20Education.pdf>

<sup>iii</sup> Obviously, from our review, we could not ascertain at what depth content from the allopathic textbooks is taught or understood. It is also not clear from these syllabi how they have been revised to address various concerns raised about the content and quality of AYUSH education.

available syllabi (updated as recently as 2012) for Ayurveda, Unani & Homeopathy on the websites of CCIM<sup>17,18</sup> and CCH.<sup>19</sup> From these syllabi, it appears that AYUSH courses remain largely modelled on the MBBS trajectory in terms of subjects, topics, duration and the notion of the internship. Sanskrit & Urdu nomenclature is employed, but course content overlap to a great extent. Additional subjects include languages (eg., Sanskrit) and pharmacology (eg., materia medica). Under the column for reference books, all major textbooks utilized in the MBBS curriculum have been listed in addition to the corresponding textbooks of the specific systems of medicine.

As Maharashtra accounts for the majority of the AYUSH colleges in India (see Box 1 on previous page), the detailed state-specific syllabus available for Maharashtra University of Health Sciences (<http://www.muhs.ac.in/>) was examined. From our admittedly limited perusal of syllabi from easily accessible resources, we came across the following illustrative findings. For one, the 3<sup>rd</sup> year syllabus of Ayurveda endorses the same surgery books as in the allopathy curriculum along with books from the Ayurvedic canon. In another example, the 2<sup>nd</sup> year syllabus of BUMS has a distinct module on modern medicine pharmacology. Finally, for BHMS, the standard MBBS textbooks for subjects are the same as those proposed for MBBS recommended reading.

### Views from the Field

While the Steering Committee on AYUSH Education back in 2006 recommended that universities be tasked with revising curricula, the current health system leadership seems to be of the view that “we should have a multidisciplinary team with CCIM and the Medical Council of India (MCI) to figure out norms. It all starts with science and syllabus.” (Key informant from our study). Indeed the Twelfth Five Year Plan’s Health Chapter proposes that “Details of modification in syllabi that would be required at the undergraduate level, in order to make such cross-disciplinary learning possible, would be worked out by a team of experts from the different Professional Councils. Collaboration between AYUSH teaching colleges and with medical colleges for mutual learning would be encouraged.”<sup>20</sup> (p.42) On the one hand, this move from universities to councils reflects lessons from history, where the greatest impetus for advancement of at least Ayurveda and Unani systems has been when the professional associations took a leadership role.<sup>9</sup> Central Councils, whose mandate includes the development of these fields of medicine and the registration of practitioners, will likely be able to reflect the dominant interests of professionals (as indeed has the allopathic Medical Council of India). On the other, even if such a revision were to be carried out, the reality pointed out in a recent study is that Ayurveda, Siddha and Unani faculties across the

country do not follow a uniform pattern of teaching and patient care, notwithstanding the standardisation inherent in CCIM’s core curriculum.<sup>11</sup> If the history of teaching is any guide, allopathy pedagogy already exists in the curricula of non-allopathic systems of medicine, but is taught in varying degrees, and with variable quality. A study participant from our study in Kerala raised concern that the quality of education of allopathic subjects in non-allopathic institutions may be incommensurate with allopathic medical college training – which means that graduates may not have the skills to practice.

From the perspective of faculty and students, moreover, practical, allopathic skillsets are highly desired: a survey of Ayurveda faculty and post-graduate students (N=124) revealed that students considered their capabilities as that “of nurses and not MBBS doctors,” that the emphasis on practical content was overshadowed by theoretical content in an already crowded curriculum.<sup>11</sup> Unani faculty and graduates (N=55) shared the view that greater emphasis be placed on clinical and practical content, and further, that more content from allopathy be included, as well as clinical research, and that the duration of particular modules in the course had to be adjusted. Further, while Ayurveda faculty and students called for greater integration into central universities and opportunities for practice under the National Rural Health Mission, Unani faculty and students called for exposure to basic concepts of other non-allopathic systems of medicine.<sup>iv</sup> From the perspective of faculty and students therefore, the inclusion of allopathy is seen as a given, diametric to the view of the Task Force on AYUSH education that this overwhelms and undermines AYUSH curricula. In the case of Ayurveda, faculty and students feel allopathic content is an element to be refined and optimised, and in the case of Unani, a module to be expanded. Ultimately, for these stakeholders, the admixture across systems of medicine is desirable, especially given the legitimacy lent to their practice through knowledge of allopathy.

### Concluding Remarks

These survey findings suggest that for at least some faculty and students of Ayurveda and Unani in India, allopathy is the arbiter of their legitimacy. This is in fact the kernel of critique raised by those who feel integrative medical education is a utopian aspiration, bound by unequal relations of power. In our study, the view of a senior official in the AYUSH ministry said of integration: “bringing in allopathy kills the traditional system- dilution of subject. Otherwise two systems remain separate. This is overpowering of one system and engulfing the other.” Moreover,

<sup>iv</sup>Only six Siddha faculty and graduates participated in the survey; readers are directed to the report for these findings (Chandra 2012: 87-91).

in her recent piece on integrative medicine, a veteran researcher on medical pluralism in India indicates that undergraduate training in Ayurveda facilitates the ability to enter into a dialogue in the language of biomedicine, but that “in an interdisciplinary team, Ayurveda professional has little control over the end result of the dialogue.”<sup>9</sup>(p.118) There is scepticism that even if the resistance of the MCI is surmounted and a joint curriculum is collaboratively worked out, it may become a process of perpetuating biomedical dominance. Such reform, these critics argue, spells major compromise for non-allopathic systems of medicine, rendering them subservient, in pedagogy and practice, to allopathy.

It seems that even with latest policy pronouncements, the age-old concern remains that the effect of such pedagogical integration of allopathic and non-allopathic systems may be incompatible epistemologically, even as integrative practice across non-allopathic systems (only) in history has appeared far less dilemmatic. (In the case of Ayurveda and Unani, this is likely because integrative practice was positioned in contestation with allopathy!<sup>7</sup>) Perhaps it is by more closely understanding these old ways, rather than trying to craft new ones, that we can address aspirations for positive change in the AYUSH medical education scenario.

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## **Addressing an Enduring Loophole in Medical Education: Reflections from JSS Animal Bites Care Program**

*-Yogesh Jain and Parag Bhamare<sup>1</sup>*

Animal bites are common in our country where seventy percent of its population lives in rural areas. The neglect of systematic Animal Bites care is an example of marginalization of health care needs of rural poor.

Over the years we have been witness to increasing deforestation and forest encroachment – a trend that has led to a rise in interactions of forest animals and rural inhabitants. Chhattisgarh is a leading state in forest encroachment. The reasons for encroachment seem to be agricultural requirements and the mineral rich soil. About 44% area of Chhattisgarh is forested and 80% population in the state lives in rural or forest or forest fringe areas. In areas where men and animals stay in close proximity, because of their mutual dependency, a certain proportion of Animal Bites is to be expected. It is however tragic that many of these result in death or morbidity. Indeed it is a major problem for the rural population of the country where even minimal healthcare requirements are inadequate. Even on the front of accountability these deaths never get consideration they deserve. The number of Animal Bites is not reliably known though some studies estimated it to be as high as 17.4 million a year. (Whitakar 2012)

The term Animal Bites has been used considering Snake, Dog, Cat or other Wild Animal Bites and also for Scorpion, Bees or Wasps Stings. Deaths due to poisonous Snakebites and rabies are an important preventable cause of death in forest fringe areas. Even Scorpion stings can give fatal outcomes more likely so in children under five years.

Of all the bites Snakebites are the most common and the most dangerous bites. The problem of snakebite in India is higher than in any other country. World Health Organization estimates that 35,000-50,000 Indians die due to this every year. (WHO 2010) The findings of a study published in 2011 found that a million Indians are bitten by snakes every year while 50,000 die accounting to one third of the global deaths. (Mohapatra B. et al. 2011) Also, the incidence of Snakebite is attributed to farming activity in

relation to rainfall and the yearly reproductive cycle of the snake. But unfortunately Central Bureau of Health Intelligence reports an annual average of only 1,350 deaths each year for the period 2004 to 2009.

The Million Death Study (Mohapatra B. et al., 2011) on neglected tropical diseases gave the list of states with high prevalence of Snakebites in which Chhattisgarh is also included. In another study, while reviewing Snakebites in South Asia, Alirol et al (2010) observe about this entirely rural problem:

Snakebite is one of the most neglected public health issues in poor rural communities living in the tropics. Because of serious misreporting, the true worldwide burden of Snakebite is not known. South Asia is the world's most heavily affected region, due to its high population density, widespread agricultural activities, numerous venomous snake species and lack of functional Snakebite control programs.

According to the World Health Organization (WHO) Bulletin (2007), around 36% of the world's rabies deaths occur in India each year, i.e., approximately 20,000 of an estimated global annual 55,000 rabies deaths, and among them three-quarter of the deaths occur in the rural areas in central and south-eastern States, viz., Chhattisgarh, Uttar Pradesh, Odisha, Andhra Pradesh, Bihar, Assam and Madhya Pradesh. A 2003 assessment carried out by the Association for Prevention and Control of Rabies in India, with the support of the World Health Organization, had estimated the number of 'furious rabies' deaths at about 17,000. A factor of 20 percent was added to take into account paralytic or atypical rabies, taking the total number of deaths to around 20,000.

With such geographic concentration, targeted rabies prevention campaigns aimed at both humans and animals might achieve a significant reduction in the number of deaths or potentially even elimination of deaths from this disease. It is estimated that 600-800 people may be dying in Chhattisgarh annually due to rabies, a disease that is easily preventable.

Scorpion envenomation is an important public health hazard in tropical and sub-tropical regions. It is said

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that Scorpion stings are 10 times more frequent than snakebites. Envenomation by scorpions can result in a wide range of clinical effects, including, cardio toxicity, neurotoxicity and respiratory dysfunction. Out of 1500 scorpion species known to exist, about 30 are of medical importance. The Red Scorpions (*Mesobuthus tamulus*) are the most dangerous. Common scorpion stings do not always lead to death but they are very painful and prompt treatment of the same is very essential. Although Anti-Scorpion Venom is available, it is not used widely in our country. Continuous training of all health care providers in scorpion sting management is necessary.

Honeybees and Wasps are very frequent complaints from forest fringe areas and they can be dangerous in some of the cases. Such bites can lead to anaphylactic shock in an occasional patient and then it would be fatal if not treated on time. It is desirable to give prompt attention to this complaint also as multiple bites leads to significant morbidity.

Bites or stings of these animals constitute a major public health problem. Not considering this so increases the gravity of the problem many fold.

#### **Animal Bites Care and Medical Education**

As animal bite cases are more common among the people residing in the rural areas such as forest and forest fringe villages, many a time people opt for traditional or herbal treatment options at the time of any Animal/Snakebite. Often the patient is taken to the hospital too late to be saved and even if he/she reaches the hospital, he/she dies due to lack of knowledge and skilled personnel as well as equipped structure to manage the snake/animal bite at the health center. While the problem of availability of drugs, vaccine and anti-sera is often an issue, information and skill base to manage these at the peripheral outposts are equally scarce.

The systemic negligence towards Animal Bites starts from Medical Education. Urban bias in distribution, orientation and educational content never gives importance to these bites which are actually taking lives more than any individual non-communicable disease in a rural community. When appropriate care at primary level can save lives of

these victims, lack of competency at primary level along with commercialization has led to shift these patients to tertiary centers wasting crucial time and making already expensive treatment much more catastrophic.

Today medical education in India is so urbanized that Snakebites or Scorpion sting management gets only a mention in the whole curriculum. Since majority of medical colleges are situated in urban areas, where burden of these bites is considerably low, students do not get enough exposure during training or even during semi-urban internships that they are asked to do. The theoretical knowledge that one is supposed to get in the medical college remains limited to Forensic Medicine and Toxicology. Standard imported textbooks that are used during the training for Medicine or Surgery do not consider these emergencies major issues and hence coaching or even reading about the same gets sidelined. And most unfortunately the subject of community medicine or preventive or social medicine does not consider this problem a public health problem.

The gravity of the problem remains underestimated and the supposedly competent freshly passed out doctor also remains undertrained for the prescribed job when it comes to management of these conditions. On another front, research and publication on the same also remains minimal and overall progress of the locally relevant knowledge about Animal Bites care is negligible. Simpsons correctly mentions this in his article on knowledge base in treating Snakebites amongst doctors as follows:

The present method of training and providing guidance has demonstrably not equipped doctors to effectively manage Snakebite. Journal publications, particularly those in Western journals are not widely read in the developing world due to subscription costs. Although they have a high impact factor amongst specialists in the subject they have a very low impact factor amongst doctors who actually treat Snakebite.”(Simpson 2008)

Educating the primary care physicians and frontline workers regarding prevention and management of snake/animal bite is very essential. For proper treatment, it is indispensable to teach the technique of identification of snake - whether venomous or non-venomous - as well as the symptoms according to the nature of the venom to frontline workers. It is also



important for communities to be able to recognize envenomation early in order to be able to seek help at an early stage. Thus, there arises a need to train the health personnel as well as the community about the severity of the problem. This problem is much more relevant in Chhattisgarh owing to its huge rural, tribal and illiterate population.

Taking cognizance of this large burden, Jan Swasthya Sahyog (JSS) - voluntary organization of health care professionals - has been addressing this problem in rural Bilaspur since the last few years by providing free care to all animal bite victims. JSS has its own Animal Bites Care Program with three sub-centers in underserved parts of the area which are well equipped to function as Animal Bites Care Centers. This year JSS is planning to take on this issue at a wider level and hence to facilitate the same Animal Bites Care Resource Material has been designed.

The **Animal Bites Care Resource Material** consists of:

#### 1. Guidelines Posters

Five medium size (2 x 1.5 feet) posters were made specifically for display in casualty rooms for easy and quick look at treatment guidelines for managing different Animal Bites.

- a. Treatment of Scorpion Sting
- b. Post-exposure prophylaxis of Rabies
- c. How to administer Anti Snake Venom
- d. How to manage neurotoxic or hemotoxic venom
- e. Bees and Wasps Sting and Anaphylactic Shock Management

#### 2. Awareness Posters

Three big size (3 x2 feet) posters were made for mass awareness.

- a. Identification of Snakes
- b. Prevention and First Aid of Snakebites
- c. Approach to a Snakebite victim

#### 3. Identification Cards

Identification is the key in management of Animal Bites. Considering the lack of skills amongst health care providers this set of 24 postcard size identification cards was prepared for easy identification of venomous and nonvenomous snakes, potentially rabid animals, red and black scorpions and vortex or honey bees. These cards will be helpful for on table identification of these

animals.

#### 4. Training Manual for Doctors in English

This manual was adapted from National or World Health Organization guidelines for Management of Animal Bites.

#### 5. Training Manual for Health Workers in Hindi

Important points for the Management of Animal Bites are given in Hindi for health workers. There is a Section on Dos & Don'ts and Myths & Facts for community understanding.

#### 6. Audio-Visual Material in Hindi

There are about 30 minutes duration available in a CD, made from short clips on different animals, symptoms and signs after envenomation, and cases recorded from Ganiyari health center. This material is useful training material and also a simple tool for revising basics of management of Animal Bites.

Considering the complexities it was understood that the problem of Animal Bites cannot be addressed with a single-pronged strategy. While ensuring proper delivery of Animal Bites Care in JSS activity area, dissemination of information and advocacy for the issue was kept in mind from all the possible platforms.

The objectives behind designing these resource material were as follows,

- To standardize guidelines for management of Animal Bites
- To prepare material that can be used for mass awareness
- To prepare material for training of health care providers
- To present and disseminate resource material all over the country to create an environment for advocacy and network of influence to devise or revise policy measures that address this neglected

#### Animal Bites Care Program at JSS



rural health problem.

With the help of the resource material, Animal Bites Care Program runs in JSS on three fronts as shown in the above illustration.

### **Community Awareness Activities**

Community Awareness activities in the program are based on secondary data analysis and also experience with the community. The first step in the process was to make the community think of the right choice to seek care whenever the Animal Bite event happens.

An upshot is that prevention and control of Animal Bites is in hands of the community. Taking few crucial steps and precautions Animal Bites can be significantly reduced. Addressing myths about Animal Bites and more specifically Snakebites is a huge challenge in tribal and rural communities. Awareness drive was conducted to understand origin and consequences of these myths and to address them in ways which the community will accept.

### **Training of Health Care Providers**

Training Health Care provider is basically focused on standardizing treatment whenever a case of Animal Bites comes to a center. Studies have shown that outcome of Animal Bites is influenced by various factors including the treatment procedures practiced by health care providers. (Simpson 2008). This training module was planned differently for different level of health care providers: Basic First Aid measures for community health workers, Health Center level training for senior health workers and beyond that Secondary Level Care training for Doctors.

Dissemination of useful material in the form of guidelines posters and manuals from the kit was planned to ensure proper delivery and reinforcement of training. Health workers were expected to display these posters in the area where they manage cases of Animal Bites.

### **Animal Bites Care Audit System**

Animal Bites Care Audit System is the system to monitor and evaluate the program as a whole. It will help identifying loopholes, weak areas and finding root causes for devising preventive strategies. It will ensure notification of each case and will be an objective guide for further improvement of the program.

### **Resource Material: Tool for Agenda Setting and Advocacy**

Distributing and presenting resource material to different organizations and groups working predominantly in rural setting environment with an aim to create agenda setting on Animal Bites was planned. Though it is a long-term process, attempts were planned right from the initial stages.

Resource material has been widely disseminated across different states and training sessions have been conducted. Along with more than 100 Health workers of JSS, health workers from different parts of the country have also been trained. Training sessions were conducted for Doctors and Nurses in various hospitals in and outside Chhattisgarh. The process has got the desired structure and with timely modification as per the experience gained, the process will be continued even in the future.

During this course of shared learning, we have received overwhelming response and interest in knowing and picking skills for management of these bites. But we have also realized the utter scarcity of knowledge and technical skills amongst physicians across the board. The overwhelming refrain has been that the issue never gets the attention it deserves in our education system.

The neglect of Animal Bites Care in medical education reflects the marginalization of health care needs of rural poor. The intervention of JSS described here is a small but definite step in reducing this injustice to rural poor. Resource material that has been made is to make community aware of this problem and also to guide possible solution to tackle the same. It has been designed to cover everyone along the social hierarchy, viz., Common people, Health Workers, Community organizers, Middle level Health Workers, Paramedics and Doctors. It would be an achievement on the part of JSS if such informative material is taken up by educational councils and promoted for inclusion in skill development, coaching or practice of all health care providers.

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## TB in Tribal Community in Uttar Dinajpur (West Bengal) in 2011

*-Prabir Chatterjee , Prakash Baag, Anwar Hossain<sup>1</sup>*

Dear Editor,

We write to report findings from the TB data in the fourth quarter of 2011 in West Bengal. When doing an analysis by community, the TB Officer found that a very large percentage of TB patients in our district were from tribal communities.

There are 9 development blocks in Uttar Dinajpur. There are 6 TU. Cases of TB were highest in Raiganj and Kaliaganj Tuberculosis Units. Karandighi and Dalua blocks.

### Cases

There were 308 new smear positive patients detected in the fourth quarter of 2011. 70 patients were from tribal communities. Tribal patients were 3 of 34 TB in Karandighi and 9 of 36 in Itahar, 11 of 68 in Kaliaganj and 31 of 71 in Raiganj. 11 of 62 patients in Islampur were tribal. In Lodhan 5 patients were tribal out of 37.

Tribals consist of only 7% of the population of Dalua / Chopra, 7 % in Karandighi, 7.9% in Itahar, 5.8% of Raiganj, 4.6% of Kaliaganj, 6.2 % of Chakulia and 5.4 % of the district.

Mirwal TB Hospital run by Missionaries of Charity (in Raiganj Block) has tribal patients from outside which may explain why the number of tribals here are three times those in neighbouring TB Units.

### ST Patients out of Total New Smear Positive under RNTCP, Uttar Dinajpur 4<sup>th</sup> Quarter 2011

Name of TU	BPHC	Town	Total New Sputum Positive Patients	ST Patients out of Total NSP	Percentage
Raiganj DTC TU	Raiganj	Raiganj	71	31	43.66
Islampur TU	Ramganj, Dalua	Islampur	62	11	17.74
Kaliyaganj TU	Kaliyaganj, Hemtabad	Kaliyaganj	68	11	16.18
Itahar TU	Itahar		36	9	25.00
Karandighi TU	Karandighi	Dalkhola	34	3	8.82
Lodhan TU	Lodhan, Chakulia		37	5	13.51
<b>Total Uttar Dinajpur</b>			<b>308</b>	<b>70</b>	<b>22.73</b>

### Area

The District of Uttar Dinajpur came into existence on April 1, 1992 after the bifurcation of the erstwhile West Dinajpur district. Uttar Dinajpur, due to its shape and length, has many special features different from other districts. While it has 227 Km long international border with Bangladesh, there is approximately 206 Km long state boundary with Bihar. This district is one of the most backward districts of the state of West Bengal. NH-34 and NH-31 are connecting this district with other parts of the State and country. Some part of Bihar particularly Kishanganj is almost encircled by two blocks of U Dinajpur (Goalpokhar-I & Goalpokhar-II). In the northern part of the district there are almost 150 tea gardens. The birth rate of 5 blocks of Islampur subdivision is among the highest in the State (36/1000 in 2001). Infant mortality was nearly 66 compared to 48 in State (NFHS-3) and MMR of 350 compared to 194 in State (SRS 2004). Home delivery percentage is also very high (79%). Female literacy was only 36.4% (2001 Census). Malnutrition rate is as high as 70% compared to state 44% (NFHS-3). Most of the people are dependent on agriculture. Mainly four rivers, Mahananda, Dock, Nagar and Kulick, are flowing through the district. They cause floods in most of the blocks. Migration is a major concern in this district. People go outside to hunt of seasonal jobs. Population is around 3 million according to the 2011 census. About 27.7% of the population is SC and 5.1% ST.

### Previous Studies

There have been some earlier studies analysing the community of TB patients. They were based on NFHS data.

One such study was "A study of gender differentials in the prevalence of tuberculosis based on NFHS-2 and

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**ST and SC as percentage of 2001 Census Population**

Name of the Block/ Municipality	Name of Institution	2001 Population	SC %	ST %
Itahar	Itahar BPHC	284256	26.7	7.9
Kaliyaganj	Kaliyaganj BPHC	188540	60.5	4.6
Hemtabad	Hemtabad BPHC	129660	34.6	3.8
Raiganj	Raiganj BPHC	394674	38.4	5.8
Karandighi	Karandighi RH	363668	30.7	7.3
Goalpokher - I	Lodhan BPHC	272273	14.3	3.8
Goalpokher - II	Chakulia BPHC	250422	23.2	6.2
Islampur	Ramganj BPHC	265799	17.4	2.4
Chopra	Dalua BPHC	245670	18.5	7.1
Kaliyaganj (M)		57347		0.85
Raiganj (M)		182683		0.96
Dalkhola (M)	(included in Karandighi)			0.45
Islampur (M)		59280		1.16
<b>Total</b>	<b>U Dinajpur</b>	<b>2694272</b>	<b>29.37</b>	<b>5.43</b>

“Persons who belong to scheduled castes or scheduled tribes (groups that are officially recognized as

under privileged) have a somewhat higher prevalence of tuberculosis than persons who belong to other castes, this again may be attributable to poorer access to medical care. The difference is not statistically significant, however.” (Note: After adjusting for other factors)

NFHS-3 data“ (ICJM) by PP Sharma et al. This study showed that Scheduled Tribe male rates of TB were around 800/ 100,000 population which is about four times the female rate of TB among urban (others). In the latter group (female urban others) the TB rate was around 200. Female rate of TB among tribals was around 350 and male rate of TB among others was around 400.

(<http://www.ijcm.org.in/article.asp?issn=0970-0218;year=2010;volume=35;issue=2;spage=230;epage=237;aulast=Sharma> and <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2940177/table/T0005/>)

The authors divided the population into 3 SLI (standard of living index) categories. The prevalence was close to 800 in the low standard of living (SLI) category and only 145 to 160 in the high standard of living (SLI) category in urban areas

[http://www.ijcm.org.in/viewimage.asp?img=IndianJCommunityMed\\_2010\\_35\\_2\\_230\\_66869\\_t5.jpg](http://www.ijcm.org.in/viewimage.asp?img=IndianJCommunityMed_2010_35_2_230_66869_t5.jpg)  
(Accessed on 11th October 2013)

The other study based on NFHS I was “Biomass Cooking Fuels and Prevalence of Tuberculosis in India” (*Int J Infect Dis* 1999; 3:119-129.) Vinod K. Mishra, et al.

The authors say, “The adjusted tuberculosis prevalence rate is 969 (per 100,000) among those living in households using biomass fuels and 378 among those living in households using cleaner fuels.”

The NFHS III study divides the community into 5 socio-economic categories. It shows that 57% of tribes in West Bengal are in the lowest socio economic category (poorest) and only 16.5% are in third or higher category (middle category upwards). On the other hand third or higher category is 50% of the total population and 39.5% of SC are in the third or higher category. 5th category is 25% of the total population and 30% of SC are in the poorest category.

So the increased prevalence in Uttar Dinajpur tribal community could be

- 1) a result of them being poorer or
- 2) it could be related to the tribal use of biomass fuels. The high rate of male TB in the NFHS studies is a pointer against biomass fuel- but this impression needs to be confirmed by clinical data and surveys (in case women are reporting TB less)

Yours sincerely,

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## Kala Azar Outbreak in West Bengal

-Prabir Chatterjee, Md Kabiul Akhter Ali, Neel Kamal and Ajay Chakraborty<sup>1</sup>

### History

Kala azar (visceral leishmaniasis) has not been common in West Bengal after the 1960s. Historically it was highly prevalent in the late 19th century and early 20th century. Satyajit Ray's father died of Kala Azar. U.N. Brahmachari was credited with preparing Urea Stibamine and treating many patients in Kolkata.

### Recent Trends

Kala azar has increased from 1238 cases in West Bengal in 2001 to 3015 cases in 2004 and from 756 kala azar cases in 2009 to 1962 cases in 2011. Cases decreased in Murshidabad from 810 in 2005 to 288 in 2011, while they increased in neighbouring Malda from 268 in 2009 to 827 in 2011. In 2011 there was a spurt in cases in Darjeeling and close by areas of Uttar Dinajpur in North Bengal. U Dinajpur reported just 58 cases in 2010 but 180 cases in 2011.

### The Outbreak in Uttar Dinajpur

Six blocks of Uttar Dinajpur were considered endemic for Kala azar. Cases were highest in Karandighi and Dalua blocks. While the number of cases was almost the same every year from 2008 to 2012 in five blocks-one block- Dalua (Chopra) suddenly detected a large number of cases in 2011.

### Locality

One area called Bohura Line in Debijhora Tea Garden (Majhiali Panchayat) had 30 patients. Another 34 patients were from other addresses in Debijhora and 6 more from other villages in Majhiali

### Seasonal Variation

Cases began to be detected in March and this continued till October 2011. Finally a special drive uncovered even larger numbers in December and 32 patients were diagnosed during this drive of which 22 were in this block (Dalua). There were another 48 KA in the first 6 months of 2012. 12 cases were reported in January 2012, 10 in February, 14 in March, 1 in April, 2 in May and 9 in June.2012.

### Cases

In all 100 visceral leishmaniasis and 6 PKDL (Post-kala azar

dermal leishmaniasis) cases were detected in this block. 72 patients were from tribal communities. There were 74 cases with 54 tribal patients in the other blocks. Tribal patients were 26 of 39 KA in Karandighi and 17 of 19 in Itahar, 6 of 7 in Kaliaganj and 5 of 6 in Raiganj. In Chakulia all 3 KA patients were non-tribal. Tribals consist of only 7% of the population of Dalua / Chopra, 7 % Karandighi, 7.9% Itahar, 5.8% of Raiganj, 4.6% of Kaliaganj, 6.2 % of Chakulia and 5.4 % of the district. This continued- in the first half of 2012 tribal cases (as a percentage of all Kala Azar) were Chopra 61%, Itahar all, Kaliyaganj 50% and Karandighi 91%

### Treatment

About 89 to 94% of patients completed treatment.

### Discussion

Kala azar is commonly found in remote areas and there is a general belief that it is common among tribals. The vector is the sandfly (*Phlebotomus argentipes*). This small insect can not fly large distances in its life time, nor can it fly very high. It is easily excluded by use of a mosquito net. The sandfly is zoo-philic. It breeds in cracks and crevices. All these factors mean that those in one-storey wattle houses (or houses with cracked walls), sleeping on the floor or mats, who sleep in close proximity to domestic animals (cattle) and not using mosquito nets are more susceptible. So these may be the factors causing the larger numbers among tribals. Tea gardens in North Bengal are not doing well economically and Debijhora had very poor access to health services especially in the last decade. All these factors may have been involved in this exceptionally large outbreak.

### Kala azar in West Bengal

2001	1238
2002	1592
2003	1487
2004	3015

Table VIII.1.5 : Reported Cases and Deaths due to Kala-azar in West Bengal, 2005 - 2011

District	2005		2006		2007		2008		2009		2010		2011	
	Attack	Death	Attack	Death	Attack	Death	Attack	Death	Attack	Death	Attack	Death	Attack	Death
Darjiling	156	1	126	0	182	1	126	0	100	0	220	0	384	0
Uttar Dinajpur	108	1	60	0	56	0	62	0	35	0	58	1	180	0
Dakshin Dinajpur	253	2	333	1	285	1	197	2	124	0	120	0	129	0
Malda	559	3	429	0	535	0	497	0	268	0	630	3	827	0
Murshidabad	810	2	575	6	630	3	265	0	149	0	279	0	288	0
Nadia	7	1	13	2	3	2	0	0	6	0	17	0	13	0
North 24-Parganas	141	0	64	0	39	0	24	0	12	0	21	0	14	0
South 24-Parganas	494	3	140	1	36	0	41	0	42	0	66	0	33	0
Hugli	10	0	6	0	3	0	4	0	0	0	12	0	3	0
Bardhaman	41	2	58	0	22	1	14	0	6	0	10	0	39	0
Birbhum	131	0	39	0	26	1	26	1	14	0	42	0	52	0
<b>Total</b>	<b>2710</b>	<b>15</b>	<b>1843</b>	<b>10</b>	<b>1817</b>	<b>9</b>	<b>1256</b>	<b>3</b>	<b>756</b>	<b>0</b>	<b>1475</b>	<b>4</b>	<b>1962</b>	<b>0</b>

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## Training and Education of Health Care Professionals: Indianization of Allopathic Medicine

*Consistent with the Economic Realities of the Indian Population*

*-Dr. S. V. Nadkarni<sup>1</sup>*

The allopathic medical science is based on the Physics, and Chemistry of the body function. Being a science, it is pure and extremely definitive; there cannot be any error in the conclusions drawn through this science. Now technology has added more precision to the already precise science of allopathic medicine. But though Allopathy is a pure science, the clinical practice of allopathic science is NOT a science. As with many other fields, application of any science brings in Art and Commerce. The mixture of the Art, Science and the Commerce in clinical practice makes it a new product—a variable product for that matter—which MUST differ from place to place, depending on the exact needs of the place. Even in the same place, the needs of the various strata of the society could be different and, therefore, the product suitable for one may not suit the other. **This is the fact not realized by most of the followers of the allopathic clinical practice and a standard format/menu is served to all**, irrespective of the actual needs of the local people. Unfortunately, too, it is the Western model which is advocated blindly, without realizing that this Western model is proved not to be suitable even for their own people who belong to the poor and lower middle class strata. ANSWER? **We must formulate our own model suitable for our own needs. This is what I call Indianization of Allopathic Medicine.**

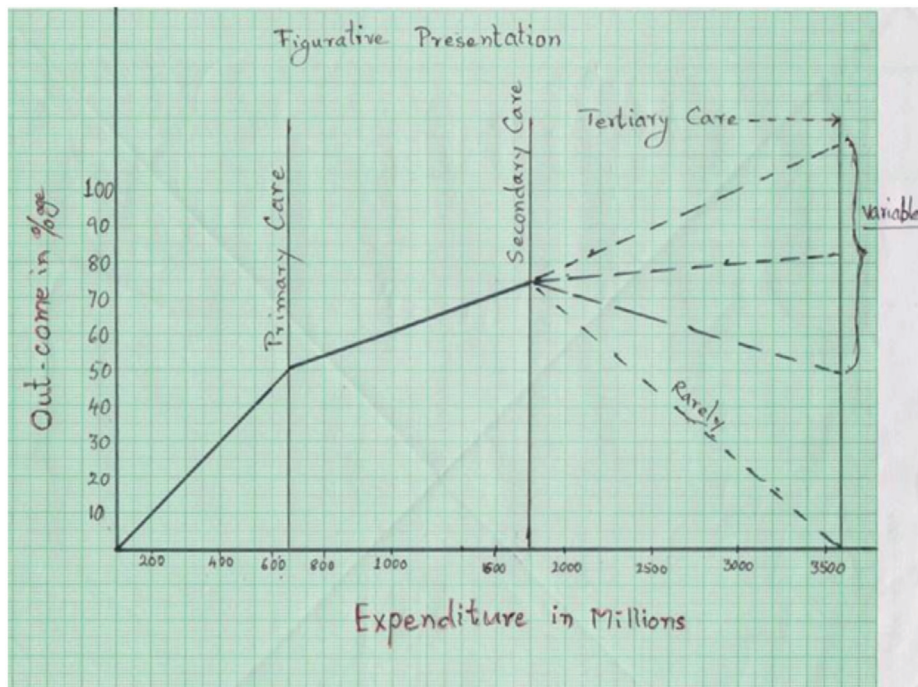
**Are the health needs of the poor any different from those of the rich? I would say “Yes”;** in fact, I dare say that the needs of the middle class are also different from those of the poor or the rich. So, broadly, the three strata of society have different health needs and that difference is due to the economic status of each strata. **This is a fact most people are not willing to accept.** How can the needs be different? It is because of their economic compulsions. Their expectations are determined by what medical assistance they are presently receiving and their knowledge about the health and disease. The poor do not understand an early disease; forget about the need to prevent the pre-disposing factors that can lead to disease. So, they usually come late when the disease is fairly advanced. The clinical manifestations are very clear and diagnosis is relatively easy without too many modern investigations. They need to be treated fast as it is difficult for them to take treatment for a prolonged period, even if it is “free”; there are ancillary expenses and other logistical problems. Fortunately, they are satisfied with immediate relief and some prolongation of life or productivity, as they do not know that better results are possible with modern methods. Not knowing much, they have to depend on the opinion of the doctor and accept the protocols prescribed without much questioning. They have to depend on the public sector - good or bad - as they can never afford the charges of the private set-up. The science remains the same, but the Art and the commerce differ; hence the “product” offered is

different. Efficiently managed, this product can give equally good results at a very low cost. Due to efforts of NGOs and the various “awareness Programs”, some of these poor are becoming aware of their health needs and have started demanding better health care. That is good, but when it leads to expectations beyond the financial capacity of the health centers, and the “awakened Poor” demand better service “FREE,” grave problems arise; often the services deteriorate, as the medical professionals go on the defensive and send the patients to higher centers for “better Treatment” and there is paucity of “better centers”. This attitude immensely helps the “shirkers” in the profession while the socially oriented “enthusiasts” who are willing to do their best under the prevailing facilities are totally discouraged; there rises a hanging sword of assaults or complaints /actions against them, if things go wrong. The community has to realize that Better treatment is bound to need higher costs, and the medical professionals have to be taught to improve their Skills to give better results without raising the costs. The rulers will have to do the balancing act.

It is quite the opposite with the RICH. They are apprehensive about each and every symptom/health complaint and wish to rule out *any* serious ailment which may cause trouble in future or shorten their life-span. They are not willing to accept a 1% error and are willing to spend any amount for investigation and/or therapy. Money is no problem; in fact, more they spend, surer they feel about the management of their symptoms by the specialists. Not that they get a perfect outcome - far from it. The middle class, as in Marxian philosophy, are somewhere between the two. They are health conscious but also cost conscious. They are well read but skeptical and will not swallow all “modern” propaganda easily. The health professional has to really discuss with the middle class patient to convince him about the diagnosis and the management. Personally, I feel he strikes the right balance.

The Health Care professionals need to be re-educated in this direction but that cannot be done unless they are made COST-CONSCIOUS, and that cannot happen, unless we do costing of every treatment protocol. The diseases will have to be classified and graded as Mild, Moderate, and severe in a standardized fashion and then only, it will be possible to co-relate the outcome to the costs incurred. Such a re-education will lead to a search for cost-effective management protocols. The “New Products” could be different depending on the facilities available. The teaching institutions will have a great role to play by doing research in this direction. Because if such new products were to be developed by the teaching institutions, they will be considered as authentic. The Science is now properly mixed with Art and Commerce to suit the existing circumstances of the local community. Each product is different but it is the most suitable for that particular locality/strata. **MADE TO ORDER — so to say.**

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On a macro level, it is seen that increasing the expenses at the primary level to upgrade them, gives maximum benefits to the community at a relatively low cost; improving the secondary services needs much higher expenses but it improves health care perceptibly. But when we come to the tertiary, high-tech, modern health care, the expenses mount sky high - yet the outcome is extremely variable. Some miracles do occur, but, in general, the real improvement in health care is very marginal for the community as a whole; in the hands of half-trained specialists, the higher expense could result in worse outcome - sometimes disastrous (see graph). The outcome being so variable, it is my considered opinion that the public sector should spend the most minimum on tertiary care and make strict rules about the referral methods. Who should get the benefits of this tertiary service should also be defined strictly in this public sector. All others may have to pay for this service.

How to make common man cost-conscious? For the success of the scheme of Universal health Coverage, it is absolutely necessary that the community becomes extremely cost-conscious; otherwise, the demands mount sky high or the expenditure is easily wasted on wrong priorities. I have suggested two methods in my other articles. One is to give him the actual bill of expenses (it can be called "cost statement" and not a bill). The other- more effective way- is to make every patient in public sector, **beyond primary care**, pay at least 10% of the actual bill. In my modified format of UHC, I have made it merely 8%, while local self govt. bodies will bear another 12%. Both will become cost conscious. Even presuming that 30% of the people are below poverty line, the scheme is yet possible, **as the government will pay for them — this is the real subsidy which now goes exactly to those who need it.**

It is not only the professionals who need to be re-educated; it is the whole community and their leaders who need to be educated on the real value of Health services.

A - All health services are NOT needs; some are demands; some are sheer luxuries. B - **It costs.** And C - as a corollary- therefore, while essential services must be asocial obligation, other services must be tailored according to the capacity of the individual or the community to pay-individually

or collectively. D - All services have to be paid for - public services through Health related taxes with contribution from all, and private services through additional health insurance or personal expenses. The medical professionals, who are going to treat the poor and the lower middle class, need to be educated as to how to treat effectively **at reduced costs within the available facilities by improving one's skills.** (Strong incentives would be necessary for this)

The role of medical colleges is grossly underestimated. **It is totally wrong to look at the college hospitals as merely tertiary centers for the treatment of complex cases.** The college and its hospital are centers to create competent doctors/specialists for the entire spectrum of health services. Therefore, it must have the widest canvas of diseases and from all possible strata of society. It is then only that the students (and the teachers) will understand the subtle differences in management of early and late diseases in various strata of society. Today, the overwhelming percentage of the poor patients is giving them a distorted training of the art of communication and of dealing with the complaints of the patients. Secondly, we are not training doctors to be family physicians at all. There ought to be a training course of 2 to 3 years for G.P. or primary health provider, I prefer to call them. The whole time table of hospital working must be looked into to accommodate the complex needs of the nation as a whole but it is a big chapter and cannot be discussed here.

In brief, the socio-economic influences on the actual clinical practice ought to be taken into account at every step from medical education to the formulation of health policies to the actual clinical practice. Unfortunately, vague ideology and euphemism are hindering the right approach and causing untold harm to the health services. We all need to be re-educated.



## Diabetes Experience – a Pilot Study

-R Srivatsan and Veena Shatrugna<sup>1</sup>

### Rationale

A major concern in India is the rampant prevalence of metabolic syndrome, which has its origins in the intrauterine period. A large number of pregnant women subsist primarily on a cereal diet which is bereft of good quality proteins, vitamins and minerals. As a result the foetus grows in an environment of scarcity with most of its organs, functions and metabolism shrunk/compromised.

**Metabolic syndrome** is the name of a condition marked by a series of high risk factors for diabetes (Type 2 ) and stroke. These are:

- A large waistline (abdominal obesity)
- High triglyceride level
- Low HDL cholesterol level
- High blood pressure
- High fasting blood sugar

It is now almost certain that vitamin B12, and amino acids like methionine, and other nutrients like folic acid largely derived from animal foods and milk are necessary for maintaining methyl transfers and preventing the metabolic syndrome described by Barker.\*

\* EC Rush, P Katre and CS Yajnik. Vitamin B12: One Carbon Metabolism, Fetal Growth and Programming for Chronic Disease. *European Journal of Clinical Nutrition* (2014) 68, 2–7.

The newborn thus emerges with a low birth weight. Such babies do not thrive as they progress through infancy because of the continued context of poverty and a near absence of good food like milk, eggs, nuts, etc. Thus they remain underweight with a poor muscle mass and a high body fat percentage. When these children grow up to be adults, their bodies and metabolism are ill-equipped to deal with any excess nutrition in their adult life. These so called stunted populations are of course from the poorest strata of society (Dalits, other castes who do heavy work as carpenters, agricultural labourers, cobblers, stone breakers, toddy tappers, metal workers, iron smiths, and many more!). When they give up their usually heavy work, and migrate to the cities, but continue with a cereal pulse diet devoid of all vitamins and minerals, you find that they suffer the consequences of metabolic syndrome.

This study is necessary to understand the ramifications of the epidemic of diabetes (Type 2 ) which is most likely to ravage the ST/ST and other marginalized groups because they are populations a) with the

largest proportion of stunting and low birth weight; and b) they are making a transition to living patterns which are more sedentary than those they followed during decades of early deprivation.

We had many rounds of discussions with several friends who were interested in the problem and then had in-depth interviews with five Dalits who had diabetes in a pilot study to understand the scope of the problem in terms of everyday life. Given that they come from middle-class backgrounds, their responses may be seen as ones that focus more around the problem of caste culture rather than class.

### Findings

The following description of findings are intended to open the problem area to research, and point to some specific hazards and difficulties we think these efforts are likely to confront. They also focus on how the patients and care givers deal with the disease in their daily lives, their experience, perspective and knowledge.

### Anxiety and Fear

Responses from our interviewees suggest that there is anxiety and panic about diabetes in the rural areas. There is a great deal of anecdotal knowledge about relatives, friends and acquaintances losing eyesight, limbs, and organs, and of dying due to the uncontrolled progress of the disease. This anxiety and the stigma associated with diabetes (which we will describe in the following section) tend to prevent people from admitting to having the disease. Therefore mindless government programmes (encouraged by Corporate Social Responsibility) screening for diabetes are likely to raise panic among populations in relation to both having diabetes and the stigma associated with it.

From interviews it is apparent that when one is clinically diagnosed with the disease, this anxiety becomes palpable fear – it is somewhat like being told how you are going to die. The expected progress of “the game” of one’s life is revealed. It is almost as if the person has been handed a living death sentence. This results in the patient going into depression for as long as a year, unable to come to terms with the disease. The effects of this depression and fear reflect in the conduct of the patient and are often the emotional burden to be carried by the care givers.

### Stigma

There is again a widespread knowledge that diabetes Type 2 runs in families. This is understood as a hereditary transmission of diabetes, leading to a social

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stigma, with the result that people do not want to be known as having the disease. In one of our interviews we were told that the father, being a diabetic, did not want to let his friends, acquaintances and colleagues know that he had the disease. The reason for this seems to be that there is a fear that the children in a diabetic's family will not be able to find a marriage match. This unwillingness to let others know the secret of the disease would be an obstacle to following diet and medication programmes that are prescribed to the patient. One of the interviewees also spoke of the irritation she felt over the excessive "concern" expressed by friends on a daily basis, asking about general health, sugar levels, etc., which she felt were none of their concern. Fear and anxiety coupled with this stigma which a majority of our interviewees spoke about are major obstacles to public health screening for this emerging chronic disease in India.

### Stress

...[S]tress has long been shown to have major effects on metabolic activity. Energy mobilization is a primary result of the fight or flight response. Stress stimulates the release of various hormones, which can result in elevated blood glucose levels. Although this is of adaptive importance in a healthy organism, in diabetes, as a result of the relative or absolute lack of insulin, stress-induced increases in glucose cannot be metabolized properly. Furthermore, regulation of these stress hormones may be abnormal in diabetes<sup>2</sup>.

Stress seems to stalk diabetes in the everyday life of the interviewees. In one case, unending stress in the project of setting up a political network against caste discrimination precipitated diabetes (no doubt the content of the activity had nothing to do with the disease). This person said that given his family history, while the disease was perhaps inevitable, it was most probably hastened by the kind of work he did. In another case, the need to take care of a diabetic father who refused to eat adequately on a daily basis resulted in extreme stress among different members of the family – wife, daughters and nephew. It is easy to imagine that this stress was also reflected back on the patient in a perpetual feedback. In a third case, the physical stress of attending a funeral of a Dalit intellectual on a severely hot summer afternoon precipitated a diabetic coma, leading to hospitalization and an ICU stay lasting over 20 days.

In general, this kind of stress seems to have common features with other diseases, as well as with other castes, communities and populations. However, our many fact finding interviews with Dalit students in

university campuses in relation to the problem of suicides makes it clear that Dalit individuals face stress at an extremely high everyday level due to the sheer pressure of living in a hostile and humiliating environment. While there is no such direct evidence in the case of the few patients we have investigated, it is easy to see the possibility of such stress from a cross-comparison. The problem would be to design probes to examine how this stress plays out in relation to the lives of diabetics.

### Doctor's Advice

Typical bullet points in doctors' advice are:

- **Do not** eat rice
- **Do** eat chapatti
- **Do not** eat meat
- **Do** eat vegetables
- **Do not** eat fruit
- **Do not** use oil for cooking
- **Do** walk for exercise

We asked the interviewees what the doctors advised them with respect to medication and diet.

The general practitioner seems to provide advice to cut down ones food. "Instead of rice, eat chapattis, eat two not four chapattis or idlis." This first bit of advice throws the patient into a confusion, and particularly in the geographical region of our study because the term for a meal, and the term for rice are the same (*annam*). Eating well translates into eating more rice. To change the cereal from rice to chapattis is a huge change in terms of habit and culture. The patient is simply thrown in the deep end and left to sink or swim. Next, "Eat as much vegetable as you can, but not potatoes or other starchy foods." And "Do not eat too much fruit, but you can eat less sweet fruit." There is some advice to spread out the eating in several small installments. Each of these lines of advice runs against the culture of patients and families. They come as a shock to the habit and sense of well being of someone living in a food culture that has so far not thought seriously about what constitutes a healthy diet. The diabetologist in contrast to the GP seems to work through charts that propose Indian diet plans and measured quantities of what must be eaten in each small meal. The chart typically shows how many measures (cupfuls, gm or ml) of each type of food may be consumed. Specialists also give readymade sheets with glycemic indices. Charts are extremely difficult to follow and the technical jargon that these charts use is incomprehensible to patients who are struggling to come to terms with the diagnosis.

<sup>2</sup>Surwit RS, Schneider MS, Feinglos MN. 1992. Stress and diabetes mellitus. *Diabetes Care*. Oct;15(10):1413-22.

Most doctors said stop eating meat. Nowadays doctors seem to advise eating some fish. One of our interviewees said that red meat eating was not endorsed. That is, the doctors he met advised a restriction of non-vegetarian intake to chicken or fish once a week.

There seem to be many misconceptions in the doctors' advice. For example, the patient is told to avoid red meat because it contributes to saturated fats and cholesterol— which is valid in the American and European context where grain and stall fed cattle (and poultry) pumped up with different hormones and steroids yield fatty and cholesterol rich red meats. In India, free range cattle and sheep grazing on grass and leaves provide meat that is not dangerously fatty. In fact, Indian beef is preferred in many countries abroad because of its healthy, low fat composition.

Initial investigations (which need to be verified) seem to suggest that Indian doctors and diabetologists simply adapt Western research results to Indian vegetarian diets according to the dominant cultural pattern. There is apparently not much thought given to developing serious dietary advice to Indian populations, given the epidemic that confronts us today.

On the other hand, doctors have no clue about the life patterns of the rural and urban poor who are now increasingly being afflicted by the disease. Simple questions have no answer: Cost of a diet, frequency of eating, and feasibility in the social, cultural and economic circumstances. There is also no research regarding dietary diversity and food choices, the availability of which would lead to strategies to make it possible for a diabetes patient have a fighting chance to have a normal life.

We do not have solutions to these criticisms but we are at this stage simply pointing to the many problems that arise in the context of the doctors' advice.

### **Guilt**

There seems to be an experience of guilt in patients, as if diabetes were punishment for the sin of a lifestyle. This is doubled by the doctors' non-endorsement of their food cultures. The lack of endorsement is liable to be seen by Dalit patients as scientific evidence that the dietary pattern of the Dalit is being proven to be unhealthy by science. This is seen in another context when students from a university came to one of the authors (VS) for a certificate that beef is healthy food, which they wanted to submit to the university authorities in order to cook beef at a festival. This kind of (not so) subtle non-endorsement could lead the patient to the ambivalent status of being untouchable twice over – once through culture, and again because

science confirms the error of “indulgence” of the non Brahmin diet. All this feeds into the guilt. In the context of the cultural hegemony of vegetarianism in India, this results in a pell-mell adoption of a diet that is a denial of all aspects of a food culture that may in fact alleviate the problem. Such flawed diet strategies include starving oneself, restricting oneself to low carbohydrate foods and some vegetables, and elimination of many key elements in diets (like animal protein to provide energy) that may help control blood sugar and tackle long term obesity. The tragedy is evident in one of our interviewees understanding about the truth of diabetes: “as a result of the disease we simply have to lose all interest in food for the rest of our lives!”

### **Dietary Chaos**

The general description of food consumption in terms of content and schedule among all the interviewees is best described as absolute dietary chaos: a) hunting futilely for foods that would be healthy without a clue about what constitutes healthy food for diabetics; b) struggling to make proper food choices work in familial constraints; c) having spouses who do not understand the disease and either strive to express love by encouraging the patient to eat more food (rice, sweets) or simply do not try to make changes to help the patient cope with the disease; d) totally denying oneself any and every enjoyment of foods that are to be eaten, indeed actually starving oneself. In addition one interviewee recalled a strong memory of the bewilderment regarding social constraints about when it is proper to eat food and what the etiquette of sharing food was in their culture, and the dilemma of circumventing these constraints to take care of the diabetic's need for frequent and small meals. For example, a Dalit teacher had to play around with the medication because a long teaching period made it impossible for him to eat a small meal at the appropriate time. Anxiety about food and places to eat on long trips makes travel a nightmare. Interviewees described a completely disoriented, sometimes unhelpful, always unassisted and nearly pathetic search for a diet and schedule that would help them cope with the complex and (for them) unpredictable turns the disease would take in the context of culture, family and social life.

It is hard for a normal person to understand this complete chaos that results from a diagnosis of diabetes. Different patients find their own strategies to cope with the disease according to their own understanding, with very little positive help from the doctors about how to do so. The seriousness of the problem arises from the fact that food culture is tied into the body's need of energy and the patient

simply goes into either a perpetual state of hunger or resigns to a loss of blood glucose control. It is our speculation (which needs to be verified by some innovative research) that the extreme weight loss seen in many diabetics in India is not only due to the disease pathology, but also due to the dietary chaos caused by misunderstanding and mismanaging this disease.

### **Destabilization**

Another insight from one of the interviews we had was that it is likely that diabetes will overturn the lifestyles of the family around the person who has it. Finding proper food, making each meal palatable, useful and healthy, making a sometimes reluctant and depressed patient eat adequately was a daily battle waged by one family. The interviewee cared for a diabetic father suffering from a low appetite and a self-imposed practice of vegetarianism (his family ate meat). This man punished himself for his disease, and as collateral damage made the family's daily schedule center on the need to take care of him: the mother had to bear the burden of his illness, the cooking, and the constant battle to get him to eat; the daughter suffered educational setbacks to help her mother take care of him; and a brother had to come and give him his insulin injections (which the patient could not take himself) whenever the man was left alone by the family. While this is common to other diseases like cancer, the duration of destabilization is very much longer and therefore has more cumulative effects with a chronic disease like diabetes.

### **Recurrent Health Expenditure**

An important implication we found from one of our interviews was that diabetes reverses the economic growth process of a not too wealthy family -- the slow and constant increase in medical and dietary expenditure sucks out family reserves at a steady pace. Spending a spot average of Rs 3,000 a month on medication from a salary of Rs 15,000 would strain the budget of most middle class families in India, not to mention the guilt the individual feels in straining familial resources to such a level. An expenditure of Rs 3000 per month over 20 years is a total expenditure of Rs 7.2 lakhs, without counting in any catastrophic expenditure that may arise due to episodes of hyper and hypoglycemia. This sort of expenditure erases the possibility long-term investments in the well being of the family members. In this sense its effect is slower than, yet as sure as, catastrophic expenditure due to acute illnesses. This could be termed "recurrent health expenditure" to differentiate it from "catastrophic health expenditure". Thus insurance systems like Aarogyasri meant to handle health care

expenditure as a public agenda or market driven process are theoretically suited to minimizing out of pocket "catastrophic expenditure", are not suited to recurrent health expenditure. No programme exists for "recurrent health expenditure" related to diabetes, which if it becomes the epidemic it threatens to be will be an immense drain on personal resources of the lower middle class patient.

There is no doubt that a crying policy need in this context is the availability of free medicines for diabetes, without which there is bound to be prolonged misery and economic chaos among the poor who suffer the disease.

### **Discriminatory Effects**

For first generation literate families that are marginal or are just beginning to achieve economic stability, a person being diagnosed with diabetes in the family may mean that a child has to drop either temporarily or permanently out of school or college. A temporary, yet crucially long, drop out period was reported in one of our interviews. Coupled with expenses, the demand on care giver time upsets family stability which is the basis for growth of well being through generations. It is impossible to provide a routine for children to study, even if it were hypothetically possible to sustain her education, when the familial routine is turned upside down by this disease. This, in one of our interviewees' account, lasted nearly two decades. This is especially critical with families who are on the threshold of moving from non-formal, insecure forms of subsistence to more stable organized forms of work. It is not so critical with families that come from better off backgrounds. Given the epidemiological pattern we have sketched in the first part of this paper, it is likely that diabetes will hit precisely these populations making a transition. It is overwhelmingly true that populations making the transition from the informal to the formal sector, and thus from the impoverished to the lower middle classes, come from the "lower" castes. Thus there is a discriminatory effect exerted by the presence of a seemingly "secular" disease like diabetes. This is because the poorer a family is, the more vulnerable to unrelenting recurrent economic expenditure it would be, descending steadily to economic and social insecurity. This means that the developmental promise held out by the long processes of disciplinary education and the acquisition of somewhat predictable formal employment are negated by the ravages of the disease on the family as a whole.

*We thank our friends and interviewees for their patient and generous sharing of time, insight and experience in this small project.*

## Homeopathy: Successes and Opposition in Odisha

-Jagannath Chatterjee<sup>1</sup>

The state of Odisha has four Government Homeopathic medical colleges at Bhubaneswar, Sambalpur, Rourkela and Berhampore offering 5 and a half year BHMS courses. There are also two private institutions offering recognised BHMS degrees at Cuttack and Baripada. While the Government colleges have a capacity of 25 seats each, the private colleges have 30 seats to offer. So the system produces 160 doctors every year. There are also many Homeopathy lovers practicing in the state, mostly as registered practitioners, who are popular and given due importance and respect by the Homeopathic fraternity. A few mainstream doctors also practice Homeopathy though it is not known what drew them to the practice.

The graduates either open clinics, be it in urban or rural areas, or sit in Homeopathy retail shops which are mostly owned by doctors. They wait in vain for low paying AYUSH jobs. They gain clinical experience during their student days by assisting their professors and teachers in their practice mostly in the hospital, but also help out in their private clinics. Since the year 2005 the Odisha Homeopathic Druggists Association (OHDA) is taking considerable initiative in adding to their knowledge base by organising annual conferences in the month of December where reputed Homeopaths and research scientists from all over India participate to share their clinical experience, research, and videotaped case studies which have to be seen to be believed. They interact with their colleagues and students to ignite their interest and impart vital tips for practice. Officials from the Central Council for Research in Homeopathy (CCRH) and AYUSH officials make it a point to be present.

All kinds of people seek treatment as the success stories have spread by word of mouth. The early Homeopaths engaged in lot of hard work to make Homeopathy popular in the state and it was they who initiated the setting up of medical colleges. The elite intelligentsia frequent Homeopaths as they have read Homeopathy themselves or have senior family members who have practiced the science on their families. The elderly prefer the system because of its gentle effects and parents of small children depend upon it as they do not wish to drug their kids very often. The poor and middle class take to Homeopathy to keep down medical expenses. There is the general

perception that Homeopathy is an answer to chronic illnesses. People getting mainstream treatments supplement their treatment with Homeopathy and it is not unusual for relatives to smuggle in Homeopathic medicines into hospitals to treat admitted relatives.

In general the Homeopaths of the state stay aloof and do not overtly criticise any other system. However the mainstream doctors are highly critical of them and berate their patients for taking resort to Homeopathy as a complementary system. The patients therefore prefer to remain silent on the issue and will hide the fact that they seek Homeopathic help. The Homeopaths say that they are comfortable that mainstream medicos are around because these days they face very complicated cases and they have often to be referred to mainstream practitioners in case of emergencies. In the process they also make friends within the mainstream system and these doctors are more tolerant of their patients' preferences. The Homeopaths point out that despite the explosion of multi-speciality hospitals in the state, the patients seeking their help are only increasing in number. Homeopathic drug companies are also witnessing increase in sales and almost all major Homeopathic brands have a presence in the state.

Privately the senior doctors resent the fate of their patients who are mostly swayed between their own preference and pressure from family members, relatives and neighbours. The emergence of major hospitals has made it a fad for patients to be admitted in hospitals and people not doing so are criticised for resorting to Homeopathy 'to keep down expenses' and 'harm the patient'. Classical Homeopathic treatment, very essential for permanent cures, often result in disease aggravations or the re-emergence of old diseases suppressed earlier and during such episodes the frightened family members go into the care of mainstream doctors who utilize the opportunity to malign Homeopathy. Subtle manipulations in the course curriculum have ensured that controversial subjects very essential to understand the plight of patients have been deleted. Mainstream doctors who teach the students anatomy, physiology and aetiology do their bit to demoralise the students. As Homeopathy rarely requires patients to be hospitalised, the budding doctors complete their residency in mainstream hospitals further adding to their confusion.

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The state's lack of will to promote Homeopathy, the constant criticism against the science, and disturbances in the functioning of the colleges ensure that generally the lowest rung seek admission. Homeopathy being a highly intuitive science tackling the person as a whole requires a perspective that only a very advanced doctor can gain. The newbies get frustrated as their disease-medicine approach does not always work. There are remedies that are very similar and require in depth knowledge of the remedy and the patient which the youngsters lack. Homeopathy requires extensive case taking, and lengthy follow up interviews during the course of treatment which requires time, energy and resources that few doctors can afford today. They cannot make a living of practice alone and open pharmacies where they become fully absorbed gradually. These lacunae have resulted in patents (mixtures of remedies) entering the market which may relieve symptoms but do little to lead to cures that is the core strength of Homeopathy, though I must say that patents do work in emergencies. But their use destroys the skill of the Homeopath in choosing individual remedies appropriate for their patients. It has also led to multiple remedies being prescribed which is against the principles of classical Homeopathy.

This fall in standards can be checked by publicizing the many benefits of Homeopathy and distributing Homeopathic knowledge and approach among the lay persons. The doctors have to struggle to get the vital symptoms from the patients as the general population has become used to diagnosis on the basis of pathological tests. Convinced of this approach they do not observe the peculiarities of their discomfort, timings of amelioration and aggravation, mental states; symptoms that are vital for a good Homeopathic prescription. The symptoms are usually very difficult to obtain as they are masked by drug effects or get lost in drug side effects.

The medical colleges have to be spruced up and disciplined so that admission procedures, classes, and examinations are streamlined. The condition of the hostels has to improve. Currently most students prefer to stay in rented houses to avoid the pathetic state of the hostels. The vacancies in teaching posts have to be filled up. Visiting faculty from within the nation and abroad should be entertained. The students should be asked to rely mainly on traditional texts rather than on test papers. The condition of the inpatient and outpatient departments should improve as the rise in patient flow will mean better exposure for senior

students. The interference of non-Homeopaths should be curtailed.

At Bhubaneswar, a few Homeopathic doctors wish to have the right to prescribe vitamins and supplements as they face patients depleted of their vital force, a force that is very essential for the patient to respond and head towards a cure. They do not seek any other concessions. Frustrated by their meagre income many of them have their children educated in mainstream. It is often interesting to see these doctors sitting in their parent's clinics and wondering how a bogus and fake science can get results. This is despite their own experiences in childhood. This reflects on the system of teaching they receive which programme them to hate and disbelieve all other systems.

I have practiced Homeopathy for some time, a long time serving as an assistant to a local registered doctor who as a Government Medical Officer had served extensively in rural areas gathering a lot of experience and a record of cured cases behind him. He was very outspoken about meddling with disease symptoms that only drives the disease further inside the body leading to severe complications which are almost impossible to treat. He was happy in rural areas serving the poor who could afford only Homeopathy. His case records showed cures of various chronic illnesses and treatment of cancer patients given up by the mainstream. I myself have observed a declared terminal cancer patient surviving more than a decade under his care. Incidentally his own wife suffered from cancer whom he treated himself despite severe opposition from family members. He belonged to an aristocratic family and held an important post in the State Government, however a tiff with higher ups led to his resignation and he took up a very uncertain career. His wife was the only person to stand by his decision.

Homeopathy has to be revived and popularized keeping in mind the steep rise in case of complicated chronic illnesses, the need for a choice for people who wish to be permanently relieved from their suffering, and for the general population who are turning paupers paying hefty medical bills. It has to be remembered that the more the choice, the better for the patients. The doctors should stop fighting amongst each other and appreciate the benefits of the various systems. After all, the duty of every doctor is the restoration of health and not bickering over which system is better and scientific. Let the results show, by offering every system a level playing field, and guide the patients to what they think is best.

## Homoeopathy in India: Practice and Perception

-Dhananjay Kakade<sup>1</sup>

In India the history of Homoeopathy can be traced as far back as the year **1835** when a Romanian man Dr. John Martin Honigberger visited India. He was called in by Maharaja Ranjit Singh of Lahore who was suffering from paralysis of the vocal cords. Dr. Honigberger treated the Maharaja dispensing a Homeopathic medicine “Dulcamara” (extract of a plant woody night shade) in wine, in low potency. Around the same time in **1836**, in Tanjoor (now Thanjavur), Dr. Samuel Brookling, a retired surgical officer, dispensed Homeopathic medicines to civilians and army officers stationed at Madras. In Bengal, Dr. Mahendra Lal Sircar, who famously cured Ishwar Chandra Vidyasagar of asthma and effectively paved a way for popularity of Homeopathy in Bengal. The first Homeopathic medical college in India was established in the year 1878, under the name of Calcutta Homeopathic Medical College. Right from the introduction of Homoeopathy in India, the influence of Bengal on the Homeopathic system of medicine has been significant.

Popularity of Homoeopathy had reached its peak in India in 1902, when Father Augustus Muller treated an epidemic of pneumonic plague in Mangalore District. His intervention was so admired by the British that he was given the Kaiser-e-Hind award.

### Important Policy Milestones in Development of Homoeopathy

Even a cursory look at the archival documents related to recognition of Homoeopathy as one of the systems of medicine, would give a glimpse of how policy makers viewed all non- allopathic systems of medicine namely- Ayurveda, Unani, Siddha and Homoeopathy. In 1968, a joint Bill for establishing the Indian Medicine and Homoeopathy Central Council was introduced in the Rajya Sabha. It seems little attention was given to the fact that fundamentals of all these systems were different. However a Joint Committee of the Parliament was convinced by Homeopathic practitioners to grant separate status to Homoeopathy. The Committee amended the Bill suitably and made provisions for a composite Central Council for the three Indian Systems of Medicine and a separate Council for Homoeopathy. It should be noted that the special panel of Planning Commission was recommending constitution of Central Councils

of India Systems of Medicine and Homoeopathy since 1952, however it materialised only after 20 years in 1972 when the Bill was introduced in the Parliament. On 17<sup>th</sup> December 1973, the Homoeopathy Central Council Bill was passed by Parliament.

### Institutionalisation of Substandard Education

The Central Council of Homeopathy (CCH) is the apex body to monitor the quality of Homeopathy education in India. According to many respondents, with whom I spoke while writing this article, unequivocally opined about incompetency of CCH and its collusion with private education sharks. While private medical education has been a contentious issue in general and not ‘pathy’ specific, anarchy in Homeopathy medical education is particularly astounding. Consider the following -

1. Minimum percentage required to get admission in Homeopathic Medical college is 50%, as per CCH norm. However many institutions are not following this rule. One of my respondents told me that during the last three years the average 12th standard marks of the first year entrants in his college as well as many colleges in Maharashtra, has been consistently between 45 to 48%!
2. Payment to teaching faculties is abysmally low - Rs 6000 to Rs 8000 rupees per month, for the post of an assistant professor.
3. In 2011-13, many graduate doctors opted for ‘external’ MD degree. The only requisite to get this degree is to appear for final examination. After a lot of uproar this scam was stopped by CCH.
4. Most of the medical colleges do not have mandatory hospitals attached to it. Many interns end up doing their internship in allopathic hospitals.

This grim scenario is a necessary prelude for any analysis of present practice of Homoeopathy. It must be kept in mind that present practioners and prospective students of Homoeopathy have studied and would be studying into these institutions of mediocrity, until the entire system of Homeopathy education in India undergoes radical changes.

### Being Homoeopath: Self-Esteem, Client Base and Relationship with Mainstream Allopathic Practice

Barring a few, who voluntarily opted for Homeopathic education and are doing Homeopathic practice with

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equal passion, a sense of “subordination” is very strong amongst Homoeopaths. In the words of a final year student ‘unless asked I never tell anyone that I am pursuing graduation in Homoeopathy, it is always better to say I am doing medicine’. Although in last year of his graduation, he still grudges about missing admission in dental college merely by three marks!

Girls seem to outnumber boys in Homeopathic institutions. When I attempted to probe this phenomenon explanations that came forth were gender-biased. One of my teacher friends said that in his 10 years of teaching experience he has seldom seen girls graduating in Homoeopathy marrying a boy from graduating in same stream.

This sense of subordination seems to be strongly linked to a lack of Government patronage, constant pressure of uncertainty associated with illegally practicing allopathy, and relatively little incentive in being a homoeopath – e.g., they cannot issue death certificate, fitness certificate - Homoeopathy is not included in the RMP Act. Moreover advances in modern medicine in the form of scanning techniques, sophistication in diagnostics, etc., also seem to be a monopolised domain of the modern medicine. In contrast Homoeopathy looks almost ancient..

Ironically there is a surplus production of Homeopathic doctors. However, there is a relative stagnation in the number of Homeopathic ‘practitioners’, conservative estimate suggests that approximately 85% of doctors end up doing allopathic practice. Even during my informal interaction with students it became amply clear that many of them are in Homeopathic medical colleges because it would pave a way, even if illegal, for allopathic practice.

While analysing the clientele of Homoeopathy, interesting insights are shared by practicing homoeopaths. Undoubtedly the foothold of Homoeopathy among educated, middle class families has become stronger. One of the simple and clichéd reason to opt for Homoeopathy seems to be an assumption that there are no side-effects of Homeopathic Medicines. At a more sophisticated level, it seems to be a well-studied conscious choice to opt for Homoeopathy. One of my practicing friends has also shared an important observation. According to her, “Homeopathic system of individualisation and case-taking is fascinating for many patients, especially for women, since they never had an opportunity to look at their corporal and subconscious existence in an analytical and intimate way. Allopathy would never give them that opportunity. Almost all homoeopaths

to whom I spoke to told me that middle and upper middle class people are their main clients. Upon asking reasons for inability of Homoeopaths to make inroads in working class community, I was told that dominant Sui (needle) culture is the main impediment and somehow the feeling that Homeopathic Medicine takes longer to cure is also dominant. However in certain other observations class bias was evident, e.g., working class “lacks patience” to continue Homeopathic treatment.

Almost all Homoeopaths with whom I have interacted had documentary evidence (in the form of case records and occasionally in form of photographs) to prove that Homeopathic medicine fares better in skin ailments, psychosomatic disorders and chronic ailments. Many allopaths also tend to refer chronic patients to Homoeopaths for treatment, particularly for skin and chronic ailments.

Interface between Homoeopaths and specialist doctors (MD, MS, etc.) seems to be far more peaceful compared to the traction between a Homoeopath and a MBBS doctor. Primarily because their clients come from the common pool: an OPD of homoeopath and an allopath would typically have same type of patients, which often results in sharp professional rivalry. Notably the recent ordinance by the Maharashtra Government to allow Homoeopaths to practice allopathy after one-year course in pharmacology was opposed by MBBS doctors far more vocally than the specialist doctors.

In a predominantly allopathic milieu, Homeopaths also tend to feel short of explaining and justifying ‘scientificity’ of Homeopathic medicine itself. Unlike modern pharmacology where action of drugs could be explained in detail, action of Homeopathic medicines still remains a mystery. In last 100 years Homoeopathy has been termed as placebo by some of the leading scientific journals across the world, which seems to be a harsh assessment since many unexplained results were achieved by using Homeopathic medicines time and again. (Sir John Forbes, a physician to queen Victoria, once said- Homoeopathy is an outrage to human reason).

Multiple arenas in the context of Homoeopathy needs attention, particularly utility of Homeopathic medicine as a preventive medicine and its use during epidemic requires serious research.

Without getting entrapped into a “Pathy fundamentalism”, I think there is a need to rethink aims, claims and assumptions around medical science itself.



## Discrimination, Mental Health, and Subaltern Healing Practices

- Shubha Ranganathan<sup>1</sup>

What is/should be the place of local healing shrines in public mental health? How do we make sense of the simultaneous existence of doctor and the healer? What happens to those whose practice of visiting religious shrines for mental healing is now illegitimized? These are some important questions to reflect on when thinking about 'discrimination' and 'mental health', particularly when the focus is on subaltern groups who come from historically disadvantaged sections of society.

Much of the debates on the issue of 'discrimination' in relation to 'mental health' have focused on the different ways in which persons suffering from mental distress or psychosocial disabilities are denied opportunities for full participation in society, whether in terms of employment or marriage prospects, property ownership, inheritance, or child custody. But what is also now emerging is that there are racial and ethnic dimensions to this discrimination, as the next paper on *Race, Discrimination, and Mental Health* points out, so that the mentally distressed from racial minorities become 'doubly disadvantaged' and 'doubly discriminated'.

In the Indian context, one of the ways this 'double discrimination' occurs is by delegitimizing certain help-seeking practices, such as people's resort to religious shrines for healing. Social scientists have long established that large sections of the Indian population—particularly those suffering from personal and social distress—resort to visiting religious shrines that are seen as having healing properties. This does not mean that they do not seek medical or biopsychiatric treatment for their problems. In fact, the practice of simultaneously seeking treatment from a general medical practitioner, psychiatrist, herbalist, and visiting a shrine is only too common. Patients often adopt a pragmatic approach to help-seeking, consulting "medical doctors for the medical problem and spiritual healers for the spiritual affliction" without perceiving any contradiction in this practice.

Yet, when it is subaltern groups who engage in certain cultural practices—such as visiting healing shrines—double discrimination results in these healing practices being framed as unscientific, ineffective, and therefore, illegitimate. *Inevitably, it is the cultural practices of those coming from the lower castes and classes that become the target of illegitimacy or 'reform' endeavours.* This means that a Dalit with psychosocial distress who trances in an obscure Mahanubhav temple is likely to be seen as 'ignorant' and 'irrational' while the upper caste sufferer who makes an offering in a Hindu temple of the Brahmanical tradition might be excused for his/her

'religious belief'. Thus, after the Ervadi fire tragedy, one witnessed the systematic targeting of *sufi dargahs* by the state, media, and activist organizations (termed 'witch-hunting' by Davar and Lohokare, 2009) even while several temples of the great tradition are left alone even when they are used for similar purposes.

But what is it about healing shrines that are powerful enough to draw large sections of people to them? In most residential healing shrines, it is not the use of a substance or the performance of an exorcist ritual that is important but the stay within the shrine premises. Suffering individuals reside within the shrine for a specified duration of time and carry out their worship activities, such as singing hymns. They may also experience trance, which is believed to draw out the ghost from the body and heal the afflicted person. Importantly, in Mahanubhav temples, as well as several other kinds of healing shrines such as *sufi dargahs*, people are neither subjected to exorcisms, nor forced to carry out any practices. While many of them do go into trance during the worship sessions, these trances are not coercive but participative. Staying in the shrine is an accepted practice, which does not make the person a 'patient'. Thus, one can say that as healing temples, the Mahanubhav temples are distinctive in the absence of any 'healers' or 'exorcist' practices.

From the modern, 'scientific' perspective, healing shrines are seen as exploitative and ineffective spaces that prey on the blind beliefs of susceptible villagers for their personal benefit. Yet, this modern, 'scientific' perspective often fails to engage with the 'irrational' subject, who is seen as fatalistically resorting to healing shrines either because of no other option or because of ignorance. My own long-term field research on residential temples of the Mahanubhav sect in Maharashtra indicates that people are not simply passive victims of exploitation and superstition. In most cases, they make a clear choice about whether to visit the shrine as well as when to leave. In fact, not all who turn up at the temple doorstep take the path of trancing and healing.

Thus, for instance, Sneha, an eighteen-year-old woman complained to a temple official that her mother 'dragged' her to the temple every year. Sneha's mother was convinced that Sneha was a victim of possession due to the series of problems that she had: repeated headaches, typhoid, and poor school performance. (Note also, that Sneha's problems cannot be delimited to the category of 'mental illness' but reflects a general sense of dis-ease due to the successive life difficulties she encountered.) She hoped Sneha's illness would 'come out' in the temple through the trance. Sneha,

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however, was convinced that her problems were related to 'tension' and she never went into trance in the temple. Although this worried her mother further, there was nothing that she could do. In fact, the temple official commented to the mother that Sneha did not appear to have a ghost in her. Regardless of the 'real' cause of Sneha's problems, what emerges from this case is the space afforded by the temple for women to 'refuse to trance' if they so wished. The idea, therefore, that women frequenting shrines are gullible and powerless victims of exploitative forces who inevitably become indoctrinated into believing they are possessed is not supported by field data.

What is also often not acknowledged is that healing shrines play an important role of providing succour, respite and refuge for those in distress. Particularly since these shrines tend to be visited by women who have to contend with the struggles of everyday family tensions and domestic responsibilities, they provide much-needed spaces of respite and refuge. For instance, an eighteen-year-old newly-married woman Gayatri, who was having trouble adjusting to the additional demands made on her in her marital home, stayed in the temple for a month to heal her affliction. During her initial days in the temple she frequently described her temple as "peaceful and calm", unlike her tension-ridden home environment. However, she gradually became reconciled to her new role as a wife. By the end of her stay, Gayatri was no longer troubled by the increased housework she was burdened with in her marital home. She had learned to make compromises and adjustments to her marital family. On their part, her marital family had accorded her the allowance of the temple stay, which provided the required buffer time for Gayatri to adjust.

Another middle-aged woman Vimla complained of having frequent quarrels with her husband and mother-in-law. She would often visit the temple to gain respite from these fights. Gradually, after her frequent stays in the temple, Vimla was able to convince her husband that they move out of his parents' home and live separately with their children. Meanwhile, her husband began to accept her frequent stays away from the home. Through a process of mutual adjustments and compromises, Vimla and her husband were able to come to some kind of resolution.

These cases illustrate that women are able to negotiate their demands and needs after their initiation into the temple community. While some women move out of the in-laws' home with their spouses, others move to another village. Given that these women lack realistic options to resist subjugation, the opportunity to stay in the temple (away from the home) with a community of sufferers, works as a powerful alternative that provides them some degree of negotiability. In allowing for such symbolic but significant modes of

conflict resolution and distress management, these shrines play an important role as community spaces of healing in society. They are all the more crucial given the severe dearth of options for women to redress family conflicts, and the abysmal absence of non-biomedical and community alternatives for managing psychosocial distress.

Given these observations, one might believe that it would be beneficial if healing shrines were incorporated formally into the mental health circuit. In fact, the Global Mental Health Agenda endeavours to expand community mental health service delivery through 'low-cost alternatives' such as using shrines as important agents and sites for the delivery of services. Thus, for instance, one witnesses government-supported efforts that provide free psychiatric consultations and medications, *within healing shrines themselves*. On the one hand, it is laudable that biomedical treatment is provided alongside spiritual healing, but one worries that with the attempt to recruit shrines within the GMH agenda we might witness increasing homogenization of these shrines. Healing shrines are not equivalent to mental health service centres, and their role in society extends beyond the narrow domain of 'mental health'.

Moreover, the drive to use healing shrines to reach out to those in mental distress is based on the assumption that all individuals frequenting healing shrines are actually mentally disturbed and require psychiatric intervention. Yet, as the cases above describe, people's distress is often not individual or personal but psychosocial. Therefore an individual-centric form of intervention, such as psychiatric medication, might not be appropriate. One might think of Gayatri or Vimla and wonder what psychiatric medication might achieve in such cases. Would psychiatric medication enable Vimla to move out of her home and seek respite in the temple? Instead of simply using healing shrines to gain access to those in psychosocial distress and medicate them, what is required is the strengthening of strong *non-biomedical* alternatives in society that women in distress can turn to. Without providing such alternatives, the transformation of religious shrines into 'community psychiatry sites' might actually take away what is most powerful about them – the fluid and unstructured healing that restores persons without making them 'patients'. Although the drive to provide psychiatric medication in *dargahs* is couched in the language of 'mental health rights', without attending to the broader psychosocial concerns of sufferers, such intervention might be nothing more than an appropriation of healing shrines.

#### Endnotes

<sup>1</sup>Davar, B. & Lohokare, M. (2009). Recovering from Psychological Traumas: The place of Dargahs in Maharashtra. *Economic and Political Weekly*, 44 (16), 60-67.

## An Exploratory Note on Discrimination and “Race” in Relation to Mental Health in the West

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The history of psychiatry shows that “race” has long been an influential concept in determining human behavior, problems with living and their management and treatment. More recently, this history shows how systems of mental health provision and policy affect racialised<sup>1</sup> communities living in the west. For example, as late as 2003, an inquiry into the death of a 40-year old African Caribbean man, David Rocky Bennett led to an in-depth examination of mental health care in the UK. The report found the National Health Service to be “institutionally racist”.<sup>2</sup> Institutional racism was defined in an earlier inquiry into the murder of a young black man, Steven Lawrence as “a feature of institutions where there are pervasive racist attitudes and practices, assumptions based on racial differences, practices and procedures which are discriminatory in outcome, if not in intent, and a tolerance or acceptance of such differences.”<sup>3</sup>

In Western countries where there are substantial populations of people from communities and backgrounds other than indigenous/occupying white populations, racial discrimination interacts with structural (social, cultural) discrimination against people deemed mad or “mentally ill”. This multiple discrimination happens in several contexts affecting the practice and theory of psychiatry and mental health. We attempt to examine some of these contexts below in six sections a) the racist underpinnings of the history and development of psychiatry; b) racialised theories of the psyche, emotions and mental health/ill-health; c) racism as cause and context for mental and emotional distress; d) Racial discrimination in relation to access of health and healing systems; e) discrimination against alternative meanings and contexts of healing and health; and f) multiple discrimination based on notions of “race” and “madness” within societies and communities.

### Racist Underpinnings of the History and Development of Psychiatry

*On that day, completely dislocated, unable to be abroad with the other, the white man, who unmercifully imprisoned me, I took myself far off from my own presence, far indeed, and made myself an object. What else could it be for me but an amputation, an excision, a haemorrhage that splattered my whole body with black blood . . . My body was given back to me sprawled out, distorted, recoloured, clad in mourning . . . I was battered down with tom-toms, cannibalism, intellectual deficiency, fetishism, racial defects . . .*

- Franz Fanon, *Black Skin, White Masks*<sup>4</sup>

Psychiatry and allied disciplines and their categories and practices have, throughout their history, been heavily influenced by social constructions of “race” – the supremacy of the white races and the inferiority of other races – and by philosophical ideas of Eugenics.

Psychiatric disease classifications and explanations of human behaviours were an aspect of colonial forms of knowledge. They were used to justify practices of subjugating populations and for instituting power structures. We examine just two of these contexts:

#### 1) Diagnostic and explanatory “disease” categories

In the mid- to late 19<sup>th</sup> century, Samuel L Cartwright coined two diagnostic categories specifically relating to slaves who tried to challenge or escape from slavery.

Dysaesthesia Aethiopsis was a condition described by Cartwright in 1851 as afflicting the body and mind of slaves, especially “free slaves living in clusters by themselves than among slaves in our plantations, and attacks only such slaves as live like free negroes in regard to diet, drinks, exercise etc.”<sup>5</sup> A perceived “insensibility to pain when subject to punishment” was one of the symptoms [emphasis added].

Drapetomania was another “disease” defined as a condition “that induces the negro to run away from services”, a condition perpetrated either by “treating them as equal” or by “frightening them by cruelty.” The treatment proposed included, along with care and attention, punishment “until they fall into that submissive state which was intended for them to occupy in all after-time...” [emphasis added].<sup>6</sup>

2) In more recent times, in the 1980s, a very British psychiatric diagnosis emerged specific to African Caribbean migrant communities living in the UK. The popularity of this diagnosis, records show, coincided with the race riots. The diagnosis confirmed public images of the riots, nurtured both by the media and by the state that associated African Caribbean communities with drug abuse in general. More insidiously it interpreted the anger expressed by young black men against racism as associated with cannabis use. It has been argued that this diagnosis neatly packaged the moral indignation against drug abuse and violence and the political need to invalidate a people’s struggle into a pathology of anger and discontent.<sup>7</sup>

But perhaps most telling of all is the controversial diagnosis of “schizophrenia”. From the time “schizophrenia” was constructed as an explanatory model and diagnostic category to understand certain human experiences and behaviours its validity has been in question.<sup>8</sup> In almost all Western countries, more black<sup>9</sup> people, especially young men of African and Caribbean backgrounds, are given a “schizophrenia” diagnosis than other (especially white) people. This disproportionate overrepresentation is a phenomenon not common in black countries. In a study<sup>10</sup> enquiring how “schizophrenia” became a black diagnosis, Jonathan Metzl presents historical evidence showing that the concept of “schizophrenia” went through significant revisions – first from a change (splitting/

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transformation) in personality into one of “masculine belligerence”. Later in the context of the mid-1970s civil rights movements in the USA, “schizophrenia” became a diagnosis disproportionately given to black men. This pathologisation of the continuing anger and disaffection among black communities is coupled with the racialised stereotype “big, black and dangerous”. It continues to colour psychiatric diagnosis in contemporary Britain, US, Canada and other Western countries with large populations of immigrant communities.<sup>11</sup>

### A. Racialised Theories of the Psyche, Emotions and Mental Health/Ill-Health

Several studies over the decades have found less incidence of mental “illness” among non-white populations in non-Western environments. This has led to several racialised theories about their mental and emotional capacities and, consequently, their ability to feel distressed. For example, in a 1947 analysis of Africans in a Kenyan mental hospital, J.C. Carothers<sup>12</sup> justified the “rarity of insanity in primitive life” as reflecting the absence of problems in the social, sexual and economic spheres”. This apparently resulted in a process of natural selection: “the African may be less heavily loaded with the deleterious genes than the European... [because]... natural selection might be expected to eliminate the genes concerned more rapidly in a primitive community.” Carothers made further analyses that went on to influence psychiatric practice worldwide. These include a) the idea that a lack of qualities such as self-reliance, personal responsibility and initiative is the reason for reduced rates of depression among Africans when compared to Europeans; b) the idea that there was a “striking resemblance between African thinking and that of leucotomised Europeans” – meaning that Africans underused their frontal lobes;<sup>13</sup> and c) that the Kikuyu who participated in the Mau Mau uprising were suffering a form of “mass psychosis” arising from “a crisis of transition between primitive and modern worlds.”<sup>14</sup>

Racialised theories of “differentiation of emotions” have been used more recently to justify the different outcomes found in the International Pilot Study of Schizophrenia. People in “developed” countries showed higher ratings for anxiety and depression measures in these studies when compared to people in “developing” countries. This has been justified by the idea that people in “developed” countries showed a “greater differentiation of emotions” when compared to people in developing countries; the only exception was African Americans.<sup>15</sup> This theory was further developed as representing an evolutionary process.<sup>16</sup>

This racial prejudice persists in the practice of psychiatry today: a quick example is the recent call for “social engineering” to combat a perceived “epidemic of schizophrenia” among the African Caribbean populations in the UK.<sup>17</sup> The racism and discriminatory attitudes involved in the assumption that Western cultural constructions of mental “illness” and disease can be easily transplanted across the globe have also been highlighted in the critique of the Global Mental Health programme.<sup>18</sup>

### B. Racism as Cause and Context for Mental and Emotional Distress

*When I was a child we lived on an all-white road. Nobody was friendly to us and, as luck would have it, our next door neighbour was a member of the National Front and he kept throwing abuse over the garden wall at us... It was really horrible, horrible stuff. And when you were growing up as a child, you think that's how the outside world sees you. You are not going to have pride in yourself and you actually fear the world around you. I can see where that has had a knock-on effect on my experience or “paranoia” but then all you are told is “schizophrenia” ...*  
- Kalathil, *Recovery and Resilience*<sup>19</sup>

The history of racism has a tremendous impact on how mental health and ill-health/distress is perceived and categorized in relation to different racial groupings. Racism has been the broad ground on which different aspects including statistics, diagnosis, treatment, legal determinations and popular cultural myths have thrived. This ground includes the migration of ex-colonial populations into North America and Europe, bringing with them the history of being subject to colonialism and slavery. These continuing prejudices co-exist with prejudices against “new” migrants (including other white communities from an expanding European Union, for example), and the refugee and asylum seeker population. Such prejudices are fuelled by public imaginings of a dangerous and parasitic “other”, defined variously from “the benefit scrounger” (i.e. feeding on a wealthy and benevolent state) to “the terrorist”. Racist discrimination in all these contexts leads to external oppression and in addition the internalization of oppression (leading to issues of self esteem, sense of self, confidence). In turn, low self worth can and has led in many cases to a tragic inability to succeed in an immensely hostile environment, leading to profound distress that is most often categorized as “mental illness”.

### C. Racial Discrimination in Relation Access of Health and Healing Systems

*The concept “high-risk” was associated with mental health service users who represented a “close fit” with the archetypal risk figure of the young male with a diagnosis of schizophrenia or personality disorder, where the focus was on the potential for violence to other people rather than for self-harm by these individuals. [It] was associated even more strongly with young black men from this category... In this instance, the location of risk was therefore closely related to the social location of the individual in terms of their age, “race” and “gender.”*

- Warner, “Community care and the location and governance of risk in mental health”

Research over the years in the West has shown that “pathways to care”, i.e., the way in which a person seeking help for mental or emotional distress comes in contact with the mental health system, differ radically between white and non-white populations. Some key facts from the UK illustrate this disparity:

- Rates of involuntary admissions are 2-6 times higher than average for some minority ethnic

- groups, especially black groups
- Detention under the Mental Health Act is 2-13 times higher than average for some black groups
  - Rates of supervised community treatment orders (CTOs) show that people from black communities are 5-7 times higher than those given out to white people
  - The category “high risk” is most likely to be attributed to young black (African Caribbean) men with a diagnosis of “schizophrenia”
  - Women from black communities are four times more likely to be under compulsory admission, less likely to be referred to crisis houses or to therapeutic interventions such as IAPT (Improving Access to Psychological Therapy, a government policy initiative), and most likely to have their children taken away by social services.

In many Western countries, evidence shows that rates of voluntary admissions into mental health institutions are going down while involuntary admissions and compulsory treatment in the community are increasing. This situation is even more dire for people from minority ethnic communities, including migrant, asylum seeking and refugee communities. Despite “multiculturalism”, stereotypical views of the behaviour and motivations of people from racialised communities combined with the stigma and anxiety associated with mental “illness” affect the way in which mental health services assess and respond to communities seen as “alien”, resulting often in more and more coercive and controlling treatment. Consequently, people approach mental health and other support services with caution, even fear. This situation is well explicated by a study that analysed the relationship between mental health services and the black communities in the UK.

*When [racial] prejudice and the fear of violence influence risk assessments and decisions on treatment, responses are likely to be dominated by a heavy reliance on medication and restriction. Service users become reluctant to ask for help or to comply with treatment, increasing the likelihood of a personal crisis, leading in some cases to self-harm or harm to others. In turn, prejudices are reinforced and provoke even more coercive responses, resulting in a downward spiral, which we call “circles of fear”, in which staff see service users as potentially dangerous and service users perceive services as harmful.<sup>20</sup>*

#### **D. Discrimination Against Alternative Meanings and Contexts of Healing and Health**

*“I left home with just the clothes I was wearing and no money and seven months pregnant. And from there to where I am now – working, I have a car, I’m earning money, I don’t take benefits... People say, oh you have done well, but what’s the criteria? Who’s grading? Who’s the judge to say I have done well? What will they say if they know I still hear voices?”*

- Kalathil, Recovery and Resilience

The dominant model of mental health is the medical

model, which treats ‘illness’ as degeneration of or fall from mental health and “cure” as facilitating the return to some norm of mental health. In the last few decades, the concept of recovery has been developed from a service user/survivor point of view with meanings beyond definitions of illness and cure. The concept of recovery embraces a journey of resilience, discovery and hope, self-determination, agency and empowerment. In this mode of thinking, recovery is not a return to a former state of normality, but a process of negotiating strategies and contexts from which to lead a meaningful life. Sometimes these strategies include ways to live with ongoing realities of voice hearing, self-harm and other aspects that are often diagnosed as “illness behaviours”. Recovery, in effect, is a process of meaning making. It is intrinsically linked with the ways in which people make sense of their own distress, its socio-cultural, familial and personal, and bio-medical causes and contexts.<sup>21</sup> Narrative research exploring the experiences of mental health service users and survivors has shown that social justice is as much a root to recovery as is medication or psychological therapy. This is especially true for people who have been subjugated by systems of oppression.<sup>22</sup>

However, mental health systems and psychiatric knowledge have been in many cases slow (if not entirely resistant) to accept the experiential narratives and theories of distress. The healing and recovery that arise from these positions have also not easily been accepted as part of valid scholarship and evidence. Personal narratives and survivor theorisation become part of the knowledge base of psychiatry only to strengthen the “technological” or “ameliorative” aspects of an authoritarian paradigm of mental health, that is, to provide experiential views about the effect of a certain medication or as part of an anti-stigma campaign or news story.<sup>23</sup> More recently however, there is some hope for Reason in the processes of “re-balancing” psychiatric scholarship that are underway with survivor research gaining momentum in many parts of the world.

Some recovery processes and their implications in the Indian context are discussed in Shubha Ranganathan’s paper (in this issue) on healing shrines in this volume.<sup>24</sup>

#### **F. Multiple Discrimination Based on Notions of “Race” and “Madness” within Societies and Communities**

There is evidence from all over the world that people diagnosed as “mentally ill” or perceived as mad face stigma and discrimination in all walks of life, including education, employment, marriage and relationships, housing, property ownership, citizenship and voting rights and so on. Evidence also shows that this discrimination is multiplied when the person perceived as mentally ill belongs to a racialised community. For example, a national study of six major employment services for people with mental health problems and disabilities in the UK found that people from racialised communities were significantly less likely to find work (even

when severity of mental health problem was not a debilitating factor).<sup>25</sup> In a survey assessing attitudes to mental illness, while 29 per cent of participants said that they would not like to live next door to a person with mental health problems, this increased to 47 per cent if that neighbor was a Muslim with mental health problems.<sup>26</sup>

As discussed at the beginning of this note, there are parallels between “institutional racism” and the discrimination imposed on people with mental health problems within society and culture (structural discrimination). The multiple effect of this may explain the situations described above; and the answer to address these issues may not lie only in health and social care contexts but in social justice contexts.

#### Endnotes

1. The language used to refer to ethnic minority communities in the west is rife with controversies. In the UK, the preferred term is BME (Black and Minority Ethnic) communities. In this note, we use the term “racialised communities” to foreground not just the possession of identities that are different (in terms of “race”, ethnicity, nationality, culture, religion, skin colour etc.) but the processes and power structures that perpetuate differentiation and “othering”.
2. Norfolk, Suffolk and Cambridgeshire Strategic Health Authority (2003) *Independent Inquiry into the Death of David Bennett*. Cambridge: NSCSHA.
3. Macpherson, W (1999). *The Stephen Lawrence Inquiry: Report of an Inquiry*. London: The Stationery Office.
4. Fanon, Franz (1952/1988). *Black Skin, White Mask*. London: Pluto Press. p 85
5. Cartwright (1793-1863) was a Louisiana physician, member of the Confederate States of America during the civil war and a contributor to the development of “scientific proof” of the inferiority of the negro race. The report has been republished in Caplan, Engelhardt and McCartney (eds) *Concepts of Health and Disease*. Reading: Addison-Wesley, 1981. Also see for an extract: <http://www.pbs.org/wgbh/aia/part4/4h3106t.html>. According to Cartwright, the symptoms of included “insensitivity of skin”, “hebetude” of mind and lesions on the body, along with raising disturbances and destroying private property. Cartwright advised the application of oil to the skin “and to slap the oil in with a broad leather strap, and then put the patient to some hard kind of work in the open air.”
6. This idea of pain and punishment as curative is extremely important in later development of coercive psychiatry in general and how it affects black communities living in the West in particular: several justifications for the increased rates of black people in compulsory care, including compulsory admissions often involving the police, in control and restraint rates, seclusion and isolation etc. continue to be made by mental health services based on this idea.
7. See, for example, Hickling, FW and Hutchinson, G (1999). “Roast breadfruit psychosis: disturbed racial identification in African-Caribbeans.” *Psychiatric Bulletin* 23.3, 132-134 and Fernando, S (2010) *Mental Health, Race and Culture*. Basingstoke: Palgrave Macmillan (Revised edition).
8. See, for example, the review of arguments by Bentall, R (2013) “Would a rose, by any other name, smell sweeter?” *Psychological Medicine*, 43.7: 1560-1562 and for testimonies of people affected by the diagnosis: Inquiry into the “Schizophrenia” Label, [www.schizophreniaenquiry.org](http://www.schizophreniaenquiry.org).
9. The term “black” is used in this document to refer to people of African, Caribbean and Asian origin. It acknowledges the political use of the term to refer to people who have been historically discriminated against on the basis of their skin colour and “race”.
10. Metz, J (2010) *The Protest Psychosis: How Schizophrenia became a Black Disease*. Beacon Press.
11. There are other examples of political and social unrest/questioning leading to psychiatric diagnoses in the annals of the history of psychiatry. For example, see the development of “Borderline Personality Disorder” as a uniquely female diagnosis in the context of feminist movements. Wirth-Cauchon, J (2001) *Women and Borderline Personality Disorder: Symptoms and Stories*, Rutgers University Press.
12. J.C. Carothers is the author of the 1953 monograph *The African Mind in Health and Disease* written for the WHO in which several of his racist ideas are explicated. This monograph still features on the WHO website: <http://apps.who.int/iris/handle/10665/41138>
13. Carothers, J.C. (1951) “Frontal lobe function and the African”. *Journal of Mental Science*, 97, 12-48
14. Elkins, C (2005) *Imperial Reckonings: The Untold Story of Britain’s Gulag in Kenya*. Henry Holt. Carothers theorized that the only “cure” for this psychosis was confessing their role in the uprising and helped the British government organize a programme of recovery that resulted in years of torture and forced confessions.
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