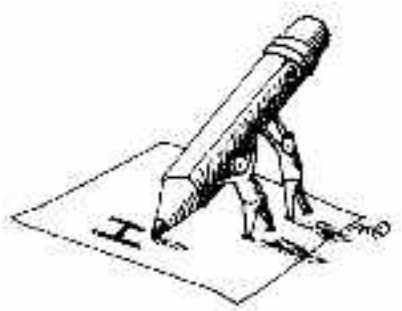
BUILDING BLOCKS DECEMBER 2010

SOCHARA ,Community Health Cell ,Bangalore



Editorial Note

Giving Wings to Those Who Dare to Dream

Dear Friends,

We are pleased to release Building Blocks, the occasional newsletter of the Community Health Learning Program (CHLP). The year 2010 is an important landmark bringing to an end the second phase of the Learning Programme. The CHC team is glad that among over eighty participants in the CHLP, each person has been able to find a direction, to make a paradigm shift, to cross bridges in their individual journeys towards the goal of 'Health for All'. The diversity of the interns, close engagement with communities and the open learning atmosphere offered by CHLP have been its strengths.

In 2010, we had fourteen interns (three flexi and eleven full time), with a majority from Tamil Nadu and Karnataka. Everyone came with a richness of experience and knowledge and contributed to the group learning individually and collectively. They hailed from different backgrounds, and communities. Some were computer friendly, while others had strong skills in working with rural communities. The focus on community health was integral to the entire collective learning sessions viz the orientation, the midterm meet, the six monthly review and the final review sessions.

The group lab and personality development workshops helped them introspect, understand their strengths and weakness, and internalize the dynamics of community and community health. This inner learning is of course a life long journey. Interns also had specialized workshops on Participatory Rural Appraisal (PRA) techniques and research methodology. In all their fieldwork, the interns were able to appreciate the role played by gender, caste and poverty and the ensuing powerlessness resulting in poor access to health care. Our interns and alumni are making sincere efforts in analyzing and questioning the embedded systems of social exclusion and marginalization, and other underlying determinants of health. They work against odds with a sensitivity grounded in building and empowering communities for health.

A National Workshop on Community health and Public Health Learning Programmes was held in Bhopal in October 2010, in association with the Public Health Resource Network. The workshop facilitated sharing of the experiences and challenges of different fellowships that have recently evolved in India (community health, nutrition, mental health and Indian systems of medicine). It was a precious moment to collectively engage in thinking of the way forward, given the spaces

for engagement of communities and civil society with the public health system.

The Alumni Workshop held on the 26th and 27th November 2010 marked the end of the second phase of the CHLP with the coming together of alumni and interns to share experiences. As always, there were interactions with communities facing social stigma and discrimination, yet who have dared to be different.

We are proud of the work done by our interns and alumni. They walk along with many in the country and elsewhere who work for health, sustainable development and equity. Our interns and alumni are deeply sensitive and caring individuals who are working for justice and health through campaigns, movements and community health action.

This newsletter brings to you the musings, reflections, learning, study findings and experiences of our interns and alumni. The articles share perspectives from different community based involvements.

Anand in his article Children of a Lesser God highlights the working and living conditions of agarbhatti workers, and the health related issues arising thereof.

The Invisible City Makers by Sathyasree highlights the plight of Bangalore's homeless population giving the findings of an action research study.

You will find in Bhavya's study, titled Failed by the System, Naveen's article Our tryst with medicines and Sejal's article on Food for Thought the lacunae in systems to ensure that all citizens have access to basic necessities of essential medical services, essential drugs and food.

Hanumanthappa shares the work of Jagrutha Mahila Sanghatane (JMS), an organisation that works for the marginalized community in Raichur.

The poems by Lavanya and Vidhushi reflect the quest for self-discovery that has percolated in the consciousness of the mind and heart, being in the midst of stark social realities.

The continuing thread in all these articles is the dimension of inequity in health and the urgent need for transformation towards peace and Health for All.

We are glad that CHLP has been a space for young individuals to shape their quest for justice and rights, to mould their perspectives to dare to work for the marginalized and oppressed in the context of our capitalist consumerist society. The energy, fresh ideas and insights of the interns reenergises and motivates the CHC SOCHARA community. CHLP has helped give wings to dreams.

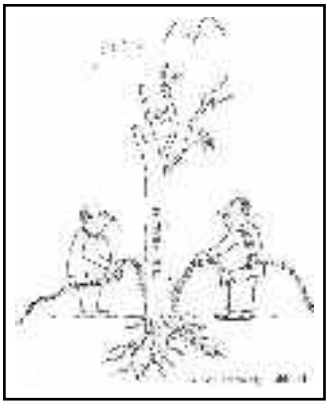
To each of the fellow travellers who stopped at the inn called CHLP, may the New Year usher in hope and optimism of a brave new world. May their dreams find great heights to soar through the clouds of change.

CHC Editorial team,

Joyce Premila, R.Sukanya and Thelma Narayan

'The CHLP is all about perspectives. You are transformed to think practically and realistically. If you feel disillusioned about ways in which you may help, the leap from blind knowledge to purposeful action through the CHLP would be the best option you could ever choose.'

Malavika Thirukode



THE HARD GROUND OF REALITY

Children of a Lesser God : *The Plight of Agarbatti Workers in Bangalore*

Anand Kumar

The incense stick (more popularly known as *Agarbatti*) is used in every devout Hindu household for pujas. It is widely used all over the world. Unfortunately, no one has thought of how these agarbattis are produced.

Agarbattis can be manufactured anywhere. All that is required is a wooden board, raw manufacturing materials and anyone can be trained to roll *agarbattis*. Companies that sell *agarbattis* under various brands have exploited this. Although the *agarbatti* industry falls under the Factory Act in Karnataka, many of the manufacturing units are housed in a shed in the house or individual homes in slums, that are often unregistered and do not come under the purview of labour laws. It is estimated that there are around 250,000 workers engaged in the Bangalore – Mysore region alone, which is the highest in the country. The companies contract the work through middle-men to the workers in the households and there is distinct lack of employee – employer relationship.

In a place called Ullau on the outskirts of Bangalore, all the workers are women and children, belonging to either poor Muslim or dalit households. Poverty, the double burden of earning and taking care of the family and patriarchal norms force women to take up this home based work. The workers earn around Rs. 20 to Rs. 22 for every 1000 sticks (piece rate basis. Depending on the type of *agarbattis*, a worker can earn roughly about Rs. 100 to Rs. 120 a day if she labours for 9 to 10 hrs. The same 1000 sticks fetch the company Rs.1,000 to Rs. 1.500 extending up to even Rs. 5000 a piece!

Women work in dark dingy rooms with no safety gear. Common health problems faced include muscle pain and body pain due to long hours in a specific posture, and repetitive nature of work; skin and dust allergies; gynaecological problems such as abdominal pain, irregular menstruation, urinary problems and white discharge. Unfortunately, there are no studies done to determine clear linkages between working conditions and health risks.

The *agarbatti* production process in the households constitutes only 10% of the total cost of the final product including raw materials. The rest 90% cost goes into perfuming (which is usually a trade secret), packaging and marketing of the brand that is factory based.

The condition of the workers in the licensed *agarbatti* manufacturing units is no better. They receive a fixed salary, and are entitled to social benefits such as Provident fund (PF), Employee State Insurance (ESI) scheme, bonuses, pension etc. Workers are denied access or expected to pay bribes for these services.

The government and trade unions don't recognise the women who are home based or in unregistered units as workers. They are looked on as housewives earning an extra income. The middle-men can shift or close units as there is a steady supply of cheap labour. Women need their jobs and are under the mercy of the middle- men who also lend money. Many of them remain perpetually in debt.

Given that 50 million workers in the entire South Asia are engaged in home based work, it becomes imperative for unions to organize workers around household communities. There is an urgent need for unions to provide a platform for women workers to demand for the stipulated minimum wages and social security benefits from the government. It is also important to question the policies that define wage structures and social security given by the government. In the context of the conditions of poverty in which workers are employed, radically different social measures are required. We need to redefine who controls the institutions of labour, welfare and governance, and put them firmly under the control of workers and trade unions, which is the only guarantee to them achieving a decent employment, a living wage and social security.

Anand Kumar gave up a career in clinical research, to follow a path of social activism, he understands pharmaceutical policies and how it impacts the poorest of the poor in this country. He has, since his fellowship (2010 Batch) worked closely with unorganized workers. He has very recently joined the Centre for Studies in Ethics and Rights, Anusandhan Trust, Mumbai

PEOPLE AND PLACES

The invisible City Makers

Satyashree Goswami

Most of the homeless in Bangalore come in search of a better life. They often migrate from villages driven by the failure of the agrarian economy mainly based on land. Failed economy in the rural areas does not provide even the minimum standard of living that forces people to migrate to cities. The worst affected are children, elderly and the disabled with women bear the maximum burden.

"Homeless are those who sleep with mere plastic/tin sheet roof or without roofing (even if it's for a few months of the year) in parks, railway stations, under Flyovers, on pavements, vacant sites (Private/Public), in front of temples, mosques, churches etc."

This definition was developed by NGOs involved in a study on the homeless in Bangalore. The term "*city makers*" was coined by a group of activists working for the cause of the homeless across cities in India. The primary occupation of these people was rag picking, street and public facility sweepers, domestic workers, street vendors etc. These are thankless jobs, rarely acknowledged services, rarely visible workers because of the timing and the nature of work. Yet if not done one cannot imagine the plight of the city- the garbage dumps piling, the unclean roads, and the missing domestic help.

An action research was carried out attempting to capture the plight of the homeless in 8 zones of BBMP in Bangalore. A survey was carried out for 1999 homeless persons through a questionnaire followed by case studies and focussed group discussions. As part of the survey, around 18000 people were counted as people sleeping on streets, under plastic sheets and in public places like religious institutions.

It was found that nearly 75% could not read and write. Nearly half of the people belonged to Scheduled Caste (SC) and Scheduled Tribe (ST) communities and 25% were from backward classes. Sixty percent had no identity card. Almost all were daily wage labourers, most carried out a combination of work like rag picking in the morning, part time house-maid work and other daily wage labour. Nearly half the people interviewed lived on footpaths or pavements and more than 30% lived under plastic tents. More than sixty percent respondents defecated in open empty places.

The most pressing problem was that of access to drinking water which often had to be fetched from nearly one to two kilometres distance. Children waiting in queues at public taps lost out on recreation and study time. Often adults broke their plastic pots left in a queue when they went to refill water back home leading to them being abused and beaten up even at home. The most severely affected were those individuals or small groups who did not live as a community and had to use pits or ponds for water, for bath and washing clothes.

There is a strong perception that homeless people are criminals leading to their arrests and imprisonments, without trial. They are vilified as 'illegal-migrants,' 'gate-

crashers,' 'queue-jumpers,' and 'invaders'. Thus, prevention of beggary laws and rules are used in some cities to clear the streets of homeless people. Many thousands of street children are arrested and imprisoned without trial for crimes they did not commit.

In reality, the homeless are extremely vulnerable to exploitation. They reported high levels of anxiety linked to the insecure life in the city, their homelessness and struggle for survival. They face the constant fear of harassment by the local goons, and of having to pay money to local landlords and goons. There was a feeling of unsettledness in occupying somebody's land, due to

threats of eviction from the police and government officials and miscreant activities leading to fire and loss of their belongings. The single most pressing need was of a secure shelter without the fear of eviction, demolition, threat or fear.

Most of the homeless lived in families, except for those who lived alone on pavements. Grown up children were seen as additional earning hands. The elder siblings took care of younger children though they wanted to go to school and even parents wished to educate their children. Education was a distant dream because of the need to struggle for survival. Added to this was the uncertainty of tenure of stay at any place, fear of eviction

and not having any identity proof that could give them a sense of 'existence'.

The study also finds that the mentally ill were abandoned by their families to fend for themselves. Men and women took to alcohol probably as a coping mechanism. Women narrated instances of rape, molestation and of spending sleepless nights guarding their young adolescent girls.

The elderly expressed a sense of acute despair and helplessness.

The story of each homeless person is a saga of a vicious cycle of helplessness. Failure of agricultural economy, family quarrels, rejection from family, floods and calamities, unemployment in the villages, debt etc. push people to migrate to secure a livelihood in a city. They become homeless in the cities. The trap of poverty again catches on with the homeless, pushing them to poverty with no promising future!

Satyashree worked in the development sector for ten years prior to joining the CHC program. She has worked in Assam, Arunachal Pradesh and Ananthpur. She currently facilitates organisational learning and organisation development workshops with organisations working on the issue of food security, Dalit and campaign for human rights in Orissa, Rajasthan and north Indian states.

FIELD REALITIES

Failed by the System :
Struggle for Quality Maternal Health Care by the Urban poor in Bangalore

Bhavya Reddy

In the last quarter of the Community Health Learning Programme, I gained insight in the Millennium Development Goal no. 5-Maternal Health.

My intention of conducting ten semi-structured interviews with women from an urban slum in Bangalore was to understand the ways in which marital and familial relationships, as well as quality of healthcare, impacted their lived fertility experience. This was explored through in-depth discussions about menarche, marriage, contraceptive use, pregnancy and childbirth. What emerged however, was a scathing picture of the quality of maternal healthcare for the urban poor in Bangalore, and the inherent flaws within the healthcare system that continue to risk women's lives. My most significant learning was that safe motherhood takes considerable precedence over any challenges surrounding family planning.

Nine of the ten women interviewed had a health outcome during pregnancy, delivery or in the postpartum period. This happened despite being situated in close proximity to both public and private maternal healthcare providers; hence, services were both available and relatively accessible. In addition, there was clear health seeking behaviour during the antenatal period, with all women seeing a minimum of two and up to five healthcare providers until the time of delivery.

The women's narrations drew attention to serious challenges in the pursuit reducing maternal mortality and morbidity. Below I discuss the salient factors.

Poor Antenatal Care

"*They told me everything is normal. But if you saw me, my hands and legs were fat, so swollen. They said there's nothing wrong. In the end when I got my labour pains...they said 'we can't manage it here, your blood pressure has gone up too high*".

All the women interviewed went to monthly antenatal check-ups during their pregnancies. Despite this, three women nearly lost their lives during delivery and one neonatal death occurred. The majority of antenatal check-ups were done at the nearest government healthcare centre. Women reported a number of drawbacks ranging from discrimination and apathy to not diagnosing symptoms of hypertension and anaemia. There was also a lack of communication between doctor and patient and many women felt their questions were not answered or their concerns acknowledged.

Verbal Abuse

Verbal abuse, especially by nurses at the time of delivery was described by many of the women. This threatens the woman's ability to report symptoms and discomfort, and discourages her from seeking help, grossly compromising the quality of care. Such abuse in the healthcare centre where they are humiliated and devalued further undermines women's voices and normalizing abuse.

Corruption and Affordability

"The doctors themselves take [bribes], from every

single person who comes there, on an average of Rupees nine-hundred to a thousand per person".

Corruption is deeply entrenched in the public healthcare system. Bribing is customary especially at the time of delivery and is detrimental to the quality of care women receive. Women and their families have to pay bribes for essentially free services. Even if largely unaffordable, five of the ten women were forced to access a combination of public and private healthcare providers, paying exorbitant bills in private hospitals and bribes at public hospitals.

Referrals and Accountability

The challenge that poses the most serious risk to women's lives during pregnancy and delivery is the lack of a functioning referral system, an accountability of actions, and coordination as a whole.

Bangalore has multiple service providers, both public and private, but there seems to be no referral system between providers or even within the public sector. Essentially, even in the most critical situations, only the woman and her family are responsible for the continuum of care.

Although not conclusive, the narrations suggested that some tertiary institutions in the city are not equipped with emergency obstetric care.

Reflection

While I entered conversations with these women with the presumption that women's subordination within the home prevents them from controlling their own fertility; I learnt that nothing is more paramount than surviving pregnancy and childbirth, and surviving without serious morbidities.

I appreciate the time the women from MRS Palya Slum gave me, and for their openness in sharing their stories.

I have developed essential skills and knowledge about running effective training sessions ,preparations required for trainings like budget preparations ,arranging resource persons and preparing lesson plans etc . ,

Personally I have changed a lot during the last nine months . Approaching others with positive attitude ,listening to others views , confidence in public speaking ,developing confidence in myself ,report writing ,analytical skills with positive approach and time keeping are the major personal gains for me in internship scheme

Madappan ,2010 Fellow

Bhavya Reddy was Fellow of the 2009 batch. Her areas of interest include: Children's rights, Population and development- Reproductive health and New directions in education policy. She has a Bachelor of Arts, Development Studies, 2006, University of Melbourne, Australia.

LEARNINGS THROUGH REFLECTIONS

My understanding of Community Health Experiences at Jagrutha Mahila Sanghatane

(Translated from Kannada)

H .Hanumanthappa

Jagrutha Mahila Sanghatane (JMS) has been working in 32 villages around Potnal village (Manvi taluk of Karnataka's Raichur district), with dalits, women, children, farmers, workers and other communities, in the field of community health and development. JMS was started 11 years ago by Premdas,Bhagyalakshmi, Koshy, Neju, Mita and other friends. It is now being efficiently run by Susheela, Chinnamma, Lakshmi, Devaputra, Chourappa, Kariyappa, Mariyamma, Ratnamma, Huligamma, Sakhena, Sunanda and others.

JMS has reintegrated over 400 child labourers who were mostly bonded labourers into mainstream schools through the government supported 'Chilipili' school and continues to support them in their further studies, along with providing advice and counselling.

In the agricultural sector, farmers once used to grow crops in traditional ways and prepare their own fertilizers/manure. However, with globalization, multinational companies for their own profit have induced farmers to use fertilisers that are toxic to health and the soil. JMS has been training farmers since seven years in the use of eco friendly and soil protective measures like the manufacture of neem fertilizers, vermin-compost, organic fertilizers resulting in better productivity, more employment opportunities and hence more earnings. In the creation of employment opportunities, JMS has helped 314 families that have been part of this movement to better their living standards. Women play a major role as evidenced by the fact that more women than men are employed. The groups involved in organic fertilizers produce about 75 metric tonnes of organic manure annually that is sold to various districts. The local farmers are trained to use organic manure to increase soil fertility and produce healthy crops. This is done without the help of machines.

JMS also trains women regarding holistic health care, which also includes prevention and cure of illnesses. Women are trained in the practice of home remedies, use of herbal medicines, given support to grow herbal plants, etc. Women give training on herbal remedies to various organisations and village-based health workers, thereby increasing the number of trained health workers. JMS has significantly improved the health of poor, rural women and children in Potnal.

Communities are able to get local remedies at low prices. About 23 varieties of medicines prepared from medicinal plants are available for treatment of most of the common diseases. Medicines for cough, cold, fever, body aches and other ailments, are sold during village market days. Through word of mouth the popularity and sale of these medicines has increased. Herbal medicines are available for problems ranging from gastric problems, paralysis, vitiligo, skin diseases, severe migraine, and menstrual problems. Until date, 40 patients with paralysis have been completely cured and over 100 individuals cured of white patches (vitiligo). These medicines are available under the brand name 'Chiguru'.

JMS also works towards removing inequalities based on class, caste and economic status in society. Self-help groups have been formed in 22 village and women are being trained in income-generation and health activities. Awareness on the NREGA, medicinal herbs, anganawadi, fair price shops, hospitals, organic manure, current affairs, technical knowledge and skills is also given by the JMS Sanchalakies (village coordinators). This empowers the community to raise their voice against any discrimination or exploitation and help them claim their rights.

Thirteen women of JMS are engaged in making terracotta jewellery. This is a creative art that is low cost, and yet very attractive. Raw material is procured from outside and the women create jewellery and decorative items using clay and paint. The terracotta items are exhibited and sold in various districts and sales outlets in different states. This has helped improve their living status.

The situation of the villagers, especially the marginalized, remains dismal. They live in small huts where smoke arising from cooking has an adverse effect on people, especially on children and infants who suffer from chronic cough, asthma, and other respiratory disorders. JMS has provided bio-stoves (chulikas) to around 250 families. Chulikas help save firewood, time and money; prevents smoke related illnesses thereby improving the living standards and conditions of the families.

Hanumanthappa is associated with the Karnataka chapter of the People's Health Movement, the Jan Arogya Andolana Karnataka. He has been working on issues of Disability, Right to Information Act, HIV / AIDS and TB, NREGA.

IN FIRST PERSON

I want to be

Lavanya Devdas

I want to be the tree that shades the desolate under a busy road
I want to be the leaf of that tree that catches dust day after day
I want to be the leaf of that branch that falls down by evening
I want to be dust of the leaf that dissolves into the earth

I want to be the flower that blooms in the chill morn of spring
I want to be the due drop that settles down on an obscure forest flower
I want to be the unknown of the unknown and yet be the joy of flowering
I want to be the petals scattered on an un-treaded path that leads to a ruined temple

I want to be the soul of a child that cries to be held to the bosom of love
I want to be that love that holds the child whispering tenderness
I want to be the tenderness that holds like the girdle of comfort
I want to be the child that smiles at a face with the tears that I was just a minute ago

I want to be the agony of your heart when alone, morbid and lost
I want to be the lost, the morbid, the lone, to take in my palm your ruffled heart
I want to be the arguments and counterarguments that loses its intensity in time
I want to be the tear of the dry eye that is delicately filled to the brim

I want to be the breath of your now, to breathe the joys of knowing
I want to be the inhaling of the suffering, to breathe out for you peace and stillness
I want to be the hand that you can hold, when you know your soul churns
I want to be that smile of your face to know that you have found

I want to be the earth from which we are born
I want to be the fire that comes from the earth of love, hate, misery all mingled with contradictions
I want to be the phoenix that burns in hope, every time she burns into ashes
I want to be the hope, the possibility of being when the earth, the river, the cloud breathes its last

I want to be

Lavanya Devdas was coordinate and active member of the Association of India's Development (AID) for over six years, involved in grassroots efforts expanding from rural-urban development, child health, and women's empowerment to areas of communication, management and public relations. She has over 10 years of work experience in reputed technology companies as Senior Technical Communicator, managing and implemented projects from both the US and India. She has proactively participated in Corporate Social Responsibility through the 10 years of her IT profession. Her interests are in the area of Child Rights and Communications.

ON THE OTHER SIDE

Our Tryst with Medicines :
The investigations of a Community Health Worker

Naveen I .Thomas

Vani works as a domestic help Bangalore. She has two children. They were abandoned by her husband two years ago. She now works double time to meet the family's expenses. When her younger son developed severe stomach pain some time ago, she did a round of doctors, including the state-run hospital. Because each day's absence from work meant a cut in her wages and in a bid to balance work, income, taking care of her older child and taking the younger one to hospitals, she finally settled for a clinic close to her house. By the time the boy finally began to respond to treatment, she had lost all her savings, and could not afford to buy the prescribed medicines!

It was at this stage that we met Vani. She approached our organisation for help, through a women's Self Help Group that we organised in her area. We had heard this familiar story over and over again – child after child, woman after woman, family after family slipping into poverty because of the high costs of medicines and medical treatment. A closer look at the prescriptions revealed the pathway to ruin – overpriced, irrational and unscientific medicines taken consistently over a period. When Vani was told that half the medicines bought were irrational, and the other half could have been bought at a fraction of a cost from other manufacturers, she broke down.

She asked. 'How could this doctor do this knowing our poverty?' How indeed?

Was the doctor not aware of the generic equivalents of the costly branded drugs he had been prescribing?

Were these medicines prescribed because the doctor's continuing education about new drugs was from the marketing literature provided by medical representatives of different companies?

Was she a victim of the deeply embedded doctor-pharma industry nexus?

These questions and related issues led us to investigate a bit more intensively into the drug industry.

Our first shock came with the realization that policy making for medicines was not handled by the Health ministry, but by the Chemicals and Fertilizer Ministry! This explained the vast differences in the goals of the Pharmaceutical Policy 2002 and the National Health Policy 2002. It perhaps also explains why health care is the second most leading cause of rural indebtedness in India, as medicines constitute 50 to 80 percent of health care costs.

The second shock came when we realised that the prices of the same types of medicine in India varied drastically, sometimes as much as 20 times more than the lowest-priced one. For example, Risperidone 2 mg, a medicine used for psychiatric ailments which costs only Rs.1.69, was priced at Rs.27.00 by another company (16 times); Letrozole 2.5 mg – a medicine used in cancer treatment, which was priced at Rs.9.90 by one company was priced at Rs.181.50 by another (18 times). Given the public awareness of medical knowledge, if a doctor chose to prescribe a costlier medicine, the patient had no way to determine if a cheaper equivalent was available in the market. That made us wonder why there was no rule that made it compulsory for medical practitioners to prescribe medicines by its generic name. Very recently, generic prescriptions are being practised in some parts of India and by few physicians.

This also led us to the whole issue of the pricing of medicines in our country. We discovered that even the so-called free market countries of the EU and UK have some form of control over medicines, such as price controls, volume controls or cost-effectiveness controls. On the other hand, in India, the number of medicines under price control is steadily declining over the years. Even if individual medicines were under price control, manufacturers found a way around to get out of the price control. In this situation, the very least the Government could do was to bring in price regulation on all medicines in the National List of Essential Medicines based on therapeutic class rather than on individual drugs. Our investigations and understanding are still ongoing, and we are searching for the answer.

Naveen belongs to the first batch of the internship program. He along with a couple of friends founded Headstreams an NGO, that is today a movement of people who are dedicated to shaping a world where everybody has an opportunity to reach their fullest potential in all spheres of life - physical, social, mental, emotional and spiritual. The belief that human potential is best reached in conditions which foster human freedom and dignity has been the core of Naveen's journey.

VIEWPOINT

Food For Thought

Sejal Parikh

What fraction of people in India is poor, officially?

Arjun Sen Gupta puts it at 77%, N. C. Saxena estimates it to be 50%, while the Tendulkar Committee's figure is 37.2%.

The reference data used for all the three estimates was the same. The figures vary only because of differences in the way the mysterious poverty line has been defined. Of course, the Planning Commission chose to tell us that 37.2% of our citizens are officially poor.

Parallel to this, UPA-II has been working on the National Food Security bill, which effectively strives to increase food security in some ways. Food security as defined by the bill only includes distribution patterns (even worse, giving no entitlements to APL cardholders unlike the current situation), while disregarding the issues on the production side. As if this was not enough, several plans of cash transfer or food coupons being discussed within the future framework of the Public Distribution System (PDS) might prove to be a grave threat to food security.

Despite all the corruption, the PDS has been ensuring two major aspects of food security: provision of subsidised food to the poor, and Minimum Support Price (MSP) to farmers. Procurement of grains by the government also ensures that food production meets the demands. The introduction of direct cash transfers or food coupons raises serious concerns.

The purported idea behind cash transfer or food coupons is to get rid of the corruption issues within PDS, but the expert arguments prove otherwise:

- There is no clarity as to whether these cash entitlements will take future inflated food grains prices into account. While buying from the open market, there's no way of knowing what prices are charged to the poor by the private shops. In the case of food coupons, just like in PDS, there are high chances of the private dealer charging a commission to give food grains in return. There is also a possibility of giving out low quality grain at the rates of normal quality grains. In case of government licensed fair price shops, at least there are better mechanisms of monitoring such issues (provided there is a will to do so!).

- The majority of the poor already in heavy debt may find the cash a handy tool to get rid of debts; hence, this won't necessarily make them hunger-free. If given food coupons, they may again exchange it for cash to pay their debts. There can also be black marketing of food coupons, as is happening with Grains in PDS. Duplicate or fake coupons too are very much a possibility.
- There are issues with cash transfers via banks or post offices. The access to banks is already a challenge in many rural places and opening bank accounts on such a massive scale is in itself a big task. Already some of the NREGA cases have reportedly been suffering from delayed payments due to bank and post office transfers. Here too, people may lose out on giving some money as a commission to those who help them withdraw it.
- In Indian's patriarchal system, where, primarily men are the decision makers with regards to the spending cash, there's no assurance of this cash being spent on food.
- Cash transfers or coupons assume that food is available in every part of the country, where as the reality is different in many parts of rural India, where private shops do not exist in the first place.

Hence, instead of strengthening the PDS and looking at the more important matters such errors in exclusion and inclusion of BPL card holders, promoting local procurement and storage, etc., promoting such cash transfers or food coupons will only serve to dismantle the food security of the country.

This is one of the few issues the Right to Food Campaign is working on.

How did the Right to Food Campaign Begin?

With drought at its peak during the early years of the 21st century, starvation took its toll on many innocent lives. Even after numerous reports of starvation deaths, the Union Government of India did not declare a state of famine. High levels of food grain buffer stocks were not released to the needy, and rumours abounded of plans of either selling it in the open market or dumping in the sea (as the government was at sea on figuring out the right usage of it)!

These were the years, when The People's Union of Civil Liberties (PUCL) in Rajasthan took the lead on questioning the system with the help of law. A Public Interest Litigation (PIL) was filed in the Supreme Court in April 2001, arguing that the right to food follows from the fundamental "right to life" enshrined in Article 21 of the Indian Constitution. It also demanded that massive food stocks (about 50 million tonnes of grain at that time) be immediately released to prevent hunger and starvation. Going further petition asked to (a) provide immediate open-ended employment in drought-affected villages, (b) provide unconditional support to persons unable to work,

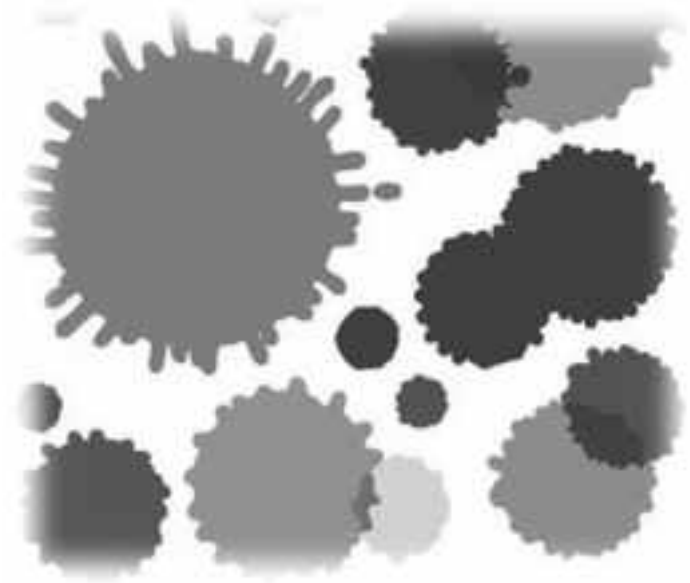
(c) raise the PDS entitlement per family, and (d) provide subsidised food grain to all families. The case resulted in landmark judgements passed by the Supreme Court, in terms of regular interim orders related to the implementation of many schemes (such as PDS, ICDS, Mid-day meal, old age pension) under the case, after converting them as legal entitlements.

This PIL was the pioneering milestone for the Right to food campaign, which has now grown strongly as a movement. Time and again, 'interim applications' have been filed resulting in 'interim orders', directing central and state governments to take necessary steps on the larger issues of starvation and malnutrition for all the states in the country.

For more information, visit:
http://www.righttofoodindia.org/

The right to food campaign is an informal network of organisations and individuals committed to the realisation of the right to food in India. We consider that everyone has a fundamental right to be free from hunger and Undernutrition. Realising this right requires not only equitable and sustainable food systems, but also entitlements relating to livelihood security such as the right to work, land reform and social security. We consider that the primary responsibility for guaranteeing these entitlements rests with the state. Lack of financial resources cannot be accepted as an excuse for abdicating this responsibility. In the present context, where people's basic needs are not a political priority, state intervention itself depends on effective popular organisation. We are committed to fostering this process through all democratic means.

Sejal has a bachelor's degree of engineering in Electronics & Communications. She has been a volunteer in the 'Struggle against GM foods', Health related initiatives at Noida slum community, Flood relief activities for Bihar and Orissa. She has also contributed to Zero Waste Management initiatives of Association for India's Development (AID) Bangalore.



INK BLOTS

THE JOURNEY OF SELF DISCOVERY

Vidushi Madaan

While traversing through this journey,
Where reality loses its identity,
Illusions take the shape of reality,
Our mind walks behind them blindly,
Our dreams take us to a new world,
And we happen to fly,
Traversing the journey,
Behind these thoughts,
OOPS!

When we hit the edge of the mountain.
We realize,
The thoughts have,
Passed the highest mountain,
And we are still at stake.

Uplifting our heads,
From the edge,
To the tip of the mountain,
Immediately our heart gains momentum,
And Roars

"It is just impossible."
Fear of doubt creeps in,

And you start
Losing your inner vision.
Ignoring all the dreamy thoughts,
Loosing the biggest opportunity,
To know YOURSELF,
You become the-
Old one and the usual.

And I feel…
If the vision is lost,
The self is lost.

And finally,
The day comes…
When it's your last breath,
You fall aback,

Regretting
The missed chance of knowing
"The human potential in you."

Vidushi completed her Msc. Microbial Biotechnology from Panjab University and was keen to understand the relevance of scientific research for communities and broaden her understanding of health research.

WHY DOES BINAYAK SEN MATTER ?

Rakhal Gaitonde and Thelma Narayan




Binayak Sen, paediatrician, social thinker and citizen of India decided early to work on the underlying social determinants of health. That fearless decision led him through many a twist and turn in life to his conviction last week by a Sessions Court judge to life imprisonment under charges of sedition. Our collective conscience has been stirred, as it has been time and again by those who speak truth to power.

Why is it important for us to reflect on the life work and current circumstances of Binayak Sen? Every doctor treating patients with malnutrition, nutritional anaemia, tuberculosis, persons affected by domestic violence, attempted suicides and other preventable and eminently treatable illnesses; all health workers; and those studying the distribution of death and disease among populations very quickly come face to face with the underlying structural determinants of health. As eminent epidemiologist, Prof. Geoffery Rose said *"The primary determinants of disease are mainly economic and social and therefore the remedies must also be economic and social. Medicine and politics cannot and should not be kept apart"* (Rose G, 1992, The Strategy of Preventive Medicine).

Binayak Sen's work over decades in central India brought him face to face with the fundamental contradictions and vested interests in today's social structure. This work led him to confront the roots of structural violence that maims and kills thousands of poor and marginalized persons from easily preventable diseases, which pushes thousands of farmers and other young Indians to suicide, and displaces thousands upon thousands of peace loving Indians to the indignity and ignominy of urban slum-life and rehabilitation camps.

Binayak, trained in a premier medical institution could have followed the beaten track to the west, to lucrative practice and intellectual thrill. Yet he and his wife Ilina chose to travel a different path. After completing postgraduate studies with distinction from Christian Medical College, Vellore, he chose to work in Jawaharlal Nehru University in the Centre for Social Medicine, the only post-graduate community health teaching program embedded in a department of social sciences. From there he went to work in the heart of rural India, worked closely with the inspirational trade union leader Shankar Guha Niyogi and was one of the founding doctors of the unique Shahid Hospital in Dalli Rajhara (one of the few examples of a hospital built by people for the people and truly of the people). He worked on adult malnutrition, raising issues of poverty and health. He was convenor of the Medico Friend Circle, a nation-wide 'thought current' that works for people-centred health care and is a part of the Jan Swasthya Abhiyan. He worked in civil liberties organizations to finally become a national Vice-President of the Peoples' Union for Civil Liberties (PUCL).

During his career so far, this paediatrician has shuttled back and forth between running regular clinics in remote areas with no access to health care like in Bagrum Nallah, to leading fact finding missions on encounter deaths and the Salwa-judum and raising the issue of corporate takeover of our natural resources in Chhattisgarh. This exposed a number of vested interests in the heart of one of India's states rich in natural resources. A state where precious resources are sought to be sold to the highest bidder with little thought to the peace loving and dignified adivasis who live there since generations. This is the background we must all understand when we reflect on his conviction and what we can learn from this.

The picture that has emerged may sound dismal. However, the Binayak saga has become a rallying point for national and global concern, thought and action. While this may often focus on the injustice done to him, it is important to continue to address the issues of social injustice that Binayak and Ilina are committed to, we believe that the path Binayak took was right. We believe that the roots of poverty, hunger and ill health are not ignorance, laziness and lack of hygiene, but result from deeply socially embedded inequalities and hierarchies that exclude a social majority. These are exacerbated by forces that place profit and GDP growth before people. Poverty is not an accident. It is caused by design – that allows individual profit and hoarding to unimaginable extents that allows inequity to grow, that talks of safety nets instead of Health for ALL.

This is why we visited Binayak Sen in jail when he was incarcerated for 2 years before being released on bail, this is why we went on a fact finding to Dantewada to study the public health situation in the camps created for displaced adivasis due to the Salwa-judum campaign, this is why we held a series of Binayak Sen solidarity health camps all over India, this is why we took to the streets, this is why we held Binayak Sen solidarity rock concerts, this is why we wrote poems.

Binayak Sen's path so far tells us that the path of your conscience in today's world mostly leads you to no good, but the response to Binayak's arrest and conviction reassures us that his is not a forgotten path, that many are willing to raise their voices in protest and a few even to dare to tread that, or similar paths.

I am a doctor and not a lawyer, and I will not argue about the law, but I will say this much - a law which can find such a man as this guilty needs to be seriously re-looked at. I will go further and say a society that can find such a man as this guilty, needs much greater introspection and transformation. In today's polarized world with the space for dissent narrowing more and more, the lines are indeed blurred. A state which allows its women and children and poor to die because of corporate greed, which is willing to allow its natural resources to be sold to the highest bidder, which is so tremendously corrupt, which is more interested in getting a seat on the UN Security Council than providing food for its hungry and starving, that is more interested in hosting extravagant festival of games rather than provide its citizens health care, that is more interested in the latest brand in fashion than in farmer's suicides, is left with very little legitimacy and right to draw any lines. In such a context, with increasingly narrow spaces for dissent, blurred lines and vested interests this judgement only forces us to look deeper within ourselves and the social system we are a part of.

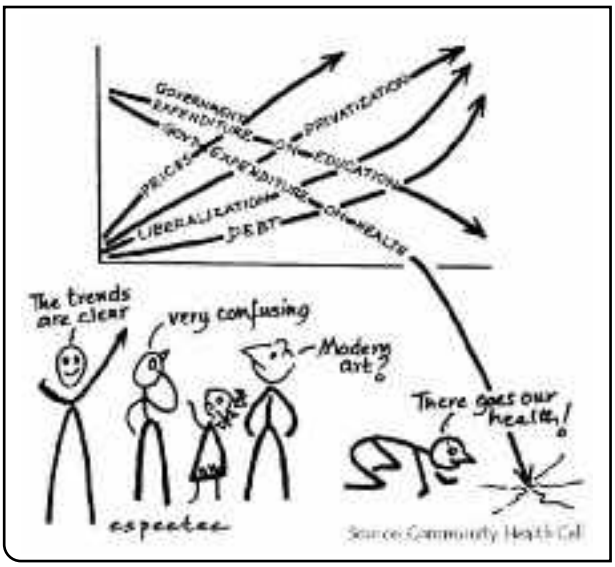
"*Dr. Binayak Sen has been true to the spirit and vision of his alma mater and has carried his dedication to truth and service to the very frontline of the battle. He has broken the mould, redefined the possible role of the doctor in a broken and unjust society, holding the cause much more precious than personal safety. CMC is proud to be associated with Binayak and Ilina Sen."* Citation by Christian Medical College, Vellore, 2004 when given the Paul Harrison award for his work.

SOCHARA : WE ARE

The Society for Community Health Awareness ,Research and Action (SOCHARA)registered in April 1991 is a professional resource group in community health and public health , rooted in civil society . It has spearheaded community health action, innovative training, networking, and policy action research in community health and public health since its inception in January 1984 .SOCHARA has actively worked in the global People's Health Movement (www.phmovement.org) in an effort to strengthen the public health system and address the underlying health determinants based on the goal of achieving health for all .

Community Health Cell (CHC)is the functional unit of SOCHARA .The CHC run Community Health Learning Programme (CHLP)focuses on persons with a deep interest in health ,development and justice issues in the voluntary sector . (See website www sochara org) .

For information on community health initiatives in India see www.communityhealth.in, a wikipedia under construction.



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