# Community Health Learning Programme 2010




Source: Community Health Cell

## A Report on the Community Health Learning Experience

Anand Kumar

COMMUNITY HEALTH CELL

# Community Health Learning Programme

## January 2010 to November 2010

REPORT

Mr.AnandKumar
Intern,Community Health Cell

**Table of Contents**

**1. Why did I join the fellowship?**

My fellowship at CHC started on 1st Jan, 2010. Prior to this fellowship programme on community health, I had absolutely no idea on what is community health or plainly speaking what health activism was all about, until I met Dr. Ravi Narayan (CPHE, Sochara) on 24th Dec, 2009. Of course, community health is no rocket science that only Einteins could understand. I had vague ideas on how health care system ought to be such as health care means both preventive & curative aspects going hand in hand, health care has to be demystified, medicalization of health should stop, appropriate technology was the answer not the mindless introduction of new technology, health care must be a service not a commodity, privatization & capitalist led globalization were responsible for the current crisis in health care, Public financing & control of health care was the key to answering this crisis & re-orientation towards society.

My understanding of health at that time was confused over the health care aspect of health not the physical, social or mental well being as the WHO defines health. But to put it in short, I had all the ingredients to make me a health activist, but the only key link that was missing was a sense of direction on how to go about it. I had done my graduation in Biotechnology & my post graduation in Clinical Research with 1 year of working experience in a Clinical Research Organization (CRO). Though none of these experiences were to my liking, I was rather forced by my parents (perhaps with good intentions on their part), but it did give you an understanding on how the system of education & health functions in India today.

For eg., the course fee for my post graduation studies cost us about 2 lacks. The fee itself acted as a barrier & restricted genuine & well meaning students from all backgrounds with a genuine interest in research. Rather it sets in motion a newer field for all those would be opportunists & careerist to explore, with an eye for money & as agents for procuring 'guinea pigs' for multinationals as well as Indian pharmaceuticals, all in the name of research & development (R&D).

My 1 year experience of working in a clinical research company in Bangalore literally left me disgusted with the corporate system. It could probably have been described as a scenes in an Orwellian novel, where your every move was monitored, how you behaved with others, disapproval of dissent during debates, psychological games played just to expose your inner thoughts & use this against you whenever convenient, threats of termination as ways of silencing & make sure one may never speak up or is afraid to speak up against the company.

My work though not directly involved in the clinical trials, was to look for hospitals throughout India that were willing to conduct trials. I was assigned to Uttar Pradesh, India's most populous state & one of those states in India having one of the worst social indices especially in health. What I found during my visits apart from the poverty that seems to be everywhere, was the fact so many hospitals (both govt. & private) were willing to conduct trials on their patients without much consideration as to how genuine such trials might be & actually benefit their patients. Most of the trials conducted were on non communicable, life style diseases & none absolutely on communicable, tropical diseases that plaque the region. And most of the drugs would probably be beyond reach of the majority in this country once they are marketed.

It was instances such as working in a corporate environment & exposures to real life problems in the country that prompted me to look beyond clinical research & begin to take activism seriously. Incidentally I had had an opportunity during my post graduation days to do my thesis on antibiotics resistance in Lower Respiratory Tract Infection. It was a prescription survey on the use of

antimicrobials in children. What I found in the course of my little study was a large number of first time patients were being prescribed antibiotics for common symptoms such as cold & cough without much recourse to restriction on its usage. There were several factors that contributed to this including people themselves asking for antibiotics. What the study revealed to me was that such a trend of overuse & abuse of antibiotics was a direct condemnation of the current health practices if not the health system itself. It was these observations over a period of time that has actually moved me to take up issues in health seriously enough to take up a fellowship programme in community health.

I cannot fail to mention a personal incident in my life that still continues to haunt me to this day. It had to do with the circumstances that lead to my mother's death last year. I shall not go into all the details here, she died of rare form of cervical cancer due to misdiagnoses at an earlier stage. Despite so much money spent in private hospitals & expensive clinics, the fact that not only was she misdiagnosed, but none of the hospitals or doctors showed much concern or cared as to what her actual problems were, or for that matter providing clear information & finally when they found no use of her (to make more money), they quietly asked her to go home & take rest! This is the state of the private health care in India, that only sees you as a commodity to make as much money as possible & throw you out when it doesn't need you.

And finally I cannot forget to mention the Marxist in me. I have been a part of a small Trotskyist group in India called New Socialist Alternative (Indian section of the Committee for a Workers International – CWI) for the past four years, which too has played a role in shaping my thoughts about socio-economic system of this country. One can say that it is a mixture of working in corporate environment, personal experiences & experience in being part of anti-capitalist globalization struggles that have molded me to take up the 'health for all' issue seriously enough from the point of a passive observer to an active participant.

## 2. My First Two Months at CHC Prior to the Orientation

Unlike my other fellows, i had the opportunity to spend 2 months with CHC prior to the orientation programme. Hence I shall include in my report my 2 months at CHC (January & February) apart from the orientation programme itself, as a background which helped me set up my objectives.

*Beginning at CHC*

As mentioned earlier, I met Dr. Ravi Narayan on 24th Dec, 2009. Since I knew next to nothing about how health activism has evolved over the years, Dr. Ravi was able to put a picture before my eyes on how it all began with the medico friends circle, Alma Atta, the People's Health Movement, public hearings ...etc..etc..... a whole new world had opened in front of my eyes in a space of just 2 hrs! Since at the time, I was more interested on issues pertaining to drug policies, ethics of clinical trials, antibiotic resistance (since I had been directly connected to these issues), that meeting left me with a sense of feeling that this was not all. There was more to it than meets the eye. There were so many issues, all interconnected & interlinked in health. It gave me a vague feeling of sometimes helplessness & even wonder whether all these issues will be addressed in one's lifetime.

This was the time I started beginning to think whether Politics of Health should be my main focus, it was just a feeling at that time. After all, I had one advantage, being a political activist, a Marxist at that, because Marxism as Dr. Ravi mentioned to me allows you into a kind of analysis of the system that gives deeper understanding of how the system functions, however much its critiques may disagree (agreeing to disagree!).

The next person I met at CHC was Mr. Eddie Premdas on 25th Dec, 2009. Premdas had just come from a public hearing in Davangere (a district towards the center of Karnataka). During the course of the meeting, Premdas suggested to me to make use of 2 months time before the orientation programme to be held during March (2010), to understand the process of public hearing being held mostly in Northern Karnataka & to work with Jana Arogya Andolana -Karnataka (JAA-K). Until that time I had never heard (out of ignorance) of what was JAA-K or what the public hearing was conducted on, it was all so confusing. And all this sounded so much unconnected at that time with what I wanted to do i.e., on issues related to clinical trials, drug policies etc. Until then I had thought of CHC fellowship as some kind of a academic programme, I had never imagined it to be associated with so much practical work. Being a bit academically oriented myself, I was left wondering how am I going to handle all this when I had absolutely no idea about any of this. But I agreed nevertheless as I sensed behind what Premdas was saying was a specific purpose why the public hearings are so important & were once in a lifetime opportunity. And how true it turned out to be!

On the very first day of my fellowship at CHC, I went with practically no idea on what to do. Having chosen the path of social activism & not working in regular office jobs like others makes all the difference, with the concerned family members always barging with questions about this chosen path instead of a lucrative corporate job. Though making ends meet was not much of an issue in my case, but one has to realize that taking extreme political positions is sometimes difficult in real life. It was in this state of confusion that I happen to flip through those reports of former CHC fellows & to my surprise, I realized that I was not alone in this world, there were many like me although with different backgrounds & ideas, but with the same amount of confusion! That's when I started to feel at home & began this new journey at CHC.

*Visit to North Karnataka*

I visited North Karnataka regions 2 times during that period & 2 times during the orientation & what a revelation it turned out to be each time. Thanks to some unforgettable people like Obalesh (Dalit activist & JAA-K member), Swarna Bhat (Jagruti an NGO working on the rights of the marginalized especially women) & especially Karibassappa (a former fellow at CHC), who made the trips all the more pleasant & comfortable. I have visited North Karnataka before, but never as a conscious observer or activist, but always as a tourist. It made all the more difference, because now you are all the more sensitive to the place & its people, & not merely clicking photos!

My first visit during the fellowship was in the 2nd week of January. It was a 4 day trip to Badami (Bagalkot district), Belgaum city & Hospet (Bellary district). The first thing I noticed when I reached Badami on 10th January was gullies around houses overflowing with sewage & swine, the first sign of ill health! When swine flu hit the headlines last year, millions were spent on either containing the disease or screening people at airports. But we refuse to acknowledge the situation happening right here in our country (not distant Mexico!) & are not even prepared to do anything about it. Who knows what dangerous new strains of virus could evolve in the future if the situation continues to be the same?

*Process of Understanding the Public Hearing*

My visit to Badami was to attend a meeting on the forthcoming public hearing on the sttus of Primary Health Care services in Bagalkot district. In the meeting, everything appeared so new & what were these people talking about – denial cases, PHC's, Janani Suraksha Yojana (JSY's), Madilu kits.....etc....so many words which seemed to make no sense at all that time & that dialect of Kannada made it even more complicated. It was not as if they were talking Greek or Latin, but I out of ignorance & urban life, was out of touch with reality. The meeting was held at the Headstream office (an NGO working on disasters) in Badami.

As the meeting progressed, things suddenly started to make sense, whether it was due to the enthusiasm of Swarna Bhat or the energy of Karibasappa or Obalesh's oratory & not to mention all the others who contributed (except for me) & somewhere at the back of my mind, all the puzzles started to fall into place – health was not just about disease it is everything to do with the social determinants such as lack of proper housing, poor basic facilities, bad infrastructure, decent wages & much more. This was my take away message from my first meeting.

My next trip was to Belgaum & then Hospet before returning to Bangalore. My next visit to North Karnataka was during the month of February where I visited Belgaum once again, then to Dharwar, Badami & Haveri before returning back to Bangalore. I could go on describing each & every visit. But that is not the point, what was important was that each visit helped me understand the process of public hearing better. The entire process of public hearing involves a step by step process, before the actual hearing itself which is usually held at the district headquarters. It involves groups & organizations working on various issues, not necessarily health. Bringing all of them together into a single platform is a huge task in itself.

The very first meeting usually involves an introduction to Jana Arogya Andolana – Karnataka (JAA-K) & the need to conduct a public hearing on the health services in that particular district. The process is entirely voluntary with no financial backing from outside. After the first meeting, a second meeting is called to train the cadres on basics of public health, conducting surveys of select Primary Health Centers (PHC) in the district, how to document denial cases & finally on how to

conduct public hearing including setting dates, meeting district officials for availability, printing invitation cards, holding press conference etc. The next process is the actual survey itself were the surveyor visits a particular PHC, interviews the Medical Officer (MO) on the services available, inspects the PHC & finally interviews people assessing the PHC. The next step is usually a consolidation meeting & finally the public hearing itself. But what most people usually miss in a one day public hearing programme is the energies that go behind the making of a good public hearing.

On this front, I was blessed with fortune of being in the right place at the right time & among the right people! For eg., the training session on conducting a survey that I attended at Spandana office in Belgaum under the guidance of Dr. Gopal Dabade (All India Drug Action Network – AIDAN), Obalesh & Karibasappa. To explain complex issues in a simple manner, using the local dialect, making it participatory & putting the issues across to a wide range of audience from diverse backgrounds is what I consider the hall mark of good speaker. This was skillfully accomplished by Dr. Gopal Dabade & not to forget Karibasappa & Obalesh.

*Visiting the PHC's*

The 2nd instance I would like to mention was on how to conduct a survey of PHC. I had the honour of accompanying the untiring Karibasappa on two occasions, both at Bagalkot district on 4th February & 5th February, respectively. I have conducted surveys before in my previous company, but compared to how Karibasappa performed the survey, mine would fade into insignificance. It is one thing to just ask question & tick..tick..tick..but it is another thing altogether to explain to the Medical Officer (MO) that we are from JAA-K, we are going to conduct a public hearing for which we would like your active co-operation in informing us about the services available in the PHC. The important thing is not to make the doctor uncomfortable, extract the right information & at the same time watch out for discrepancies, however good the PHC might appear to be. It is very important to question the doctor & the staff about the problems they face.

The next important thing is to verify the doctor's claim by thoroughly inspecting the PHC & then verify whether the services are really up to the mark by interviewing people especially Dalits & the marginalized communities, among them women especially. This is a skill which any activist ought to master i.e. how to talk to people, get the right information, document the denial cases & importantly find out whether the people have ever visited the PHC in the first place. The faith in the masses which though I have read in several Marxist books, is something I have come to appreciate while accompanying Karibasappa.

The visit to the PHCs revealed the vast gulf between what was officially being said by the MO & the people who assess the services. For eg., a visit to Kuligere Cross PHC near Badami (10 Km) was a good example of how a govt. PHC normally functions. The PHC was located in rented building which was way too small for a PHC. It was initially located 3-5 Km from the town & many villagers & townspeople had difficulty in accessing it. A new PHC was being constructed near to the town & was to be completed in another 3 months.

The PHC was extremely cramped with hardly enough space to walk. In the 2hrs we spent at the PHC, we did not even see a single patient walk in. Apart from the 6 vacancies, 19 other staff were supposed to be present. But except for the MO, staff nurse & a pharmacist, everybody else seemed to be missing altogether. The ambulance looked as it has not been used in a long time.

Although the MO provided all the required information & claimed that he had all the medicines with him, it was otherwise when we went to verify this with the people living in the SC colonies (called Janata flats). According to them, the doctor charged Rs. 10-20 per visit (depending on the case), Rs50 – Rs 200 for Glucose bottle. Apart from not checking each patient properly & being discriminated against, every patient was given an injection whether required or not & was asked to come to his private clinics (that was run by him during the after hours) if the illness was not cured. People claimed they never got any maternal benefits unless they bribe the doctor. Apart from such unethical practices, the doctor even verbally abused patients when he was not paid properly & even threatened to complain this to the police!

This is not to mean that all doctors are corrupt. A visit to another PHC in Sulebavi proved otherwise. Apart from being generally well maintained, the women MO present did not take any bribes & the general opinion among the people was that the doctor took good care of the people in case of normal day to day problem including pregnancy. There were lots of patients at the PHC on the day we went, though the doctor was on leave on that particular day. But the PHC did not have stock of anti venom & anti rabies treatment. This was the case of the 10 year old boy bitten by a snake & had to be rushed by PHC ambulance to a Private hospital at the district headquarters after the initial first aid provided at the PHC. The family hailing from a lower caste/class background had to bear Rs.20,000 for treatment charges at the private hospital. This case was brought forth in the public hearing held at Bagalkot on 19th Feb, 2010.

*Problems of Conducting a Public Hearing*

Not that conducting a public hearing has not had its share of problems, there are several issues that it too faces. Principle one being that of finance since there are no outside backers & organization participation is purely voluntary, the issue of talking responsibility of the whole process which usually falls on the head of one group or even one person, the problem of officials not turning up during the hearing, people's willingness to divulge personal information & coming forward to give their personal testimonies in public, the problem of keeping the issues alive after the public hearing, disruptions by groups opposed to the hearing etc. One could go on listing the problems the process faces but it is important to remember that no system is free from contradictions & there is no single answer to these problems.

The one public hearing that I was able to attend was a hearing conducted at Haveri on 13th March, 2010 along with other fellows during the orientation programme. It was attended by over 300 people coming from far distances & various backgrounds & communities. The public hearing programme usually consist of an introduction to the JAA-k movement, its goals & objectives, the findings of the survey team on the status of the PHC, account of the denial cases by the affected people (usually 5-6 serious cases), the views & recommendations of the panelist & finally the response of the district officials.

As usual the officials did not turn up except for the District judge & District health Officer (DHO) (who turned up late). Apart from bringing out the sorry state of PHC's in the district, it brought to the public attention the denial cases wherein patients' especially pregnant women are being denied proper treatment during delivery thus resulting in death or denial of maternal benefits etc. Although the panelist that included members from civil society groups & other well known figures from the district gave their views on what actions need to be taken, but the only response from official side was a date to discuss the denial cases. None of the other recommendations such as conducting joint surveys on the status of PHC was answered or was simply ignored.

Overall feeling that I took from understanding the process of public hearing conducted by JAA-K was that it did have an audacity, foresight & also a sense of proportion. Meaning, they were audacious enough to question the official & bring forward the real situation in front of the public, they do have a perspective or a foresight as to where they are headed i.e., to achieve health for all & they do have a sense of proportion i.e., they know their limitations of working within the overall framework of conducting public hearings.

What I felt most was the need to convert the process into a socio-political movement as a link in the overall process of socialist transformation of society as the only way to achieve health for all. It is important for the movement to understand the limitation of the fragmented nature of work of NGOs that is very much issue based or on projects, which serve as an effective barrier to any real social change. It is at the same time important to learn from these processes to move beyond the limits of acting as pressure groups to become the real agents of change.

*Outcome of the Visit*

My visit to North Karnataka was an eye opener in many ways. Living as I mostly did in urban areas, seeing villages in the most backward regions of North Karnataka was something else altogether. I don't know whether it is the climate or poverty or neglect or the feudal structure or the present skewed economic development, but all these seem to combine to make the life for the people even more oppressive. You have sewage striven on roads, children defecating everywhere, lack of basic hygiene, lack of basic services & much more, that makes the people all the more unhealthy. But it is the system that ensures that the cycle of oppression continues in its varied forms & designs which only adds to the people's apathy. Not that urban areas like Bangalore are free from such problems, but it is usually hidden from the urban eye. But here in the most backward areas, everything is in the open for anyone to see & observe.

The visit helped me remove some preconceived notions as why for example people do not use toilets even when constructed by the govt. Many SC colonies do have a toilet in each house. But the way, in which they have been implemented, nobody would probably use it. Firstly toilets have been constructed right in front of the house (!) as there is no back space available & also very embarrassing to use as it is in front of the house for everyone to see. The only thing covering the toilet commode is a thatched covering that is so transparent that anyone can see the person inside. Most people do not have piped water connection & have to go long distances to fetch it. Most of the toilets have probably never been used or used as some kind of store room. Its only use till date would have been to figure out in the govt census list.

The visits gave a chance to have a glimpse of one of the flood affected areas in Northern Karnataka. I had the opportunity to go to a village called Kyada near Badami with Swarna Bhat that was completely washed away during the flood. It revealed the magnitude of problems facing the people there. The floods came & went, but till date many of the affected people continue to live in tin sheds (which makes life even more miserable) & are segregated according to caste & class lines. The houses are yet to be built. People have been promised sites plus newly constructed houses but most of the area is taken away by the gullies build around the house for drainage. The houses have no space for keeping animals like goats, chicken, cow etc which village folk depend for their livelihood & houses was going to be constructed in a record time of 1 month, imagine! Come next floods, everything will once again be wiped away.

Nor was my visit to North Karnataka all about understanding the process of public hearings alone. I managed to spend some time with the former fellow of CHC, Karibasappa & the work being carried out by him. I visited his hometown of Byadagi about 20 Km from the town of Haveri, to understand the work being done by his organization Nirmana. Nirmana, started by Karibasappa himself a few months ago, is rights based organization working on issues on NRHM, MNREGS, PDS & RTI. Aided by his wife & two fellow staffs, the office cum home is located in a SC colony outside Bydagi. Working among the marginalized society is one thing, but living among them & facing daily hardships such as access to water, basic sanitation & located away from town is an another thing altogether especially with a wife & a child.

*Understanding the NUHM*

The two months was not just about visiting Northern Karnataka. I had the opportunity to give a presentation on National Urban Health Mission (NUHM) to a group of organizations working on urban health. But the presentation had to be done in Kannada, which I was particularly bad at even though it happened to be my mother tongue. But thanks to Mahadeva Swamy (librarian at CHC) & also the presence of Premdas, I was somehow able to manage the presentation. Apart from helping me improve my Kannada, the presentation gave me a chance to understand the NUHM document all the better. As any of nicely worded & well intentioned document of the govt., apart from some welcome steps, the document revealed that behind that Philanthropic cover of helping the urban poor lurked the devil in the form of Public Private Partnership (PPP) & health insurance through private players. It also helped me get a better understanding of the National Rural Health Mission (NRHM).

*Understanding Drug Policies & Kolkata Visit*

The two months offered enough space for me to understand drug policies of the Indian govt. & works by activists in that area. I had the opportunity to meet Dr. Gopal Dabade in Dharwar. Dr. Dabade is veteran activist of All India Drug Action Network (AIDAN) with over 26 years of working as a activist not only on drug policies but on all other areas of health. It enabled me to understand much better, rather than just reading through books & articles, on the works going on in the area such as patents & the Novartis boycott campaign, working of the pharmaceutical industries, clinical trials etc. Incidently Dr. Dabade had asked me to read a fictional novel by John Le Carre called Constant Gardener which dealt on the use of poor African women as guinea pigs for Clinical trials by drug companies. I do not know whether this was a coincidences, but just 1 month later we had news headlines on the death of 5 tribal women in Andhra Pradesh in the HPV vaccine trial sponsored by multinationals.

I was given the opportunity to attend a 2 day seminar in Kolkata Called 'Pharmaceutical Policy in India: Challenges for the Campaign for Access' organized by Jan Swastiya Abhyan (JSA), AIDAN, CDMU, FMRAI & NCCDP. Though the programme was restricted to those with an academic understanding of the issue, but it was useful to get insights into how the whole system functions. On the one hand you have more than 600 million people without the access to medicine & on the other hand you have the govt. progressively doing away with the essential drug list, removing price control & allowing pharmaceutical giants to make huge profits. Most of these policies have come to the benefit of multinational pharmaceutical companies to make huge profits & have even further benefited by the trade policies of the govt. after signing of the WTO & TRIPPS agreement in 1995 that brought the patent law in 2005.

There were sessions relating to irrational combinations of drugs, with India having over 80,000 brands whereas WHO mandates only 270 drugs needed to treat over 95% of the illness. There were other sessions on unethical promotion of drugs, the views of the state drug control authority, the views shared by the small scale pharmaceutical industries & on the clinical trials in women especially the controversial hidden HPV vaccine trials being carried on marginalized women.

Above all the programme provided a platform to meet various activist in the field like the ever jovial Dr. Mira Shiva (AIDAN), Dr. B Ekbal, Dr. Vandana Prasad, Dr. Amit Sen Gupta, Dr. Ajay Khare & N B Sarojini from JSA, Amitava Guha of FMRAI, Gopakumar of Third World Network (TWN), Leena Menghaney of Medecins Sans Frontieres & various others who may not be be well known but equally well informed on various issues.

**3. Orientation Programme at CHC**

*The Beginning*

If the beginning 2 months at CHC was all about my involvement in the practical work of JAA-K, the orientation programme was a different ball game all together. Here you had the chance of being part of a 40 day training programme along with other fellows from other regions, with varied backgrounds ranging from social sciences to sciences, dental & even engineering/ software background. All had their different stories to tell but all united in a zeal to do something for society, to change it for better.

*Meeting the Fellows*

It was a heterogeneous group mainly from Karnataka & Tamil Nadu except for one from Gujarat. It was not just about regional differences alone but had differences with respect to urban & rural divide, North Karnataka & South Karnataka divide, language divide w.r.t those fluent in English & those in their regional languages, the digital divide, division of science & non science backgrounds, etc. Thus the group brought before you a rich variety of issues to confront.

This is not to mean that the group was a bundle of differences alone. There were similarities with respect to age & level of understanding of the subject. Remarkably many of the fellows (not all) came in the same age group of mid to the late twenties. It was helpful that many of the fellows came with the same level of understanding of the subject as I did, with none of them posing as experts & with most having some knowledge & experience from their respective fields.

In spite of there being every chance of developing groupism especially on regional lines, no groupism actually developed & everyone was able maintain friendship with everybody else despite the language barriers. This can partly be attributed to the fact group formation during sessions was never on the basis of convenience or language alone but always based on random selection that ensured that everyone got to interact with each other & got to know each other better.

Many of the fellows in the group came from working on a single issue concerns such as on women, HIV/AIDS, disability etc, the orientation provided a platform for them to put their understanding on the particular issue from a broader & a more universal perspective (particular to the universal) & relating the issue as a part of the crisis related to present model of uneven development under capitalist globalization. It even provided people like me who have mostly understood issues from a general perspective to understand it from a community perspective or an issue specific perspective.

My only problem during the entire orientation programme was the daily torturous trip from my house to CHC & back which on an average day lasted up to 3 hrs. This even prevented me from fully integrating with the group as most others came from outside & stayed together in the hostel. This prevented me from helping other fellows (especially those not fluent in English) understand the subject better especially during the after hours & in a way getting to know other fellows better. But I did get a broad idea of the work being done by fellows from grassroots level of experience especially fellows like Mallikarjun & Manjula with their years of experience in community based work.

*The Challenge*

The group posed great challenges before you especially with respect to translation, keeping different groups together, bridging the urban & rural divide & most importantly making sure all issues & debates are understood by one & all, making sure no one is left out. In the end, I come with a feeling that things were managed fairly well in part due to the excellent facilitations by Premdas & Rakhal who despite their busy schedules managed to keep things in order.

*Learning from the Facilitator*

This raises an important point of learning to all fellows i.e., learning to be facilitators. A facilitator's role is not simply about lecturing but a skill that combines with it the knowledge of the audience expectations, the translation skill, the communication skill, making the session participatory, respecting the diverse views of the audience, maintaining a neutral as well as a balanced view, knowledge & the experience of the subject, & very importantly keeping the audience engaged. The importance of a facilitator cannot be over emphasized as very activist ought to learn the art of being a good facilitator as its importance goes beyond the range of class rooms to meetings, group discussions & beyond. There were sessions were facilitations were left to the fellows themselves but very soon the session got out of hand as interest on the subject started to wane due to poor management among the fellows.

The other fascinating aspect of the session was the teaching method adopted by the facilitator. It was no longer one person lecturing to a group of passive observers, trainer & the trainee etc., but the observer as a conscious participant in the learning sessions. It adopted the method of conscientization developed by Paulo Freire that takes the life experiences of learners as the starting point to understand more complex issues while keeping the session within the range of understanding of the learners & the role of the facilitator was to fill in gaps to give a more concrete understanding on the subject.

The most important thing for community health activist is to keep the interest of audience alive, whoever they might be, whether it is SHG's, children or adults. This is done by employing different communication tools like audio/ video, skit/ drama, question/ answer session, employing drawing/ coloring skills, use of craft skills, singing/ music skills, cultural skills i.e., employing all the creative skills of the people around you. This does not mean one has to neglect one's teaching skills altogether but fine tune it according to circumstances so as to make the audience feel comfortable with community worker as part of their own community. It is very important to remember that it is not just a question of keeping the audiences entertained but to raise them from the present level of consciousness to a higher level of consciousness.

*The Different Teaching Methods*

For eg., the *But Why* methodology developed by David Werner is an interesting method of understanding the social determinants of health. Here what seems to appear as an abstract theory or principle is made simple & easy to understand by simply questioning each problem with a simple question of *but why?* Playing the monsoon games was another example of understanding farmers suicide in India but putting all the fellows literally in the shoes/ chappal of the peasant, landlord, dalit etc & understanding the problem from the perspective of rural India.

While most sessions tended to be participatory, there were others were lecturing was the norm especially when the speaker/ facilitator were from outside the CHC. There were sessions were the speaker (outside of CHC) was speaking from outside the realm of some of the audiences from rural backgrounds & some even felt left out because of the high level of English used by some of the fellows. There were sessions that were too repetitive. All in all it was not a picture perfect scenario all the time but all the facilitators from CHC did tend to make the sessions as interesting & lively as possible for everyone to enjoy rather than be passive recipients.

*Learning from the Sessions*

The sessions included topics from a wide variety of subjects such as community heath, mental health, disaster management, women issues, globalization & privatization, maternal health, primary health care, NRHM followed by discussion on various topics that brought forth newer perspectives on the issue. It gave us a chance to develop newer skills in order to convey the message to the public. For instance the looking back session everyday allowed everyone to display their creative skills on understanding from the previous day session.

The sessions allowed you to think & question the dominant paradigm of development as understood by middle class urban India & what the other side or majority of the Indian population thinks of development which is coming at the cost of losing their livelihood, the damage to their environment & a loss of their way of life, culture, traditions etc. Most of the so called development projects pushed by the World Bank & the IMF in connivance with local politicians, bureaucrats, contractors & industries like cement, steel as well as MNC's, are not only anti development, anti people & anti environment but caters to a kind of lifestyles of urban India that is highly unsustainable & will prove disastrous in the long run.

One of the most important lesson I learned during the session comes from a quote of Gandhi that says: you be the change you want the world to be. It means that you set yourself as an living example for people to change. You need to first of all get rid of all your prejudices & conservative attitudes before preaching to some else. This in no way implies a Gandhian lifestyle to be followed, but a life dedicated to both attitudinal & social change.

Of course this is not meaning to say that CHC had all the solutions in hand. In fact to none of the problems is there a fixed, one time solution. Even a socialist society will probably not have an answer to all the problems. In fact Karl Marx once said that Socialism does not mean that all the problems of humanity will be solved but only under socialism will there be a chance of first of addressing the human problem. But the fact that there is no space left in our polity today for such questions raises important concerns for the future of humanity.

*Understanding the Other*

While dealing with issues of development it is very important to understand issues from the perspective of the other such as the dalit, adivasi, disabled, & other marginalized communities. Till now I always understood the issues of the marginalized from a western Marxist perspective & going by their experience alone in dealing with the issue. I never understood for instance why forest means so much to the adivasis, reservation means so much for the backward classes, why Ambedkar means so much to the dalits etc.

*Alternative System of Medicine*

The session by Shirdi Prasad Tekur on alternative medicine made you think literally the other way i.e., alternative approach to disease & also a way of thinking. I never actually imagined that alternative system of medicine in its own way actually incorporated into its system the understanding of disease & health from a social point of view, much earlier than modern medicine or health activist thought of it. I never imagined for once that grandma's medicine is actually more effective & safe in treating common illnesses than say modern medicine.

The fact that alternative system of medicine is not really just about medicine per se but a way of life is what probably constitutes a paradigm shift from the dominant western view of thinking. This is not to eulogize the system, but the fact that it approaches disease from a holistic perspective incorporating body, mind & spirit (not to be confused with soul) is indeed an important lesson for modern medicine to acknowledge.

*Understanding beyond Health Care*

The surprising element of the orientation programme was none of the sessions dealt with disease but on the social, economic & political factors that contributes to the ill health of population. Thus it is no longer about which bacteria or virus or lifestyle that caused the disease but what were the social factors that were responsible for the ill health. It is no longer disease form the medical perspective but disease due to the lack of sanitation, basic services like PDS, water, food, proper housing, corruption, economic factors & much more. So the role of the community health activist becomes important as the point of contact with the community in not just creating awareness but also as an agent of change.

Thus it brought into question the role of the doctor in the first place. The present form of curative care places the doctor in the dominant position. Whereas the health workers like ANM's, anganwadis, male Health Worker who are the prime contact person in rural areas are placed in a low positions & looked down upon by society. It speaks volumes of the medical education in our society today that is geared towards producing specialists & super specialists but not primary level health care providers.

*The Visit to Potnal*

The orientation had a field visit programme to Potnal in Raichur to an organisation called Jagruti Mahila Samghatan (JMS) started by Premdas (current co-ordinator of CHC) over 10 years ago. The activities of JMS focuses on women agricultural labourers, issues w.r.t Dalits & especially women, bringing children dropped out from school or child laborers into the mainstream schooling through two year programme on non formal education, availing government services & other activities

include terracotta, encouraging women to form self help groups, selling herbal products, organic farming initiatives, making compost through vermicomposting & bio fertilizer (neem fertilizer).

*Alternative education*

What I liked most about our visit to Potnal is the sort of non formal education practiced by the Chilli Pilli school run by JMS to bring about 30 – 40 children back into mainstream schooling. It is based on the system of schooling developed by Paulo Friere taking the life experience of the learners as the starting point. For instance children who are in most cases illiterate (even if they have been to school before) are not straightaway thought A B C ….. as is mostly thought in other schools. Initially it started with games & rhymes to first of all make them feel comfortable in their new surroundings. Alphabets are brought in eventually & children are thought to remember these alphabets by thinking of objects or images close to heart. This form of schooling is a marked change from what most of us have been made to learn since our school days i.e., to learn by root. Children are made to think by themselves through various methods of teaching. And what was most fascinating was the children were being trained by people who are not qualified teachers by profession but who have faced the same form of oppression the children themselves have faced.

It is indeed very interesting to observe the marked changes in the way children develop from knowing nothing about the world around them to actively begin to understand their surroundings. It is very important to remember the backgrounds from which these children come from. Most of them hailing from marginalized communities who previously were child laborers in fields or bonded laborers having been through a life of extreme oppression which most of us cannot even imagine. To bring the children to accept their new surroundings is itself a very difficult task. This alternative form of education is not simply an experiment of JMS. In fact it is part of govt. scheme to bring back child laborers back to mainstream wherein the govt. funds about Rs. 11 – 12 a day per child which is hardly enough to sustain the programme. This is sustained by all other activities of JMS like terracotta, vermicompost, herbal medicnine preparation etc that helps the programme continue.

*Report on the visit to Gram Panchayats, PHC, Sub-Center, Anganwadis & PDS shop during Potnal trip*

There were four groups formed to visit Gram Panchayat, PHC etc in different places near Potnal. Our group consisted of Madappan, Shivamma & myself. We were assisted by Mahadeva Swami from CHC & Chourappa from JMS.

*Gram Panchayat Visit*

We visited 2 Gram Panchayats, One PHC, One Sub center, Two Anganwadis & one PDS shop. Our first visit was to the Rahmatnal GP. The Gram Panchayat chairperson Mutamma was not present. We were given information by the computer operator Timmanah. The Panchayat consisted of 4 villages & two camps (camps are places were agriculture labourers working under landlords usually reside). Though the computer operator made tall claims on providing work under NREGS within 15 days of application, the reality was that people were not getting work even 6 months after application. As with respect to health, there was no ASHA & no VHSC committee had been formed in any of the villages. The nearest sub center was located 3 Kms from the GP & the PHC was 10 Kms away. But the status of roads & transport was extremely bad, with people finding it difficulty in assessing these services.

The same situation prevailed in the next GP that we visited, located at Balaganur. The Gram Panchayat chairperson was not present & our questions were answered by another computer operator, Thirupathi. The GP had three villages & two camps under it. The place did not even seem to be functioning even in the mid morning, time we visited, with all the office helpers sleeping on the table. The same situation prevailed in this GP as work was not provided under NREGS months after application. Also the amount the people got under the NREGS was far lower than the labour rates that were prevailing in the market.

***PHC Visit***

Our next visit was to the Balaganur PHC. Dr.Jeevaneshwaariah despite his busy OPD schedules gave enough time for us to ask all the question we had. The PHC was supposed to have two doctors but there was only one who was an Ayush doctor & not an MBBS doctor. Total there were only 13 staff & the rest 12 positions were vacant. The doctor did not stay at the PHC quarters but stayed at Potnal & had to commute everyday from there. The PHC was a referral to 5 sub centers. There were VHSC in all the villages under the PHC. The PHC had no ambulance. Chickungunya & TB were the most prevalent diseases in the area.

The PHC had suffered heavily during the floods last year. Many of the equipments were damaged. The PHC did not have any boards on the services available at the PHC. They were yet be put up. Toilet was unusable. There was a acute shortage of staff. But things were improving after the community monitoring process with the PHC getting all the necessary equipments.

According to the Gram Panchayat member of the Balaganur there was corruption with the staff demanding Rs. 10 - 20 per patient per visit, Rs. 50 for saline bottles, Rs. 200 for glucose bottles & Rs. 500 – 60 was demanded for each delivery case. A GP member herself could not avail proper service at the PHC during pregnancy & had to spend Rs. 10,000 in a private hospital in Potnal.

*Anganwadi Visit*

Our next visit was to one of the Angalnwadi center at Balaganur. The anganwadi teacher had been newly appointed & did not have much know how. She was yet to be trained. The center was open between 9:30 AM to 1:30 PM. The children were provided with 3 types of food on successive days. One was Upma, second was a Sweet & the third was a Amylase derived food packet. According to the teacher the food packed caused vomiting among children & consequently many children could not attend. The parents usually had to bear the burden of both spending on the health bills & forgo day's wages in order to take care of their children. (Update: The food packets supplied to all Anganwadi's in Karnataka was subsequently found to be sub standard quality & unpalatable in a case filed to Lokayukta by SICHREM & the case is under investigations)

The main problem in the particular ward was drinking water problem & problem of toilet. Water was contaminated with drain water & water pressure was very low. According to the test conducted by the PHC lab technician, the water was found to be contaminated but till date no action had been taken.

Women faced a huge problem of not having toilets in their households. Women had to traverse a long distances which is proving to be a huge problem. The money provided by the government is not enough to construct toilets & people are simply taking whatever money has been given without constructing the toilets.

*Sub Center Visit*

Our next visit was to a sub center in Udpal. We met the ANM Hemalatha working there for the past twelve years. Her biggest problem was that she was the sole worker without the Male Health Worker (MHW). The other problems she had was with respect to commuting as she had to commute to other villages located far way without the reliable transport facilities. Her work was now solely restricted to examining pregnant women without performing the actual delivery itself as it had to be conducted at the institutions such as PHC. Her other functions included provided tablets in case of normal illness in children.

The village had no VHSC committee or the ASHA. Her salary was not paid for the last 3 months. She had to rely on the good will of the people to survive. No proper quarters had been provided to her & both she & her husband were staying in the subcenter cum house. Many a times the ANM was not available in the sub center & there was no one even to look after the center.

*PDS Shop Visit*

Our last visit was to the Balaganur PDS shop. The time was 4:15 PM but the shop was not open as per the rules. We met the PDS shop owner Rajashekar at his home. At first he had asked for permission but later was willing to share information after understanding our purpose.

According to the PDS shop owner, the shop was a loss making business for him because of inefficiency of the government supply. He was being forced to sell at higher prices & this was causing tension between him & people everyday.

According to the local people, there were more issues than the PDS shop keeper was revealing. In some of the months, the usual excuse of the shop owner for not supplying kerosene was he was out of stock but usually it was sold at the black market. According to the people, BPL/ APL cards kept changing with every government & government kept changing the rules & people were not actually benefiting from it.

*JMS Activities & Much More*

The JMS visit was a learning experience about the way the PHC's, sub centers, PDS shops, anganwadis, panchayat system functioned in the district. We learned on how terracotta was made, learned about the story of how herbal medicine preparation was started, the organic farming initiative, reclaiming unused land, learning the initiatives of SHG's by JMS in nearby villages. We had a chance of knowing about the work of Nava Jeevana Mahila Ookutta with issues concerning women still trapped under the devadasi system. We got to visit Ruwari, an NGO working on issues concerning sanitation, health & education, in Raichur town.

*Making Our Objectives*

Finally, when the sessions started to draw towards to a close, the entire CHC was buzzing over objectives. Every one of us was asking each other what the other's objective was. While others had focused objectives, I realized that I simply could not focus on one single issue & I needed to understand the whole first & then focus on the parts. Reflecting back on why I wanted to focus on health in the first place, came the realization that I needed to understand the politics behind it. To do that would be a lifetime task & I only had 8 months left!

Also came the realization that one needs to focus on an objective that is achievable rather focus on abstract goals. Come to think of it, every one of the fellow's objectives had politics of health in it without mentioning it by name. So when my turn came to present my objectives, the following areas of focus mentioned below would I thought partially fulfill my goals.

**4. Learning Objectives/ Plan of Action**

*1st Objective* – Main objective for the next 8 months would be to explore on issues related to health from a socio-economic & a political perspective or 'Politics of Health'.

*Methodology* –

- Reading relevant materials available on issues such as globalization, liberalization, privatization, govt. policies in relation to health & other influencing factors, contributing to my understanding on 'Politics of Health'.
- To develop a critical understanding of the People's Health Charter. Identify issues taken up in Karnataka & follow up on what actions have been taken till now
- Meeting key informants & organisations involved in the relevant issues & what actions have been taken
- Attending meetings relevant to the topic& get insights into the issue
- Field visit, if feasible & critical

*Time line* - 10 April to 14th June, 2010

*Outcome*

- Develop critical understanding on the main issues relevant to Karnataka
- Identify one issue to be taken as case study
- Write an article

*2nd Objective* - To understand JAA-K work in Karnataka by participating in the JSA learning review

*Methodology* – Process developed at national level will be used

*Time line* – April to 14th June, 2010

*Outcome* - To come up with a critique of the 10 year JSA work in Karnataka

*3rd Objective* – To identify one issue from the first objective to be taken up as a case study

*Methodology* –

- To conduct a study with focus on community within Karnataka
- Meeting key informants directly involved in the issue concerned
- To visit other field areas, if feasible
- Attending meeting on the particular issue

*Time line* - 26th June to November
*Outcome*

- Understanding the issue from the dynamics of community perspective
- To develop a long term strategy of working on the issue after a the fellowship programme
- Learning to talk to community, look for stories of people affected by the issue & articles based on that experience

*4th objective* - To understand issues related to ethics & rights in Clinical Research

*Methodology* –

- Understand the issues related ethics & rights violation in clinical trials by meeting key informants & field visits (if feasible)
- Look out for a short term project, if feasible
- Attending meetings & conferences such as the Bioethics conference to be held on November by contributing both as a participant & a volunteer

*Time line* – August to November

**5. Understanding 'Politics of Health'**

Keeping my objectives in line, the three months of April, May & June was spent on trying to understand the health politics from various angles from meeting people, to reading & even attending a 2 day meeting on that particular theme.

*Meeting in Pune on 'Politics of Health'*

After our orientation programme ended on 10 th April, there was to my surprise a meeting in Pune organized around the theme of 'Politics of Health' understanding the issue from a Marxist perspective. The meeting was organized by the Sathi group in Pune based on a paper jointly developed by Dr. Anand Phadke & Dr. Abhay Shukla (both Marxists), both leading activists in Jan Swastya Abhiyan (JSA).

The paper revolved around the theme of 'Revolutionary Transitional Programme in Health', deriving from the Transitional Programme developed by the great Russian Marxist theoretician & revolutionary, Leon Trotsky. To put things in short, the paper talked of not limiting the issue of health to just health & health care as some activists understand the PHM movement, but look at health as a catalyst & along with other issues in social services, to an overall revolutionary transformation of society moving towards Socialism.

The meeting was attended by activists from mostly CHC & Sathi, others included independent journalist Satya Sivaraman, field activists like Brian Lobo, Indayani, Jagadishbhai Patel (union leader & occupational health activist) & others. From CHC it included besides myself Rakhal, Ameer, Obalesh, Premdas & Prahalad. The paper was challenged from all sides most notably by Satya. Many could not see how the idea could be practically feasible. Though the idea sounded good in theory it did not seem to fit into current reality of India that is ridden with issues of not just

class but caste, ethnicity etc. While Trotsky never set the transitional programme inscribed in stone, this paper seemed to give the theory a rigid approach that was only ideal in theory.

My own feeling was that the paper was ridden in Marxist jargon & phraseology of the 19th century not the language of the 21st century. This seems to have done a great injustice to the great Marxist thinkers who were always dialectical in their approach to any given situation unlike many present day so called Marxist. While not fully agreeing myself with the oppositional side, I do fully agree that Marxism needs to address issues that connect with the consciousness of the present day youth & workers.

The biggest flaw that i saw in the paper was that an idea was being super -imposed on a movement, in this case JSA. The idea of a working class versus the capitalist class that was developed by Karl Marx in his monumental work *Capital* & the *Communist Manifesto* based on the industrial revolution of that era was being used in this paper to represent the govt. as some sort of a capitalist class & the people in the movement fighting for health rights as the working class. This extremely undialectical approach goes against the very traditions of Marxism, I had the distinct feeling that the title itself would have put off a lot many activists looking for newer ideas.

While re-looking at the ideas of Marxism is indeed the need of the hour especially in developing countries like India with all sorts of contradictions & different traditions of struggle (unlike the socialist/ working class traditions of Europe), the attempt by the Sathi group seemed to rehash the old dogmatic traditions of the traditional left in India. Such an approach will only result in the marginalization of the Marxist forces further given the sort of gap that exists between theory & reality.

### *5.1 Understanding Health Politics in Karnataka*

*Getting Introduced*

After my return to Bangalore, I spent some days reading articles as suggested by Dr. Ravi. The articles mostly dealt with globalization & health. But what I quickly found out was that this was not helping me understand 'politics of Health' from a field perspective. Since I was also going to be part of a JSA internal review on JAA-K work of the past 10 years (but later dropped out of it), Dr. Ravi suggested to me to understand Indian Peoples Health Charter from a Karnataka perspective by interviewing key informants on the various issues in the charter. This I think has been extremely useful for me for it has helped me understand JAA-K & also to some extent JSA, from a wide range of people not just from JAA-K but others outside it.

By keeping the Indian People's Health Charter as my reference, i set about the task of interviewing some of the key informants in the health movement involved in the various health issues as mentioned in the charter. This study was not an evaluation of the movement but more so of a personal understanding of health politics in general & help me focus more on a specific area in the next 5 months of my fellowship & after.

*Interview Sample*

The people i interviewed did not necessarily involve people from JAA-K itself, it also included people from outside JAA-K working on one or the other aspects of health. This was done keeping in mind the fact that People's Health Movement (PHM) never envisaged a movement created by a

group of organizations passionately involved in health but to include everyone working within & outside the network as working for people's health movement. The role of PHM network being mainly as a bridge in connecting various movements already taking place on the ground not necessarily just on health but on various other issues in which health is invariably linked.

*Limitations in the way*

Due to lack of availability of time, i had to restrict my interviews to people in & around Bangalore. I initially planned to interview a minimum of 40 people but ended up interviewing just about 15 people. The others could not be interviewed because of their non-availability & other engagements during that period. Many of the aspects of the charter could not be covered as all the key informants could not interviewed. The interview only covered those working on health issues in general but not those working on the social determinants of health i.e., food, water, education, agriculture & others.

The biggest limitation of the study was that the interviews could only cover those informants based in Bangalore but not outside it due to shortage of time. Thus the key districts were the actual movement was actually taking place in relation to the public hearings could not be covered & mainly had to rely on information from informants in Bangalore. Another chief limitations of the study was the time spent with some of the informants was very limited, to just about an hour due to their busy schedule & with some it ended up half way. But with some others i did manage to meet more than once.

Nevertheless, the interviews did mange to cover three – fourths of the issues mentioned in the charter which included Primary Health Care, Medical Education, Drug policies issues, Medical Research, Women & child Health, mental health, environment & health, issues of the elderly, disability issues, traditional & alternative system of medicine, & HIV/ AIDS. The main issues that could not be covered included issues on eradication of child labor, Panchayat Raj & decentralization, com-modification & proliferation of private health care services & resurgence of communicably diseases (TB & Malaria).

*What was asked in the Interview?*

The interview primarily asked each participant in the interview about their relationship with JAA-K , their involvement & their contribution to health movement. The second part of the interview dealt mainly with person's or their organizations contribution in their field area of interest & how the issue has progressed in the last 10 years. It mainly looked into the strengths, weakness, obstacles & threats that each group percieved in their particular areas of interest in achieving the vision of health for all.

Most of those interviewed were people who were involved one time or the other with JAA-K/ PHM or atleast had an association with CHC. The people interviewed could thus be classified into three categories: those deeply involved with JAA-K, those not too deeply involved & those not currently involved with JAA-K. The interview did bring out many individual/ personal bias of the informant about JAA-K or the current members of the JAA-K. This proved to be hard task to deal with especially for an outsider who was not conversant with the JAA-K ten year history. This would have required me to go in to the every detail in the history of JAA-K's 10 years, which is impossible at this point of time & beyond the scope of my study.

*5.2 Primary Health Care*

A major part of the interview focused on the issue of primary health care as many of the activists have been involved in one form or the other, within JAA-K & outside it. Likewise I met activists from different ideological backgrounds including those with an NGO backgroun to those with a people's movement perspective & those with an left party background.

*Strengths of the Campaign*

- Primary Health Care campaign is one issue that has received maximum attention among all the issues mentioned in the charter, as primary health is a base around which the rest of the issues in the charter can be taken up.
- Primary Health Care has been the main focus in the year 2010 through public hearings in 8 districts of Karnataka.
- A focus on achieving results based on a set of programme for action through public hearings has enabled JAA-K to form a network of network of organizations in various districts of North Karnataka focusing on primary health care.
- Sustained efforts before & after the public hearings through follow ups has yielded results both in the form of govt. response to address some of the demands put forward in the hearing & opened a channel of communication between JAA-K & the district public health department officials.
- Successful campaigns such as public hearings, community monitoring & also successful lobbying with govt. has placed JAA-K with MNI (PHM -Tamil Nadu) & JAA-M (PHM – Maharastra) one of the vibrant movements of JSA in India.
- The issue of Primary health care is beginning to move beyond NGO circles to trade unions in the unorganized sector & Dalit & youth groups in the district
- Understanding of primary health care from a community health perspective among all the organizations, regardless of ideology – NGO, People Movement or left organizations.
- Pro active involvement of public health activists in the preparation of the document on Karnataka Task Force on Health & the consequent efforts by successive govt. since 2004 to improve infrastructure, facilities & staff in the PHC's.

*Weakness*

- The current public hearings has not been able to involve health service providers such as Doctors, Nurses, Staff, ANM & others, & perceptions among them that the public hearing is targeting them rather than the system.
- The issue of work related problems of doctors, nurses, staff & others have not been taken up by any group or organization.
- Different organizations tending to act based on ideological stance of the group, depending on whether they come from an NGO background or a people's movement background or from leftist parties.
- Difference in opinion among some activists with an NGO background on the issue of introduction of user fees & Public – Private Partnership with reputed NGO's. The perception is that token fees would bring about much needed funds for administrative purposes & PPP with reputed NGO's with a record of service to the people, as govt. would not be able to handle everything.
- Absence of support from major Trade Unions, Student bodies & women's organization.
- Despite major focus on corruption & quality of service in the Task Force, community monitoring & public hearings, both issues are still be addressed by the govt.
- Lack of implementation of the recommendations of the Task Force by the govt.

- Major focus of the govt. continues to be vertical programmes.

*Opportunities*

- Pro-active engagement of public health activists with the govt. at both state (Karnataka Task force on Health) & national level (NRHM) have countered the aggressive push for privatization & vertical programmes
- The NRHM programme started by the UPA 1 govt. with primary focus on PHC's in rural areas & provision of community monitoring have brought community health into focus.

*Threats*

- PPP & health insurance continues to be the main mantra in NRHM.
- Introduction of User fees in secondary & tertiary care & thus bringing about privatization through the back door.

***Medical Education***

Met public health activists associated at the policy level.

*Weakness*

- Campaign against expansion of private Medical colleges not taken up as an issue by any political or civil society organization or student bodies.

*Opportunities*

- Moratorium on the expansion of private medical colleges in the Karnataka Task Force on Health through active intervention of public health activists

*Threats*

- The financial clout of the private medical colleges lobby at policy levels & continued expansion of medical colleges despite its ban.
- Medical Education continues to be hierarchical, medically oriented with no orientation to the community.

***Commodification of Health Care Services***

*Weakness*

- No organization able to evolve campaigns to check the proliferation of private hospitals.

*Opportunities*

- Recommendation on regulation of private hospitals in task force report & subsequent passing of the Private Nursing Homes & Hospitals Act in the state Assembly.

*Threats*

- Commodification of health care servicesremains the single greatest threat to the very concept of primary health care.
- The influence of private hospitals & health insurance companies at the policy making levels.
- Promotion of private hospitals & health insurance companies through PPP has enhanced their status at the expense of public hospitals at secondary & tertiary levels which continues to be neglected.

- Existing regulatory mechanism not being implemented due to the influence of private hospitals at the govt. level & regulatory laws lacking powers.

***Drugs & Patents***

Met activists associated with Drug Action Forum – Karnataka (DAF-K).

*Strengths*

- Campaigns against the amendment of the patent act & Novartis boycott campaign received lot of publicity.
- Big issues such as campaign against patents & Novartis Boycott have brought different organizations with different backgrounds & ideology to unite around a single issue.
- Campaign against closure of govt. vaccine institute at Coonor, Tamil Nadu received much attention nationwide
- Efforts to ban quinacrine with involvement of women groups in Bangalore.
- Attempt to make public aware on drug related issues through newspaper articles, magazine – Janaarogya (People's Health), books on Anemia & Drug Pricing.
- Exposure of corruption in state Drug Controller General of India (DCGI) office in a multi crore scam through the Lokayukta.

*Weakness*

- Differences in ideological approach, with one side oriented towards an NGO approach through seminars & the other side with an orientation towards a mass based approach to reach the general public.
- Intervention remains minuscule compared to scale of the problem.
- Inability to link issues of drugs & patent with other issues of the pharmaceutical industry such as trade union rights of the workers in the pharmaceutical industry.
- No coherent policy on how to deal with private pharmaceutical industry with demands such as nationalization.
- Very few organization working on drug related issues & mostly based on individual interest. Absence of younger generation of activists taking forward the issue.
- Perception of a lone battle in the absence of support from general public.

*Threats*

- Global brand image of the Indian pharmaceutical companies as provider of cheap generic drugs has swayed opinion in favor of the companies.
- All attempts to regulate the pharmaceutical industry in terms of laws or supreme court cases have proved ineffective as its influence extends from the policy level to the drug control authorities & even the judiciary.

***Ban on Hazardous Contraceptives***

Met activists of AIDWA

*Strengths*

- Ban on the use of quinacrine after sustained campaigns against its use by women's groups was the only significant work in this area so far.

*Weakness*

- Not much work in this area.

***Traditional/ Alternative System of Medicine***

Went to Foundation for Revitalization of Local Health Traditions (FRLHT)

*Strengths*

- Recognition of traditional system of medicine as a system under NRHM after years of lobbying with govt.
- Formation of Traditional Healers Association & documentation of different healing practices.
- Development of R&D in traditional system of medicine to verify effectiveness of treatment.

*Weakness*

- Institution based, largely confined to awareness & training.
- Not pro-active in other issues of health & largely confined to own field of expertise.
- Implication of globalization & commodification of alternative systems of medicine not understood.

*Opportunities*

- Globalization seen as an opportunity for interaction with traditional healers from across the globe.

*Threats*

- Skepticism from general public on the effectiveness of of traditional system of system.

***HIV/ AIDS***

Went to Sangama & Action Aid.

*Strengths*

- Situation of people living with HIV/ AIDS has improved comparatively since early 2000 with lots of funds (due to the vertical nature of the programme) & drugs available at the ART centers.
- The problem of people living with HIV/ AIDS not confined to issue based perspective but from a broader socio-economic perspective from the point of view of globalization & privatization.
- Formation of sex workers union with over 700 members.
- Brought the issue of sexuality in the forefront.
- Campaign against decriminalization of sexual minorities & Delhi High Court ruling in 2009 decriminalizing homosexuality according to Article 377 of the constitution.
- Movement does not carry the historical baggage of the past & continue to remain vibrant with 'Pride' marches organized every year.
- Issue of Sexual Minorities taken to 12 districts of Karnataka through JAA-K & part of NHA-2 in Bhopal (2007).

*Weakness*

- The funds for HIV/ AIDS programme is a vertical programme & general health continues to be neglected.
- Perception of being neglected by public health activist as HIV/ AIDS is a well funded programme.
- Stigma & discrimination at ART centers. Treatment biased towards heterosexual men. Quality of counseling remains bad.
- ART centers run under PPP model through contracting of NGO's.
- NO programme for children with HIV/ AIDS.
- Failure of activists working on sexuality issues on the implication of commodification of sex & sex industry under the notion of sexual freedom.
- Problems faced by transgenders in public hospitals continues to be neglected & deterioration of their rights in the last 10 years.

*Opportunities*

- HIV/ AIDS biggest opportunity to bring the issue of sexuality in the open.
- Opportunities under PPP to try out different innovative models with Sangama model being recognized by govt. as the best model for HIV programme.
- Intervention possible in policy making levels.

*Threats*

- Dangers of Co-option by the system
- Since HIV/ AIDS programme is a short term programme funding could stop in few years time by donor NGO's such as the Bill & Melinda Gates Foundation.

***Mental Health***

*Strengths*

- Recognition of mental health problem away from medical angle & an institutional based approach to one from a socio-economic & a human rights approach. Move towards a more holistic management of mental health.
- Strengths is associations through Community based Organization (CBO's) & networking with other organizations working on similar issues.

*Weakness*

- Yet to reach the most marginalized sections
- Not able to reach out to traditional healers
- Understanding from an issue based, awareness & NGO perspectives
- Solutions temporary, cannot address larger socio-economic issues.
- Both traditional healers & psychiatrist find this approach affecting their practice

***People with Disability***

Went to Association for People with Disabilities (APD)

*Strengths*

- Move away from services & project related activities of an NGO to one based on rights of people with disabilities.
- Formation of a federation of people with disabilities.
- Allocation for the disabled in the State & BBMP budgets after years of struggle.
- Disability act in 2008.
- Job opportunities available compared to earlier days.
- Actively involved with JAA-K on health related issues & public hearings.

*Weakness*

- Problems of getting college level qualification for people with disability
- Lack of implementation of disability act.

*Opportunities*

- Lobbying with political parties during election in favor of people with disability

***Elderly***

Went to FEDINA.

*Strengths*

- Rights of senior citizens (belonging to the unorganized category) seen from a trade union perspective & organized in the same manner into a federation of senior citizens with over 4000 members.
- Health, Housing & pension rights seen as the most important demands.
- Problems of senior citizens linked with problems of other unorganized sector workers & collaboration with other trade unions such as AITUC & NTUI

*Weakness*

- Do not believe in engagement with govt.
- Heath problems seen from curative & occupational angle than from a community health perspective. Concrete understanding of health yet to develop
- More orientation towards minimum demands & lesser towards transition to maximum & transitional demands towards social change.

*Threats*

- Govt. bureaucracy
- Neo-liberal economics

***Environment & health***

Went to Environmental Support Group (ESG) & met a fr. Fellow of CHC involved in environmental issues.

*Strengths*

- Campaign against introduction of Bt Brinjal & subsequent moratorium on the Bt brinjal
- CHESS initiative of bringing different environmental groups together, focusing on all aspects of environment & health.

*Weakness*

- Work remains less compared to scale of the problem
- Many environmentalist group funded by corporates with bad record w.r.t environment.
- Absence of a strong movement & movement remains divided between those in favor of NGO led initiatives to those advocating a political line.
- Environmentalist more focus on environmental destruction & lesser focus on occupational health problems with no connections to trade unions. Yet to evolve strategies of linking workers involved in working with polluting industries.

***Occupational Health*** (with focus on Garment industries)

Went to Cividep & FEDINA

*Strengths*

- Largely trade union initiatives with focus on organizing work from point of view of working conditions & to some extent on occupational health.
- Bringing pressure on the industry through pressures from Multi stakeholder initiatives.

*Weakness*

- Ideological differences within the trade union movement between those led by NGO's & those led by left wing parties.
- More focus on occupational health & not community health.
- Majority of unorganized sector workers non unionized.
- Inability to address psychological problems associated with harassment by supervisors.
- Loopholes within the social auditing process.
- ESI corrupt & bureaucratic, unable to address basic health problems let alone occupational health.

*Opportunities*

- Engagement with all stakeholders such as govt., brands, NGO's & trade unions through Multi Stakeholder Initiatives.
- Use of legislative measures such as factories act, minimum wages, ESI etc to fight for basic rights.

***Women & Health***

Went to AIDWA.

*Strengths*

- Focus on female foeticide, gender sensitivity in health care services, domestic violence against women & awareness on health & health rights.
- Shift from maternal health issues to one from a community health & socio-economic perspective.
- Campaign against domestic violence & subsequent domestic violence act in 2005
- Campaign with a distinct political perspective & awareness through newspaper articles & magazine (Janarogya)

*Weakness*

- Lack of united struggles due to differences in ideology from those with a left background & those with an NGO & a middle class orientation.

*Opportunities*

- Engagement with employers on health awareness.
- Support of parent organization

*Threats*

- Right wing BJP govt. in Karnataka & flawed economic policies of the central govt.

*What did I understand by 'Politics of Health' in General?*

As a strategy, primary health care has received maximum attention among health care activists compared to the other issues mentioned in the charter. The other issues have become issues specific to the organization or individuals whose primary area of interest lies in that field of expertise. Consequently, some these issues have been approached by the activists involved from the point of view of an issue based understanding rather than from a community health perspective.

Within the movement for primary health care, there are differences in the mode of campaigning that differs from organization to organization based on ideology. Those activists with an NGO background have laid more emphasis on policy level intervention through engagement with govt. or from an issue based, project specific mode compared to those with people's movement or left political backgrounds whose primary emphasis continues to be through the people. On PPP not all organization had the same vision as the charter. Some organization with an NGO background favored such partnerships as they believed that there was no alternative compared to those from an left or people movement background who strongly opposed any kind of partnership with govt. on the grounds that it was the duty of the govt. to provide services & not by means of contract through the NGO's.

*Forces promoting the issue*

Except for certain issues, most of the issues mentioned in the charter has a distinct NGO domination with those from left political backgrounds completely absent in any of them. Within the NGO circles, there are organizations or individuals whose primary mode of campaigning is towards the middle classes through seminars compared to others whose strength has been as a resource group in aiding the formation of unions, collectives or groups, as an independent base to take forward the issue by the affected people themselves.

As far as funding was concerned, while the NGO were mostly funded by foreign donor organizations, the collectives or unions promoted by these NGO's were only partially funded by the NGO, with the ultimate aim of self sustenance by collecting funds from the people themselves. Many campaigns such as the current 'primary health care' campaign in the JAA-K was not totally self funded & the attempt was yet to be made to sustain the campaign by raising the funds from the campaign itself.

*Method of Campaign*

A major strength cited by those organization with a strong base in the community were the

innovative methods used to campaign or forming groups & sustaining them in the long run. This was felt by many groups as a source of inspiration for other organization to learn from their experience. Every other organization felt that a movement such as JAA-K would be immensely benefited if such cross learnings took place regularly.

On joint action, all organizations felt that on major issues such as the Binayak Sen campaign, all organizations were able to join together in the campaign. Whereas in normal times or when smaller issues were concerned, joint actions or even solidarity have not worked out due to differences in ideology & stance w.r.t to the particular issue.

On the stance of organization with respect to engagement with govt.., all organizations (except one) including those from the left organizations believed that all possibilities, as long as it leads to betterment of the conditions of the affected people, should be explored without any compromise to principles any way. In practice while organization practiced both i.e., engagement as well as campaign against anti people policy of the govt., some organization with an NGO background laid more emphasis on the former compared to the latter.

On the whole, it was found that those organization were resilient that brought out regular leaflets, campaign material or had a regular street or group meeting, compared to those who did them occasionally. It was also found that those engaged in trade union work & those with strong base in the community, were vigorous in their day to day campaign compared to others. Barring the left political organization, none of the other organization had mass support base & mostly tried to overcome this inadequacy through network groups & through organization working on similar issues.

*Obstacles In The Way*

While many organization expressed hope & confidence on taking their issues forward in the future, few individuals & organizations did express hopelessness due to unfavorable objective conditions. The same organization also expressed the view that their issue of concern has taken a back turn in the past 10 years. They cited limited support base among the people & restriction to small pockets in the state as the primary reason for their lack of confidence.

On the major threats to gains made by movements in the past 10 years, most cited capitalist led globalization, privatization & pro -neoliberal govt in the center & the (right wing) state as the major threat to their gains. Only two organization claimed that were was no alternative to globalization & even believed that it was an opportunity to them rather than a threat. It was also noted by me that even those organization that claimed to stand against globalization have also indirectly been its biggest beneficiaries through PPP & donor organization such as the Bill & Melinda Gates Foundation.

*On Relationship with JAA-K*

All organization claimed that relationships with JAA-K were more on a personal plane with individuals rather than on a political or joint action platforms. Most organizations cited differences with respect to ideology, differences in tactics & principles guiding their action. While all organization including members of JAA-K agreed that JAA-K or JSA is yet to become a people's movement, but nevertheless most organization credited JAA-K for laying the foundation stone with regard to concept of health & health rights in socio-political space of the region.

## 6. CHLP Mid-Term Review

It was approaching mid June, it was time for our mid term review. It gave us an opportunity to interact & listen to another to share our field experiences. Listening to all the fellows made me wonder how we had all grown from what we were at the beginning of March to were we are presently.

*Listening to interns...*

Listening to the Karnataka interns present on their current work with JAA-K gave a different perspective from the realities of the field. My assumptions of JAA-K at that time was that it was dominated by NGO's. But the realities it was not merely NGO dominated but had active involvement of Dalit organizations, unions, Dalit youth groups & their activity was not restricted to primary health care but was across different sectors such as privatization of water, RTI, Right to Food (RTF), disability, HIV/ AIDS, Dalit discrimination etc. It was hard field realities that had molded them to what they are today.

It was heartening to notice that those field activists from rural backgrounds who had difficulties in adjusting to the urbane environment of Bangalore & especially in the use of English had actually stated to present their presentations in English! It was not just about sharing each others experience but also learn a lot from them in the same process. For instance, I knew next to nothing on the Right to Food campaign if it was not for the involvement of two of the interns during the critical campaigns of the RTF.

*RTF & much more...*

Until both of them spoke on the campaign, I had never particularly shown much interest in the area of food & nutrition. But listening to them made me rethink & reconsider earlier misconceptions that class struggle & industrial proletariat were the only means that could potentially challenge the state. Here was an almost anarchist kind of a movement primarily led by women activists that actually forced the central government to convene the National Advisory Council (NAC) headed by Sonia Gandhi to reconsider bringing back & universalize the Public Distribution System (PDS).

I still remember that in earlier days (before the fellowship programme) I never really used to read the articles by Jean Dreze or Harsh Mander, the two prominent advocates of RTF. But now hearing from the campaign & my later field work with the Agarbatti workers, food & nutrition prominently figures in my major interests today. It is only now that I realize how important food & nutrition or the lack of it, means to those 836 odd million people living on Rs. 20 a day.

*Training Sessions*

Of course, mid term review was not only about intern sharing, we also had sessions on various topics ranging from personality development, training the trainers, on issues of Gender & Sexuality & our field visit to Hannur in Kollegal district for PRA training. First up was the personalty development session by Shoba Mangoli. Shoba, is a psychologist by profession & runs an organization named Sukrut that offers training for those would be professional psychologist & the primary focus of her organization has been in the area of working with children with learning disabilities.

*Personality Development*

The session began with an introduction about ourselves & our area of interest in the fellowship programme, which was beginning of the first trap. The entire session was packed with mind boggling questions on why we chose this particular field? If so, will it make a difference to the community? And finally to add to our consternation, she says that I am not convinced! After going through the first session & during the break time, my question to her was – why are you playing all these mind games with us?

Shoba's session was by no means done to mock us or underestimate our our work. It was overall done to rethink the way we plan, the way we strategize, the way others think of us & how individual personality can really be change makers if we could tune our body language to the circumstances of our surroundings. The thing that I really liked about the session was Shoba made us realize our common mistakes not by any means such as an criticism of our ideological convictions but the way we are as a person & how we behave in different circumstances.

*Training the Trainers*

We had a session by Dr. Shirdi on how to hold workshops. One thing the trainers session imbibed in me was the importance of focusing on a particular subject when training the community. While it is wonderful indeed to talk of Socialism or Health for all, it would also need to take into account from the point of the people or the lay activists who is mostly looking up to you solve their day to day problems in spite of all the goodies on offer in futuristic society.

The third important session we had was on the issue of Sexuality by Satyashree (a former fellow of CHC), a freelance NGO consultant & was involved with Sangama, sexuality minority NGO working LGBT & HIV/ AIDS related issues. It was not so much a lecture session but mainly brought out through games which indeed brought out the many prejudices in us, though we claim to be activist, progressive, leftist & so forth, and was more significantly a reflection of society at large that is dominated by middle class & elitist thinking that discriminates against anything that it does not perceive as following the so called norm of society.

*Workshop On Participatory Rural Appraisal (PRA)*

By far the most important of the mid term review was the 2 day training programme organized at Holy Cross in Hannur (Kolegal district) by Mr. Sam Joseph, PRA expert from Action Aid. It was not merely a training session but also a training cum field experience on the same.

Day 1.

After an initial round of introduction by all participants present, the workshop began with Sam asking all participants on their expectations from the workshops. There were several questions many of the paticipants raised on what is meant by participation, how can PRA be strenghtened, tools for PRA, who should be involved, what is meant by PRA, challenges & limitations, applications, benefits to community etc.

Sam proceeded by answering each one of these questions by questioning the participants themselves & proceeding to elucidate the idea of PRA. His first question was what the group understood by community. The standard answer given by participants was a group of people with same purpose.

Sam concurred by saying that while the definition holds validity but at the same time it takes a lot of hard work before this can be achieved.

PRA concept began during the 80's. It was primarily based on system based thinking. But PRA today is not the social mapping process followed by most NGO's. In fact PRA, according to him, should today be appropriately termed as Participatory Learining & Action (PLA).

Sam proceeded by placing a sheet of paper right in the middle of the participants & asked each participants from different sides what they saw. While one side said that the paper read as 3, one other side said that it read as E, another side maintained that the letter read as M & the last set of participants said that the letter read as W. Sam challenged the participants whether all of them could agree on one letter & are willing to give up for the sake of the other. When no response came from the participants, Sam said that this is challenge before us. Every group or individual has their own perspectives in the community & understanding from the other's viewpoint is very important while working in the community.

How to use PRA is critical. Participation is not instantaneous. It is also important not to use the words such as stakeholders in community, as the word is derived from gambling where both winner & losser are both stakeholders. It is important that one define who should participate & not just a man from the street.

The idea of participation in a democracy was taken as an example. Sam said that democracy has two diseases. First, tyranny of vote (majority opinion holds sway & not the minority opinion) & secondly, democratic despotism (those who win use public funds to promote themselves). Thus voting is not really participatory. Consensual decision is voting. Consensus means not unanimity but is a consideration of others viewpoint.

There are two approaches to development work. One that says that government is sovereign & the other that says that the citizen is sovereign. The former is top down aproach but we have forgotten that it is actually citizen that is sovereign. Rights based approach says that we have to claim our rights. But we need to go beyond this where people solve their own problems not be mere petitioners.

Often in democracy, there are different opinions but whose opinion is right. Often we make assumptions based on our assumptions or bias. Development begins with the person suffering the problem & not coming form the development workers. It is important we learn from the people & base our understanding on their problems.

Sam stressed the importance of autonomy. According to him, basis for autonomy is free choice, which encourages participation. The first test for participation is have you created autonomy. In most NGO led participatory exercises, it merely results in creating awareness or acting as consultants for donors or merely ends up into co-option of the community, with the people not really participating. But if you create autonomy, you also co-create, where people decide.

Development begins with the people, it is only by understanding people's problems that real development begins. If people do not have autonomy, people end up into slaves or subjects citizens. When people create rules, compliance is high, unlike the other way with NGO led programmes. Unless autonomy is ensured, development will not happen.

There are three ways to development, one is relief & welfare systems, self reliant communities & systems change. David cotton defines a fourth that is people's movement. Relief & welfare are what most NGO's do whereas self reliant communities refer to formation of such groups or associations such as Self Help Groups etc. System change happens when the problems is considered from its roots & addressed from the conditions giving rise to the problem. People's movement does not not refer to movement led by NGO's but really a people's led People's movement.

*Causal Loop Diagram* – All government or NGO reports are linear i.e., line by line. Systems work in a circular ways. Any problem in development is a self re-enforcing loop. Unless this link is broken, the loop ultimately leads to destitution. The balance loop tend to be stable for long periods of time & continually re-enforcing.

*Village visit* – The second part of the day in the afternoon was spent in going to villages & doing PRA excercise. We were asked to go to villages in 4 groups (each group one village) & ask the communities in the villages to draw a picture of their own village depicting all the houses & important landmarks of the villages. Role of the group was only to facilitate not help or even draw the map for the community. Instead the entire picture was to be drawn by the community themselves. We were also asked to map the health system of the whole area from the government services, private services & even traditional healers, to find out the coverage, accessibility & availability of health services in that area.

*Day 2*

On the second day, Sam stressed the importance of Action, Experience & knowledge. He said that only from action do we gain experience & only with experience do we gain knowledge. After surveying the group activity from the previous day, Sam pointed out the difficulty in bringing about real participation. The first element in participation is understanding self i.e., respect abilities of people to survive. As long as as NGO's & development workers have a set agenda, community participation shall never happen.

In the second day group activity, we were asked to list the diseases that affect the communities in the area & find out the long term consequences of each disease. Overall it was quiet an interesting session that taught us a lot & was especially useful for our field visits later.

**7. Focusing on the Health of the Unorganized Sector Workers**

Keeping in line with my objectives for July - August, i decided to focus my attention for the remaining 5 months of my fellowship & after, on understanding the plight of the unorganized sector workers, particularly on how trade unions take up the issues such as health, apart from their day to day struggles for better working conditions

*FEDINA*

One of the important organization in Bangalore that is involved in organizing unorganized sector workers is FEDINA (Federation for Educational Innovations in Asia). Though FEDINA since its inception in 1983 was not initially involved with unorganized sector workers, but was a typical NGO involved in welfare programmes among the elderly citizens (who were formerly unorganized sector workers). But during the course of their own journey it was felt by them that they were not making much of an impact into the life of the elderly through welfare programmes. Thus the

decision was taken in the late 90's to move from welfare to rights & unionization of unorganized sector workers.

In the past 5-6 years, FEDINA has been trying to build unions among the garment workers, construction workers, domestic workers & more recently among the agarbatti workers. This is apart from the network that FEDINA has created in South India which has been involved in organizing beedi workers, sanitation workers, agricultural laborers, gem cutters, street vendors & other non union issues such as domestic violence, caste discriminations, communalism, land struggles etc.

At the suggestions of Mr. Duarte Barreto (Executive Trustee, FEDINA) i spent most of my time in July trying to understand the work that FEDINA has been involved in. I accomplished this by going along with FEDINA activists to the homes of garment workers, agarbatti workers, by physically involving myself in some of their activities, meeting the field activists working in construction workers, domestic workers & elderly people, & attending collective meetings organized by FEDINA.

I initially started out by trying to understand the living & working conditions of the garment workers. I visited a few of their homes along with FEDINA activists along with my fellow colleague Manjula. It gave me a sense of the real ground situation in the garment sector industry. I also attended a campaign by FEDINA activists on the factory gates of some of the garment industries to raise the issue of denial of Provident Fund (PF). It was signature campaign to find out whether workers were issued with a green slip each year for assessing the PF.

I participated by distributing leaflets & talking to the workers on the daylight robbery being done by the companies. Many workers confirmed that they were being denied the green slips in their respective company despite working in the company for many years. This campaign was a precursor to a protest that was being organized by FEDINA on 22nd July in front of the PF office at Shantinagar, to highlight the denial of PF. I was unfortunately unable to attend this protest (as i had to go to Nagpur to attend a 3 day meeting) which i was told was successful with over 200 workers from a garment industry participating in the protest.

I attended a collective meeting of FEDINA field activists on 12th July, 2010 to understand the work carried out by other unions that FEDINA is currently involved, such as construction, domestic & work among the elderly. Among the elderly (mostly former unorganized sector workers), FEDINA has been been involved with them in over 30 slums in Bangalore organizing around 4000 people. Their main focus has been to increase the pension, availability of medicine at Primary Health Centers (PHC's), bus passes at subsidized rate (at 50% the current rate) & housing rights. Although FEDINA activists have played a major role in propping up the federation since its inceptions, but lately many of the FEDINA activists have started to withdraw & let the elderly run the federation on their own. This has in turn led to decrease in participation of the elderly in the federation, according to the activists .

The biggest problem faced by the elderly folk in assessing pension were the bureaucratic hurdles deliberately placed by the govt. in connivance with the bureaucracy. While the entitlement has increased from Rs. 100 to Rs. 400 after various struggles launched by FEDINA, the hurdles continue to remain & has not led to any significant improvements in assessing the pensions.

The construction workers unions is a newly formed union involving 150 workers & was registered very recently in April of this year. But the fact that most of the construction workers come under a

Mason & not necessarily a owner or a contractor has placed the construction workers in difficult position to fight for better wages or living conditions due to fear of losing work from the mason. Most of the members in the union have been local workers or those settled for a long time in Bangalore, involved in small construction works such as houses & not those migrants coming from the North & Eastern parts of the country involved in big construction units.

Among the domestic workers, FEDINA has been involved along with Sister Celia of NAPM (National Alliance of People's Movement) & Association for Promoting Social Action (APSA) jointly forming the Karnataka Domestic Workers Union. The basic problem faced by these workers has been the recognition as a worker by the house owner & fear of negotiating with the latter on working conditions, as they fear losing their livelihoods if identified as a union member.

Three out of the four meeting that i attended in July were meetings organized by FEDINA which included a meeting at CHC on 13 & 14$^{th}$July, a monthly training on 17$^{th}$, July & a 3 month collective meeting from 27$^{th}$ -30$^{th}$ July, involving all the FEDINA network in South India. The first meeting at CHC involved a training programme on understanding health & looking beyond the narrow prism of labor rights. This is also a part of an ongoing discussion between FEDINA & CHC on how two can collaborate using one another expertise.

The 2$^{nd}$ meeting that i attended was a monthly training exercise organized by FEDINA at Indian Social Institute (ISI). The agenda for the month of July was on concientization process of Paulo Friare & was chaired by Mr. Duarte Barreto (who was once upon a time a student of Paulo Friare during the latter's visit to Brazil in 60's & 70's ). The meeting also dealt upon the various levels of consciousness of the working class. The sessions were not simply a mere exercise in theoretical discourse alone but raised the issues from the practical standpoint of the activists working in the field.

The last meeting that i attended was a 4 day collective meeting of the entire FEDINA network in South India. It was held from 27$^{th}$ to 30$^{th}$ at ISI which included a two day training programme & 2 day collective sharing by the entire network. The training programme was an introduction into the history of capitalist development from pre-industrial phase to the modern age.

### *7.1 My Involvement With Agarbatti Workers at Ullal*

After much consultations with Mr. Duarte Barreto, it was decided by me to work with Agarbatti workers at Ullal (located at the outskirts of Bangalore) & to involve myself to some extent with the garment workers. Agarbatti workers was a new sector that FEDINA had started only recently. Mr. Barreto felt that it would probably give me a good chance to understand on how to form unions & trying to identify the various issues in this particular sector. According to Mr. Barreto, the biggest hurdle being faced by the FEDINA was trying to identify the actual owner as the process was contextualized through many intermediaries & much of production process remained a trade secret.

When Mr. Barreto suggested that i involve myself with Agarbatti sector, i was a bit hesitant at first. This is due to the fact that i knew next to nothing about them. The specific workers that Mr. Barreto had in mind were not workers in the Agarbatti industry but those workers who were engaged in this work in their very homes. It was in a place called Ullal that Mr. Barreto wanted me to go. What he was trying to understand was the complex supplier – employer – middleman relation in the production chain & at the same time the health & working conditions of the workers engaged in this form of employment.

*Home Based Workers*

A little bit of reading here & there helped me realize what i was dealing with. A whole new class of workers that had remained completely invisible opened before my eyes. These type of workers better known as home based workers is not a new phenomenon, but had remained a closed subject as far as i was concerned.

For instance, the work of SEWA (Self Employed Women's Association) in Gujarat has revolved around the issue of home based workers for the past 40 years. Initially started out as a trade union of home based workers is today an movement fighting for the rights of home based workers. SEWA also has several co-operatives of home based workers under its wings, which is an industry in itself.

The story of SEWA is certainly not a rags to riches story, it is also about a struggle to first of all recognize home based workers as workers in the first place. While legislations have been slow in their understanding of home based workers, the fact remains that workers in this category continue to be not recognized as workers but as home makers engaged in work during their leisure time [1]. There are several reasons for this – flexible timings of the workers, no definite employer, seasonal variations of work, unlicensed units etc. It is not an entirely dismal story either, a national policy draft on home based workers is under consideration by the govt. (after years of struggle by organizations such as SEWA) & hope remains that it will implemented soon.

The figures of number of people engaged in home based work is indeed quite staggering. An estimated 50 million people [1] in South Asia are engaged in this form of work (80% of whom are women) & unofficial figures for India alone range between 30 -50 million [1] with no definite figures available. The question would naturally arise: whence they came? The only best answer that i can think of is the growing in-formalization of work under neo – liberal globalization in search for maximizing profits & in turn undermine the organized sector through cost cutting strategies such as outsourcing or contracting of work, such as the home based workers with no social security benefits.

That a large number of women in their working age are involved in home based work is a testimony to the lack of employment opportunities available in the organized sector & lack of steady income from the male members to support the family, which has forced many women to take up whatever work available including those such as home based work with low wages. While being extremely vulnerable to the vagaries of the market, what sets them apart is the distinct lack of social security net in countries such as India & lack of an organized movement including support from the left trade union movements in country.

One could possibly characterize home based work in this era, not as a return to the past (cottage industry) as such, but as typically post-Fordist in character [1]. It is also very important to understand that relations of production between Capital & Labor need not be represented in the typical definition of a Capitalist & a working class under them. In fact such a black & white relationship that was typical in the Industrial Revolution & Fordist era with sharp antagonistic struggle between Capital & labor, has today given rise to a wide range of possibilities such as home based workers, self employed workers etc.

Home based workers of today is very much a part of the world economy & not a throwback to the feudal era. And the home workers are not necessarily unskilled or semi – skilled workers. In fact, it can involve workers from skilled categories such as software to the unskilled such as rolling beedis.

What is important is the distinct absence of employee – employer relationship, with the home worker constituting merely a link in what could possibly be global chain of sub – contractors linked to Brand companies which is completely freed from the production process & merely involved in selling & marketing of the goods.

*Agarbatti Industry*

The incense stick (or popularly known as Agarbatti in India) used in every devout Hindu households for religious purposes, is today a highly marketed commodity both in India & abroad. But not much thought seems to have gone into how these agarbattis are produced or manufactured. With limited infrastructure such as a wooden board, availability of raw materials & with little amount of skill, virtually any unskilled worker can make agarbatti in any household or sheds.

The fact that manufacturing can be any household or a shed involving a few workers, is something exploited by the companies that sell agarbattis under various brands. While there are agarbatti factories, manufactures prefer to contract the bulk of production to home based workers. This is done through contractors or middlemen. The production usually involves the contractors buying the main raw materials & the agarbatti workers are given the raw materials for rolling. After rolling & drying them, the contractors supply the rolled agarbattis to the factories where perfuming & packaging is carried out.

The main ingredients used in the manufacture of agarbatti include fine flour, coal dust, jigat powder & bamboo sticks. The raw materials are mixed together & a dough is prepared using water or oil [2]. The rolling is done on a low wooden slanting board about 3 ft. in size usually done outside the houses or in a shed in case of an unregistered unit. It is then dried & given to the contractor in a bundles of 200 sticks each [2]. The raw material and labor costs involved in rolling raw agarbattis together constitute only 10% of total costs with manufacturers controlling all the high value processes (perfuming 30%, packaging 30% and marketing & overheads 30%) within the factory premises [3].

While the manufacture of agarbatti is spread across many states, it is Karnataka, especially the Bangalore – Mysore region, that boasts the highest number of these workers involved in agarbatti estimated at around 250,000 people (80% home based) followed by Gujarat (60,000) [3]. The only probable reason why agarbatti industry in concentrated around this region is probably spread of the tree species ,*Maclilus makarantha,* the source of Jigat powder in this region The other probable reasons could be due to the large concentration of slums in & around Bangalore especially women without formal employment.

As to reasons why such women are such easy targets is probably because the work does not necessarily require women to work outside their homes & thus integrating this work with other forms of household activities such cooking, washing & taking care of children. And this combined with the extreme form of poverty & destitution that families face forcing many to take up such activities under non negotiable conditions.

Another distinct feature in this production process is the near absence of an employee – employer relationship. As most work is contracted through a middleman or contractor or sometimes even a trader, most workers do not know who is controlling the thread of the production chain. But at the same time, workers are under no obligation to meet production targets even in unregistered units such as sheds & most workers have enough freedom to produce according to their capacities. But

given the extreme poverty & destitution faced by these people, most in fact labor 9 – 10 hrs rolling over 5000 battis, as any other factory worker in the same industry.

In Ullal, for instance, located in the outskirts of Bangalore, all the workers are women & even involving children, belonging to either poor Muslim or dalit households. Most of these women have taken up this profession due to their extremely miserable conditions & trapped by traditions to be confined within the house to do household chores or look after children.

Interestingly, agarbatti industry falls under the Factory Act in Karnataka alone & in no other state. But many of the manufacturing units being poor households in slums or unregistered sheds, they do not come under the purview of any labor laws as their factory counterparts do. Thus homebased workers do not receive any benefits apart from their wages in contrast to factory employed agarbatti rollers who receive provident fund, leave, medical and maternity benefits. Factory workers have a six day working week and are entitled to one month's leave with full pay. Medical and maternity benefits are covered under the Employees State Insurance scheme and 12% annual bonus and provident fund are provided for under the provisions of the Factories Act. In comparison, the lot of home workers is pitiable with no provisions for maternity leave, child care support or fall back arrangements during times of illness [3].

Wages are paid on a piece rate basis & most workers at Ullal earn anywhere between Rs. 20 – Rs. 22 for every 1000 sticks (piece rate basis) & depending on the type of agarbatti they produce, a single worker can earn anywhere between Rs. 100 - Rs. 120 a day if she labors for 9 – 10 hrs. a day. Given the high inflationary situation in the country at present, the amount these workers earn is a pittance compared to the rate at which it is sold in the market at Rs. 1.00 – Rs. 1.50 to even Rs. 50 a piece (!) depending on the type & quality.

Thus there is a huge disparity between the wages earned & profits made by the brands. This is especially so since agarbatti is no longer local commodity but a branded global commodity today, earning huge dividends for the brands that market them. Given the inflationary situation with basic food prices sky rocketing, one is left wondering how on earth do the women eek out a living.

As far as the working conditions are concerned, home based workers definitely would fare better compared to those working in sheds or their factory counterparts. In many of the household based ones, agarbattis are usually rolled outside their homes in the pavements & lanes with enough air & ventilation. But in case of sheds involving groups of workers, the working conditions are dismal in dark, ill lit rooms with little or no ventilation. Even in cases of home based workers, the work is sometimes confined within the household especially during the monsoon season, when living space is also the workspace, which is usually very small, congested & dark with no ventillation [2].

The conditions of those workers working in licensed agarbatti manufacturing units is no better, who sit in rows of workbenches in dingy, ill-lit, sooty surroundings [3]. The only difference being women receive a fixed salary & are entitled to namesake social benefits such as Provident fund (PF), Employee State Insurance (ESI) scheme, bonuses, pension etc. Most of these social benefits hardly meet the criteria for decent living standards. ESI continues to be corrupt institution with workers assessing benefits only by bribing the staff & treatment services provided under ESI run hospitals or clinics are at best second rate.

An agarbatti worker has to bend down and work on a wooden board with their legs stretched under these tables for 8 to 10 hours a day to roll over 5000 agarbattis. The task is extremely arduous &

repetitive with workers are especially vulnerable to postural and locomotive system problems. A detailed health study by SEWA in Ahmedabad in 1988 revealed the following health problems among women agarbatti workers: back pain, blisters on hands, body ache, chest pain, dizziness and exhaustion, eye problems, headache, nausea, neck pain, pain in abdomen, pain in limbs, shoulder pain, white discharge, heavy bleeding, early periods, drying of breast milk and itching or burning while urinating [3].

In a later comparative study of 4 home based occupations by SEWA, agarbatti workers complained most of back pain and pain in limbs. They also reported the other problems listed above. In terms of gynecological problems, these workers complained of abdominal pain, irregular menstruation, urinary problems and white discharge. The study reported that no protective or preventive measures were taken by the workers as these could hamper speed and hence earnings and that little medical aid or counsel was available to them [3].

*My Experiences at Ullal*

As mentioned earlier, my field work at Ullal started somewhere in late July & lasted throughout the month of August. Unlike many of the new layouts sprinkling around Bangalore, Ullal has a history behind it. Many of the resident's at today's Ullal were formerly oustees from the govt. slum clearance programmes in the last 20 years to make way for so called development projects in Bangalore.

Though many were relocated to Ullal as means of compensation, what they found on arrival was lack of minimum basic facilities like water supply, electricity, roads, transport, sanitation apart denying them land title deeds. So it has been a literal struggle for many of the residents of this area thanks to which people today have some sort of basic facilities & have been granted land title rights.

FEDINA's involvement started in the late 90's & has continued all throughout the last 10 years with three full activists employed by FEDINA from the same area, who have lived & struggled with residents of that area. Earlier FEDINA's work at Ullal was mostly with respect to welfare programmes such as construction of toilets in the Sulabh model (with biogas plant) run by the community (due to lack of sanitation facilities in the area), vermicompost production, formation of Self Help Groups (SHG), housing & their primary focus with the elderly such as providing them medical services & access to pension rights. Though many of these programmes have continued to this present day, FEDINA has recognised the limitations of these programmes, some through bitter failures & others due their unsustainability in the long run.

With a shift from welfare to rights & unionization, the main concentration of FEDINA at Ullal has been with unionization particularly focusing on garment & construction apart from organizing the elderly. Agarbatti has only been a recent addition started only a few weeks before I joined. One reason cited by Mr. Barreto for focusing on Agarbatti was a large number of women taking up this profession in the past few years & many women (rolling agarbatti) coming up with health & other related problems being faced by them in SHG's meetings (in which some of them are members).

Most of the women engaged in Agarbatti at Ullal belong to predominantly Muslim, Dalit & Adi Dravida communities. Each of these communities have been segregated arbitrarily by the govt. with each community living in a separate locality earmarked for them with Dalits living in Ambedkar Colony, Muslims in Muslim's colony (unofficial name) & Adi Dravidas separately. The presence of different communities in the same area has not resulted in caste or communal tensions, with most

communities living in relative harmony with one another.

When i first started to go to Ullal daily, i had little idea what exactly i would be doing there. We decided as a start to do an informal sort of survey on the number of workers engaged in Agarbatti rolling. This involved going from one house to another looking for those invisible workers working in their households & sometimes outside on the pavements or on roads.

When we visited each of these workers, it was not only with an intention to collect information but also with the message about unionization, its importance & whether they would be interested in collective meeting of all households engaged in agarbatti rolling. Our survey revealed a large number of workers engaged in agarbatti rolling i.e., around 500, out of which 60 – 70 were involved in agarbatti rolling in the sheds with groups of 10 -15 women each.

It was a new experience for me since until then, my interaction with ordinary people has been at a minimal & definitely not to the extent as in Ullal. It broke down lot of barriers that existed between me & ordinary people. It was an experiential learning as compared to theoretical knowledge that restricted interaction with ordinary people.

It was also experienced by me when i actually started to write about the conditions of the agarbatti & garment workers in our paper (bi-monthly newspaper of the New Socialist Alternative). What i strongly observed was my writing had a strong grounding on reality as opposed to earlier which treated people as inanimate objects without life.

We had decided on holding out a collective meeting of all agarbatti workers in Ullal on 12th August, 2010. As a precursor, we decided to hold local level meetings at different localities. We held 4 such local level meetings plus one collective meeting & each meeting had something new for me to learn.

For instance at our very first meeting we held at Muslim colony, around 20 – 25 women participated. At this particular locality, most worked in sheds given to them by a contractor. While most women seemed to be receptive to the idea of a union & need to form unions, their skepticism lay with gaining anything at all from the contractor. Many were also burdened from the contractor in the form of loans & the cut being taken by the contractor (Rs. 1 - 2 per 1000 battis) to provide them work. Any slight demand by the workers to increase wages only resulted in the contractor threatening to move out as there was plentiful labor available outside.

In our second meeting with agarbatti workers predominantly from the Tamil community, involving around 20 home based workers, the mood was gloomier compared to the first one involving shed based workers. Their relationship with their contractor (who were mostly traders) were even more distal compared to the shed workers as it was only a buying & selling relationship. I distinctly got the feeling that while a union may work out in shed based agarbatti workers as all the workers congregated in one place. But in the case of home based workers, none of the workers congregated at one single spot or had a same relationship with the contractor as compared to shed based workers.

What made the idea sound even more revolting was when FEDINA activists explained to the workers that in order to form a union, home based workers workers need to observe factory discipline such as follow strict timeliness like 9 AM to 5 PM working hours, no flexibility in work, etc., in order to be recognized as a union. I distinctly felt factory based concept of a working day could not be simply be transplanted to home based workers & FEDINA was trying to impose a

certain concept of unionization based in a factory on the shoulders of the workers without understanding ground realities.

The third meeting that we held involved mostly shed workers in a more middle class neighborhood. The meeting included over 20 members mostly listening to us as they worked (since they could not find break from their work). But most women seemed to show a disinclination towards us. The reason cited by the activists was that most of these women were recent additions to the area compared to other workers in the last two meeting who had a history of struggle behind them. Though the problems faced by them were universal, they were yet to learn from experiences. Another reason according to the activists was the large presence of middle class in this area that had an influence on the consciousness of even older workers in this particular locality.

The last meeting we had was in a predominately Dalit & scheduled class locality called the Ambedkar colony. Most of the workers in this locality were home based workers. Despite the best efforts made only around 10 workers came despite one of the activist from FEDINA actually belonging to the locality. Whether the problem was due to local politics based on the communities suspicion of outsiders or workers lack of interest in union formation as most of these home based workers lived several distances apart, there was not much interest shown among the workers who attended the meeting.

All in all we held meetings involving around 75 workers that included both shed based & home based workers. While enthusiasm for the union formation was palpably higher among the Muslim & Tamil community compared to the Dalit communities & others, the best reason i can think of was probably due to FEDINA's activities that have concentrated more on these communities in the last couple of years compared to others due to the reasons sited above. This was also reflected in our stocktaking of the four meeting that we conducted after these four meetings, that cited lower enthusiasm among especially home based workers for unionization that reflected in lower turnout.

We held a collective meeting on 12$^{th}$ August, involving main office bearers from the FEDINA head office, of all agarbatti workers of Ullal at the local community hall at Ambedkar colony. Despite the best efforts made to get more than 100 workers only about 50 workers (home based) mostly from the Tamil community turned up (despite the distance from their locality). Apart from a few workers from the Muslim community, none of the home based workers from the Dalit or the other Muslim communities turned up (despite the closeness of the location). This even resulted in some of the workers questioning why only a particular community presence was more compared to the rest in Ullal.

The meeting once again reiterated the importance of unions, the process of unionization & need to organize unorganized sector workers, i got a feeling that workers had lost some their initial interests. This is when i started to incline towards alternative methods of organizing the workers especially those from the home based sectors. The immediate example that i could think of was the SEWA experiment that organized home workers which were at the same time a union, a cooperative & a women's movement into one.

I discussed this idea with the main activists of FEDINA but their response was that a cooperative & union at the same time cannot work & cooperative would only end up into a shortcut of trying to bypass the exploitative middlemen without facing the realities of the situation. They also cited the problems faced by their cooperatives in the past which had ended up into failures. While not fully convinced over their replies, i came to the conclusion that both cooperatives & unions were long

term processes which cannot be realized in the short term of my fellowship. What was more important was to fulfill the main objective of my fellowship i.e., bringing health into the picture while keeping FEDINA's objectives in perspective.

In order to better understand the problems being faced by the workers in the agarbatti industry, we decided to go & meet one of the labor lawyers representing the agarbatti workers in the industry. The response we got from him was dismissive. He stated that forming a union will only result in the contractor moving away leaving the workers destitute & also cautioned against any move to complain to the labor department which would result in the same. The best suggestion he could give was trying to push forward a legislation such as the Beedi & Cigar Workers Act, 1966 who are also mostly home based workers but enjoy some protection under law. On the question of union support to the home based workers, the response he gave was truly shocking & reflected the attitude of a conservative labor union leaders: keep off from the issues of agarbatti industrial workers nor are we interested in yours & don't expect any help from our side in terms of solidarity.

Next, we met with the representative of the Agarbatti industry in the Federation of Karnataka Chamber of Commerce and Industry (FKCCI). The body represented over 200 agarbatti industries in the state of Karnataka. He plainly stated that the body could do nothing as far as home based workers are concerned. If it was a question of labor issues in the industry, there were legislations to protect the workers. They themselves were not aware on how many industries engage home based workers as it was illegal to do so & most industries usually claimed that they do not employ or contract home based workers (which was not true according to him).

All these instances only strengthened my conviction that a cut & paste attitude such as union formation cannot work in the long run. What was required was not only alternative modes of organizing the workers but also engagement with various stakeholders at the policy level to bring any meaningful change in the lives of home based workers.

*Health of the Agarbatti Workers*

While my discussion with the workers could not much focus on their health problem, many did complain on suffering from mainly of back pain & limb pain due to their sitting posture. Many complained of skin allergies & dust allergy. The other common complain was with regard to gynecological problems such as irregular menstruation & white discharge.

While home based workers did have the option of sitting outside their homes for rolling the battis, the shed based workers were confined to dark dingy, non ventilated rooms filled with dust & the strong smell of the incense. This sometimes even involved children. Not that places were these women work are deliberately left unclean by the workers themselves, but the process of agarbatti making pollutes the environment around which the women work.

I even met women working since their childhood days to present old age who claim to be fit & healthy without having to undergo any major health problems due to their working conditions. Women also claim that they become sufficiently immune after a period to the dust, smell, allergies etc. While health problems remained a strong issue among many of the workers, many due to the helplessness of their situation have had to bear the problem in silence in the absence of other alternatives.

The issue of basic facilities like water, toilet etc was not an issue among home based workers, but

the shed based workers are not provided with any such facilities by their contractors. As many of their homes are usually close by, all of them tend to manage on their own, without considering this as too big a problem to demand from the contractor.

*Heath Center at Ullal*

There is a Health Center at Ullal which is attached to a PHC some 5 to 6 Km away. The doctor visits the center every day between 11 AM – 1 PM . It mainly caters to immunization of children & maternity related issues. While the doctor is not said to levy charges on his patients, the patients are routinely demanded money from the nurse for issuing medicine or to assess any service at the center.

The centers is certainly not equipped to deal with occupation related health problems faced by the workers. For instance there is no educational awareness on how the workers can deal with occupational related hazards such as dust & allergy or how to avoid this through face masks, importance of ventilation, cleanliness, basic hygiene etc. The same was the case for the other category of the population in the same area such as construction workers, garment workers, others such as elderly whose needs were hardly met at the center.

Thus without understanding the actual needs of the population in the area, the center functions on the whims & fancies of the health department. Service provided at the center hardly met the criteria of providing basic health care let alone occupational health or comprehensive health care. Primary Health care was completely divorced from the social determinants such as water, sanitation, food, housing etc. Many of these priorities have ended as functions of NGO's such as FEDINA with their limited beneficiaries & leaving people at the benevolence (or mercy?) of the NGO's.

***7.2 Garment Industry***

The other unorganized sector that i was also able to look into initially was the conditions of the workers in the garment industry. In fact as mentioned earlier i started out by trying to involve myself with the health issues of the garment workers. But consequently i did come across the problems faced by garment workers in Ullal which boosted a large number of garment workers with many garment industries located nearby.

I began by visiting garment workers along with with my fellow CHC colleague Manjula (also placed in FEDINA) & a field activist from FEDINA. We visited houses of garment workers working for Buddy Fashions (which employs 300 workers, mostly women) who were involved in organizing union in their area in Kuvempunagara, Bangalore. The biggest problem faced by garment workers according to these workers was the denial of Provident Fund (PF) by the company by using many loopholes in the law & the corruption in the ESI department ultimately resulting in workers either being denied reimbursement in case of leave or denial of proper treatment in the ESI hospitals. The common compliant was that workers were made to go from one place to another & often to bribe the officials before assessing the benefits. Thus most workers preferred to go to private practitioners rather than ESI.

The health problem faced by these workers due to the working conditions included frequent headache, eye pain, stomach ache, allergy problems (due to the dust) & back pain. Though the company provided the workers with masks to prevent inhalation of dust, many workers do not use them. Another added problem faced by these workers was the foul language used by the supervisors

who were usually male.

The garment industry in Bangalore with about 1200 registered units employing over a half a million workforce & one of the biggest sources of exports in the country. But hardly is there any mention in the media on the living & working conditions of the workers who are the real makers of some of the top brand clothing in the world.

Earning anywhere between Rs. 3200 to Rs. 4000 a month, which is pathetic sum especially given the the rise in food prices & the sort of profits being made by the contractors & the brand companies. Comprising of mainly unskilled or semi skilled women workers & mostly hailing from rural, lower class - caste backgrounds, between the age group of 20 – 40 years, most of these workers are hardly aware of the benefits that they are entitled, giving the company management & labor department a free hand in denying them their basic rights.

But the biggest problems that is faced by these workers is the lack of organized unions in every factory to fight for increasing their wages & their basic rights as human beings. Although coming under the factories act, governed by minimum wages, covered by Employment State Insurance (ESI) scheme, most of the companies hardly adhere to these laws given the laxity in implementation by the govt. & loopholes in the laws that allow the companies in denying the workers their benefits.

A common practice followed by the company management is the denial of gratuity benefits & pension benefits after 5 yrs of employment by asking the workers to rejoin as fresh employees & thus denying them this benefit. A second ploy used by the company is the non payment of Provident Fund to the concerned labor department & using this money to build as capital, while the workers remain seemingly unaware of this denial until the day of their resignation from the company. Another important right concerns health care services covered by the ESI which continues to be a regularly denied unless by bribing the officials of the concerned department.

An emerging trend in the garment industry was contracting of workers to do piecework which left the employers not shouldering the burden of giving the workers social security benefits. And many workers fell for the trap due to the higher pay drawn in piecework compared to the normal wage labor. This also had a bearing on the full employment of workers throughout the year with workers on contract having work only during some periods & not during lean periods.

The regular harassment faced by workers by their male supervisors to meet their production targets is one of the most humiliating ordeal faced by the workers daily in the industry which has a bearing on their mental health. Most workers are also made to work overtime without compensation, working anywhere between 9 – 10 hrs a day. All these is besides lack of provisions of some of the basic amenities in many of these units such as drinking water facilities, proper rest time, inadequate lunch hours, toilet facilities, besides domestic violence commonly witnessed in their homes, all of which has a general bearing in terms of deterioration of their health.

On the question of forming unions, many workers were simply afraid of committing themselves to being part of the union as many feared losing their jobs & many workers showed apathy believing unions do not solve their problems. As a start, many workers in some garment factories were involved in forming committees within their factories without registering themselves a union.

The picture may sound dismal, given the low levels of consciousness of the workers (as many workers are fresh into the industry), lack of unions & Bangalore not having witnessed any major

confrontation of the garment workers & company bosses. The NGOization of the union movement has put a further dampener on the combativeness of the workers, instead of workers direct action against injustices such as bad working conditions, low pay, sexual harassment, safety regulations. implementation of labor laws etc., they are now taken up with the 'Brand people' of different MNCs who are basically exploiting the workers for dirt cheap labor. It is now they who insist on the factory managements to adhere to the laws because it would be a bad publicity for their Brands abroad, workers rights have become a mere PR & HR exercise, which is pathetic, this has taken the power out of the hands of the workers for collective direct action and struggle.

While there are many NGO workers, very motivated activists and fighters among the NGO sponsored unions who sincerely believe that they are engaged in alternative radical politics, but the dominant ideology of most of the NGO's is " conflict management". CITU and AITUC who have their base among the salaried, permanent and organized sectors do not have the vision to reach out to the low paid workers.

*References*

1. Shalini Sinha., 2006 Rights of Home-based Workers. National Human Rights Commision, New Delhi.

2. SEWA Academy., 2000 The Fragrance of Hard Work:Women Incense Stick Rollers of Gujarat. SEWA. Gujarat.

3. Manjul Bajaj., 1999. Homebased Women Workers in the Agarbatti Industry in India. Invisible Workers, Visible Contribution: A Study of Homebased Women Workers in Five Sectors across South Asia.

**8. Six Monthly Review**

It was beginning of September, it was once again time for the six monthly review. This time we did not have much of training sessions as was usual in the orientation & mid term review but was more to do with preparing our project plan. Of course, we had 4 sessions, one by Shoba Mangoli, one HIV/ AIDS & the other two by Dr. Ravi & Thelma Narayan.

We had our sharing of our field visits with each of us presenting our different experiences. Everybody had something significant to tell us based on their field experiences. Many of the interns also expressed how the fellowship programme gave them a different perspective altogether & how they were able to apply them on the field.

*Protest Over Beggar's Death in Bangalore*

We had an opportunity to attend a protest march from Town Hall till Mahtma Gandhi Statue at MG Road in Bangalore against the death of 30 inmates due gastroenteritis at the so called Beggar's Colony (Beggar's Rehabilation Center). The important aspect of this incident was how immediately we were able to relate what we had learnt during the fellowship on availability of basic health care which could saved the lives. Based on this incident, I wrote an article on the same (See Appendix).

**9. Project Plan: Post September Review**

***Title*** – Agarbatti Workers (Home – Based) Health Awareness Project

***Goal*** – The overall goal of the project will be to guide the agarbatti workers (Home based) to take minimal steps to tackle the occupation related health problems. To evolve ways of organizing these workers & to help them understand the problems faced by them from a broader perspective.

***Objectives & Activities of the project include:***

***Objective 1***- Make the Agarbatti workers conscious of their occupation related health problems

*Activities* –

- Spend time with a small sample of workers (representative of the population) to understand occupation related health problems from their perspectives.
- With help of a resource person, conduct small workshops in different localities on health & occupational problems & help them take small steps to tackle the problems faced by them
- Evaluate the effectiveness of the workshop by way of follow up actions being taken by the workers & feedback from the field activists involved & the workers

***Objective 2*** – Organizing of agarbatti workers to struggle for their basic rights

*Activities* -

- To look at different ways of organizing home based workers & try to evolve a framework that best suits their needs
- To learn with the activists of FEDINA of organizing workers & bring the experience of other organizations working with home based workers
- Areas of interventions through the labor department on the denial of basic rights & social security to home based workers

***Proposed Time line:***

| ***Objective 1*** | |
|---|---|
| ***Activity*** | ***Timeline*** |
| Understanding occupation related health problems | September - October |
| Holding Workshops | October - November |
| Evaluation | Ongoing process |

| ***Objective 2*** | |
|---|---|
| ***Activity*** | ***Timeline*** |
| Organizing Workers | Ongoing Process |
| Study of Home based Workers | Ongoing Process |
| Other Interventions | Ongoing Process |

## 10. Understanding the Health Problems of Agarbatti Workers

*Introduction to ROHC*

According to my project plan for three months i.e., September, October & November, I planned to hold focused group discussion with the agarbatti workers of Ullal, along with Regional Occupational Health Center (ROHC), Bangalore. ROHC is a branch of the National Institute of Occupational Health (NIOH) located in Ahmedabad (Gujarat), which is part of Indian Council for Medical Research (ICMR), focusing on the occupational related health problems of the unorganized sector workers.

As Dr. Ravi was a scientific advisory committee to ROHC, he referred me to Dr. Asha Ketharam, the social scientist at the center, who was involved in conducting studies on occupational health, particularly among the unorganized sector.

After a discussion between myself, Dr. Ravi Narayan & Dr. Asha Ketharam (social scientist at ROHC) it was decided to do a joint study on the occupational related problems of the agarbatti workers. Dr. Asha had previously done a study on the agarbatti workers near Binnypet mills a year previously. But the study could not conduct a medical camp as recommended by its scientific advisory committee due to several logistical constraints. In order to find out more linkages between occupation & health, Dr. Asha mainly wanted to do a medical camp, with Ullal as its project area, to complete the earlier study.

*A Chance for Collaboration*

This joint study opened up a channel of communication for FEDINA to collaborate with ROHC for more studies on occupational health problems & as a point of engagement with a central govt. institute. It provided me with an opportunity to look at first hand to compare at close quarters two important dilemmas of social activism: engagement with the govt. at policy levels & at the same time pressuring the govt. through opposition against privatization. Since FEDINA was an organization that believed in the latter position it was interesting to see how an organization that was skeptical on engagement with govt. at policy level looked at collaborating with a govt. institute.

On the ROHC side, due to the proactive engagement by Dr. Ravi & Thelma Narayan, ROHC has come tc recognize the inevitability of engaging with civil society organization & trade unions to do joint collaborative studies with civil society organization, rather go it alone or through the industries, in order to get real data, as most industries are either downright hostile or use political influences in undermine the study. In the short term ROHC wanted to conduct a workshop involving various civil society organizations working on labor related issue & look at long term feasibility of a partnership with them.

The dialogue between CHC, FEDINA & ROHC has only just begun & it would be premature to conclude anything. Nevertheless, I can say confidently that our joint study on agarbatti workers involving myself (through CHC), ROHC & FEDINA was a testing ground on which a long term relationship could mature in the future.

*Conducting the Study*

During the study, we managed to have 10 focused group discussion involving over 50 workers,

besides my daily visit to Ullal to keep in touch with the day to day union work by FEDINA. We could have had more such focused group meetings but it was due to clash of dates on the availability of FEDINA activists (due to various other engagement) & Dr. Asha (who had other studies to conduct besides this) that this could not happen. While 5 of the discussions was conducted along with Dr. Asha & the rest 5 was conducted on my own.

Our discussions were not organized in group meetings specially organized for us by FEDINA activists. Instead we went to the workplaces of the workers which usually were in small groups outside their homes (in case of home based workers) or we asked workers nearby to come to meeting point nearby along with their materials without hindering their work in any way. In case of shed based workers, we actually sat down with workers in the shed to hold discussions with them while they continued to work.

While 7 of the group discussions were with home based workers engaged with water based agarbattis, the rest of them were held with shed based workers engaged with oil based agarbattis. We usually spend over 3 – 4 hours with each group that we met. We spent quite an amount of time in trying to breaking the ice so that workers did not feel that we are outsiders. We did not even start with rapid fire of questions like it is usually done in a survey. We started with how the workers began their day, what they had for breakfast, what was the lunch being prepared & so on, then we slowly proceeded on questioning them.

The one advantage I saw in this method was workers began to talk freely about their life, their problems, issues in their households etc. The issues that we usually managed to cover included whether they had breakfast & lunch on time, do they drink water regularly, do they have toilet facilities, normal health problems they face, the health service that they usually visit (govt. or pvt.), their production targets, loans, daily spending, use of tobacco, domestic violence, alcoholism among husbands, opinion about FEDINA' s work among them & how has it helped.

We specifically asked them whether a medical camp to identify their basic health problems would actually help them in any way. Finally, we even asked them whether this discussion was productive to them in any way & will future discussions help. The best part of this whole process was that we weaved the whole discussion into a form of a story & did not follow the usual method of questionnaire based survey. We let the workers speak for themselves.

*What we Learnt*

Most of the workers we spoke to had an average of 2 to 3 years of experience as agarbatti rollers. And of course we also met workers working since their childhood to their tender old age. Most of the workers among the home based agarbatti rollers started their day around 10 in the morning, only breaking for lunch & continue to to work till 5 to 6 in the evening, managing anywhere between 2000 – 3000 battis based on their experience. But in case of shed based workers, many workers usually began their day very early at 8 in the morning continue till night rolling more than 5000 battis in the process.

Our basic findings during this discussion process was the biggest problem facing them was the low socio-economic index. The case of shed based workers (mostly from Muslim communities) were even worse compared to home based workers. Most of them were indebted to middlemen or the banks. Most of them usually had vegetables occasionally & fruits were a rarity, their lunch usually consisted of rice & sambar. While Muslim communities suffered with a relatively lower socio

economic index (as most of them lived in rented homes without toilet & all of them indebted) compared to the rest, they considerably spent more more money on their food (living for the day) consuming non vegetarian food quite often.

While there was no difference in terms of wages in shed based or home based agarbattis, most home based workers did not go to shed based work as most found it difficult to manage the dust, headache due to the smell & cramped conditions. But the oil based agarbatti despite its health effects, was a much easier as the raw materials were ready to use & easier to roll compared to water based.

While toilet & water facilities were not much of an issue among the home based agarbatti workers, none of the shed based workers were provided with these facilities & most of them did not have toilet in their own homes & many had to go far distances to relieve themselves. Hence many of them usually do not get up during work to relieve themselves & held on for long periods of time.

The major health problem that majority of them faced were ergonomic (related to posture) & gynecological problems such as white discharge. The problems related to posture included backache, joint pain, leg pain & mostly musco-skelital. More than half of them reported fatigue & stress (both related to work & family problems). None of them reported the respiratory problems due to dust or allergy & skin problems due to direct skin exposure.

Most of the shed based workers also reported that they did not get hungry during their working time & usually went on with their work having late lunch. Most of them tended to manage by drinking tea very often. Another common habit among them was the use of tobacco or snuff in their nostrils. Many justified the use as it helped them forget their day to day problems & as a relief from headache.

Alcoholism was a major problem among many husbands & domestic violence was common. But husbands did contribute to their family income. The number of single women run household was very small. Most house holds we came across were nuclear families & agarbatti was not a traditional family work. Many learnt rolling agarbatti only after coming to Ullal.

On children (girls) participation in the agarbatti rolling, a majority of shed based units had child laborers. Large number of children working in agarbatti rolling came from Muslim households & many tended to drop from school to aid in increasing their family's income.

On the health service provider, most workers complained that the Health Center did not have the required medicines & had to buy it from outside. Nobody complained of corruption & most said that the doctor was okay. Many cited that since the doctor's working hours were only between 11AM to 1 PM they hardly had time to see the doctor as it was usually crowded.

As part of our own interest, we wanted to experiment whether use of masks, gloves & rolling the battis on a higher platform. On the few workers that we experimented, many found it very uncomfortable to wear to masks, which prevented them talking & many found it hard to wear it for long. Also use of gloves many founded it difficult to get the grip nor was it helpful in raising the platform as they could not get used to it.

On the feedback from our focused group discussions, everyone we met said that it was a productive discussion as it did not hinder their work in any way. In fact most said that talking to each during their work actually increased their productiveness and was a way out of the boredom doing

repetitive work.

*Progress in Unionization*

On the progress of union work of agarbatti workers at Ullal by FEDINA since September, it is mixed sort of picture. While FEDINA has undoubtedly raised the consciousness of the workers through group or street level meetings, attendance at monthly meetings of all agarbatti workers of Ullal has fallen. From around 50 – 60 in the first two meetings in August & September respectively, it has nose dived to around 10 in the last meeting in October. Reason could be many, but the fundamental reason which I think is cause of this is the limited amount of time available with the workers to attend meetings & distance to walk from one locality to another.

But at the same time, FEDINA has been able to build a rapport among the workers in all localities of Ullal. Holding group level meetings or street meetings has become a relatively simple task with some pro active workers themselves taking the initiative of holding the meetings & bringing the workers together. The process of registration of union is yet to begin but the ground work for this initiative has started. However it remains to be seen how the union forming process or group level meetings is to yield results in the form of wages increase & other entitlements due to them.

*Organizing the Medical Camp*

Given our major findings based on the focused group discussion & the limitation faced by FEDINA in organizing the workers, we decided to hold a medical camp instead of a health camp as was originally envisaged. We even abandoned the hope of holding an awareness programme due to the severe time constraints of the workers. To reduce the time constraint of the workers, we decided on holding the camp at 3 different localities of Ullal.

The medical camp consisted of 3 components: socio – economic survey, basic tests related to Hematology: Hemoglobin, Total & differential WBC count, blood grouping, BMI, BP, urinary analysis & random blood sugar. And finally an examination by the doctors. We kept the sample for the medical camp at 100 with around 33 patients per day. We planned the camp in such a manner that the workers did not lose more than half an hour of their precious time.

On arranging the medical camp, we initially wanted to conduct the camp via the Health Center itself. While the PHC doctor was willing to offer his service provided we have the permission of the District Health Officer (DHO), who was incidentally on leave. We even tried to get doctors from Bangalore Medical College (BMC) as we thought that it would be useful for follow up. We had to abandon this as we did not proper response. We finally settled for an arrangement through Rajarajeshwari Medical College located nearby, through their Community Health department which promised to provide free medical check up for follow up. We even made an arrangement with the Health Center to serve as an referral to patients for providing medicine in case of need & as a follow up after the medical camp.

The camp was conducted on 3 days – 16$^{th}$, 18$^{th}$ & 19$^{th}$ Nov. in thee different localities. We engaged 3 women doctors (MBBS graduates) posted in the community medicine department. The camp went very well without any hitch. Basic complaints included suffering from musculo skeletal problems related to joint pain & back pain,. They also complain of stress related symptoms,- of lack of appetite, sleeplessness, anxiety & head ache.

On the whole, it was a different sort of an experience. On the one hand to do from an institutional perspective, trying to collect data & on the other as an activist to try to see how this can be used as an opportunity to improve the lot of the workers. As most studies conducted by ROHC have ended up in the bookshelves without an iota of an impact on the govt. policy level, it would be interesting to see in the future how pressures from civil society organizations & trade unions can change all that & make some impact on the govt. policy level.

**10.1 Preliminary Analysis of the Ullal data**

Total subjects covered- **131**
Agarbathi workers- **121**

Out of 121, for one subject data on differential count not available- **slide not proper**
Total WBC count data not available for 12- **slides not proper**

| **Anaemia** | **No** |
|---|---|
| Normal 12 gm/dl | 55 |
| Mild 10-11.9 gm/dl) | 38 |
| Mod (7.9.9 gm/dl) | 28 |
| Less than 7.0 gm/dl | 0 |
| **Total** | **121** |

**BMI Data (According to Indian standards BMI range as corrected )**

| **BMI ($Kg/m^2$)** | **Weight status** | **No** |
|---|---|---|
| Less than 18.5 | underweight | 13 |
| 18.5 to 22.9 | Normal | 41 |
| 23 to 24.9 | Overweight | 16 |
| 25 and above | Obese | 49 |
| Data Not available | | 2 |
| **Total** | | **121** |

**Socio-economic Profile**

| **Age (Yrs)** | **No** |
|---|---|
| Less than 14 | 1 |
| 15- 25 | 19 |
| 26-35 | 37 |
| 36-45 | 27 |
| 46-55 | 11 |
| 56-65 | 26 |
| **Total** | **121** |

| **Religion** | |
|---|---|
| Hindus | 88 |
| Muslims | 30 |
| Christians | 3 |
| **Total** | **121** |

| **Type of family** | |
|---|---|
| Nuclear | 99 |
| Extended | 13 |
| Joint | 9 |
| **Total** | **121** |

| **Marital Status** | |
|---|---|
| Single | 8 |
| Married | 112 |
| Widowed | 1 |
| **Total** | **121** |

*What the data Revealed*

in generating the ROHC, the above data was the only data made available tome during the final drafting of this report. Out of the 131 people who attended the medical camp, about 121 were agarbatti workers & the rest were non agarbatti who mainly wanted basic health check up by the doctor.

Of the 121 who were checked for their blood hemoglobin level, 54.54% were in the mild & moderate category of anemia & no single worker reported with severe anemia. Of the anemia cases, 57.57% were in the mild category & the rest in the moderate category. In the BMI analysis, 54.62% were in the overweight & obese category , while 34.45% were normal & 10.92% were found to be underweight.

On the socio economic profile, 30.57% of the workers were in the age group of 26 – 35 years of age, 22.31% & 21.48% belonged to the 36 -45 & 56 – 65age group respectively. 15.70% belonged to 15 – 25 age group & only 0.8% belonged to less than 14 years of age.

On the religious profile, 72.73% workers belonged to Hindu community (caste data yet to be made available), 24.79% to the Muslim community & the rest were Christians. 81.81% belonged to nuclear families, 10.74% to extended & the rest were joint families. 92.56% were married & the rest were single.

While this data does not tell us much w.r.t the link between agarbatti rolling & health problems, it can be assumed that problems due to agarbatti rolling cannot be understood in isolation compared to the other socio-economic & the general health problems faced by women everywhere due to their low socio economic index. Majority of the problems reported included postural related & gynecological (data yet to made available).

One thing that I definitely learned from this experience was that occupational health cannot be separated from the overall health problems faced by others in the area. Hence the importance of approaching any health problem from the community health perspective rather than looking at it from the occupational angle alone.

This does not however mean that this was perfect study. There were definitely deficiencies & the study probably may not even qualify for an in dept analysis into occupational related problems of the agarbatti workers. Nevertheless, it is beginning in my understanding how studies should actually be conducted.

## 11. Chennai Visit Report

I was apart of a group visit to Chennai to look into the state of primary health services in that city. Apart from CHC fellows, there was a group of JAA-K field level activists from various districts of Karnataka. There was a lot of miscommunication in planning the event which ended up in lots of time being wasted in traveling from accommodation to the field area, but the visit was nevertheless a eyeopener in many ways on the status of primary health centers. Apart from visit to a PHC, we got the opportunity to visit RUWSEC which is a hospital run primarily for the Dalits in the Chengalpet area in the outskirts of Chennai.

Our first visit on day 1 was to a PHC in Medavakom in Chennai. It seemed at first glance that we are entering into some sort of resort for the PHC was elegant & well maintained with gardens. The PHC had all the hallmarks of a well equipped hospital unlike other PHC I have seen so far. From all the various opinion the place seemed to be free of corruption & provided other services compared to a normal PHC which included such services as dental checkups. There were lacunae w.r.t waste disposal, but the PHC seemed to be running smoothly & efficiently with all the qualified doctors on board.

Probing a little deeper & things started to become much clearer. Much of the services in PHC was run under the model of Public Private Partnership. This particular PHC was being used as a model by the Tamil Nadu govt. of a successful PPP to showcase the glory of such a partnership. It had all the big companies on board. The idea was to showcase to the world at large that this PHC in a major metropolitan city in India had a successful primary health care delivery system in place.

Would they emulate this success story in each & every corner of India? Not a chance! As the 108 service (which is also run under PPP) has glaringly showed, ambulances only operate in major routes of the country while the backwaters of the country continue to be unconnected by this service. It is not as if the govt. does not have any money. If there is money for PPP or health insurance, things would have been a lot different if the same money were put into the public health delivery system instead of promoting private players whose sole worship is profit & not service.

Next, we visited an NGO named RUWSEC at Chengalpet in the outskirts of Chennai. This was an NGO that was founded over 30 yrs ago by mainly Dalit women. Our visit concerned primarily with the focus on RUWSEC hospital that was founded over 15 years ago. RUWSEC hospital was not founded for competing with either public or private sector for better health care delivery. Its main purpose was borne out of a frustration by Dalit women who were routinely discriminated in the PHC's.

Nor is RUWSEC free of charge. But the fee is very nominal & definitely affordable, but the most important factor was that Dalit women got the dignity & respect which they were denied elsewhere & was something they could call their own. RUWSEC had also had its fair share of problems but yet they have continued their service to the most poorest & the most backward communities especially Dalits & among them women. As more & more Dalit women have started to assess the PHC's RUWSEC has begun to contemplate the idea of withdrawing its services in some areas, the main goal being the achievement of health for all.

My only observation about the RUWSEC experiment is that there are many such experiments scattered across India but all these experiments have continued to remain local despite the best efforts to scale up these operation in other regions.

## 12. Understanding of Primary Health Care

My experience on the field (mostly Urban & Rural to some extent) plus to an extent at a policy level has provided me with a varied experience on my understanding of primary health. For instance primary health varied very differently from a prime urban settings than with its rural counterpart & more also at a policy perspective that focuses more on primary health in a rural setting than an urban setting.

For a rural dweller a primary health care system represented a lifeline in the absence of any other reliable system to address the basic medical needs. But for an urban dweller (including urban poor), faith (or the lack of it) in the primary health care system was a bigger issue due to the mindless proliferation of private clinics & private/ corporate hospitals that promises immediate service (though at a higher cost) in contrast to the corruption & bureaucracy involved in the govt. services.

I worked with Agarbatti workers (Home based) in Ullal, Bangalore for over a month. There are over 500 such workers engaged in Agarbatti in that particular area. While there is a sub center in that particular area & the PHC is about 5 Kms away, both the centers are not equipped to deal with occupation related health problems faced by the workers. For instance there is no educational awareness on how the workers can deal with occupational related hazards such as dust & allergy or how to avoid this through face masks, importance of ventilation, cleanliness, basic hygiene etc.

The same was the case for the other category of the population in the same area such as construction workers, garment workers, others such as elderly whose needs were hardly met at the center. Service provided at the center hardly met the criteria of providing basic health care let alone occupational health or comprehensive health care. Primary Health care was completely divorced from the social determinants such as water, sanitation, food, housing etc. Many of these priorities have ended as functions of NGO's with its project mindset & limited beneficiaries, leaving people at the mercy of the NGO's.

There is plethora of schemes that come & go, but nothing is permanent everything remains transient or temporary. And most schemes are targeted to a particular population leaving many others behind. Most of these schemes don't address the basic issues at hand but very specific issues & don't go beyond that.

In another instance, at a meeting of a group of garment workers in Kuvempu Nagara, Bangalore, even though most of the women workers were covered under Employee State Insurance (ESI) scheme & could go to any of the ESI run clinics or hospitals for services, but most never go to ESI because of the corruption & bureaucracy along with substandard treatment. Given the urgency of the conditions, most workers rush to the private clinics or hospitals with most never bothering to think of claiming ESI or its services.

What the two instances revealed to me was while most have to rely on out of pocket expenditure to meet their health problems, they also incur substantial debt in the same process & the debt burden hangs on most of their shoulders. It is very evident from this that the state has relegated the responsibility of a comprehensive primary health care system based on the people's needs, leaving the workers to fend for themselves or at the mercy of private health care.

It was not as if there were no laws or welfare benefits in protecting the workers including health, there is plethora of them but lack of implementation & also in many cases the lack of proper

awareness (improper decimation by the govt.) given the nature of employment of these workers which is unorganized, in-formalization of the economy that is taking place with no social security benefits & social background of most of these workers belonging to mostly lower class/ caste backgrounds, lower educational status & lack of political platform that deprive many workers the necessary knowhow on how to fightback.

Instead of a common universal health care for everybody, we have one meant for the general population, ESI for state employees & certain category of unorganized workers, other schemes for central govt. employees, & not to forget empaneling of private hospitals for some other category, etc. All these multitudinal level of health care services or provisions for different categories of population only ends up confusing the idea of universal health care & especially the concept of primary health care, giving the idea of health among general public not in the way WHO defines health but everything to do with medicine, doctor & one big hospital.

It is sad fact indeed that the concept of primary health care has taken a beating in the conscience of the people especially in urban settings. There are several factors to blame including the neo –liberal economic policies that lay emphasis on lesser or no govt expenditure on social services & the resultant proliferation of private sector, the targeted approach adopted in most PHC & the resultant apathy of the people against anything govt.

A very different picture was encountered by me when I visited some of the PHC's in the rural areas of Bagalkot & Raichur. Here while people do rely on PHC for their basic health needs, it was primarily felt by many that system was corrupt from the top denying most people access to essential medicine, proper care, discrimination based on their caste or lower economic status, referral to private hospitals in case of complicated cases etc.

None of them represented the comprehensive health system that addressed all the social determinants of health. The backward status of these districts further complicates the problem due to lack of priority from the govt. And the problem does not end there, it extends to all other categories such as right to food, water & sanitation, housing & others. It is as if the social service system in these areas were meant to fail its people.

The PHC also revealed the vast gap between what was officially stated & the realities on the ground. It was all self evident that none of the schemes intended to benefit the people hardly ever reached many of them unless by paying a bribe. But this also did not mean that all doctors were corrupt, there were well intentioned doctors as well, but as the saying goes good intentions is not enough, especially as the problems are rooted in the socio-economic & cultural aspects of the society.

My one observation in all this was how the primary health care in our country is completely divorced from the people's needs & the concept of universal health care that would ensure health for all. Instead the system has ended up as belonging to the whims & fancies of the health department rather than the people & this in turn is reflected on how people perceive public health system in our country. To say the least, the system has failed its people more than anything else. Or how else would one witness 28 deaths for gastroenteritis that took place in Bangalore recently ($16^{th}$ Aug) at the Beggar's Rehabilitation Center in spite of an PHC in the institution itself.

## 13. Other Meetings Attended

*Socialism in the 21st Century (23rd July - 25th July, 2010)*

Besides my involvement with FEDINA, i managed to attend two other meetings in the month of July & August. One meeting was a 3 day meeting organized by Samuhik Khoj, a marxist discussion circle. The theme of the current meet was 'Socialism in the 21st Century'.

The 3 day programme included understanding how Socialism had evolved from the 19th century, the Russian experience, understanding from the present experience of the Latin American left especially in Venezuela & the implications of understanding this in the context Socialism of the 21st century. The discussion involved around 30 – 50 people coming from diverse backgrounds excluding the traditional left parties such as the CPI(M) & CPI.

Though the discussions centered around the experience of Latin American & presented from the standpoint of Marxist scholor Michael Lebowitz, what i felt that was distinctly lacking in the whole process was on how to evolve a programme for action for the masses in the Indian situation, which came clearly in criticisms of many participants. I strongly felt there was no need to debate 2 days on what happened in the Soviet union then later in China & Cuba, but could have directly started from the lessons of the Latin American experience & its implication in the Indian context which is very much the need of the hour. True there were discussions on this theme on the last day but much shorter than desirable. There was a lesser representation of the present day younger generations of activists who could take the process forward but mostly included older generation activists only.

*Universalization of Social Security in India* (16th August, 2010)

I attended a one day seminar on Universalization of Social security organized by Social Security Association of India (SSAI) with informal sector & health as its main focus. Virtually every speaker in the meeting was a govt. Official associated with either state health department, ESI, ONGC who spoke out in the official govt. Line & virtually extolling the virtues of public – private partnership.

There was hardly anything new in what the speakers were saying with the general opinion being that govt. Cannot do much in populous country like India & universalization can only be achieved through private health care providers & insurance. While speaker upon speaker praised the Rajiv Gandhi Arroyga Shree Schme in Andhra Pradesh that provided health coverage to BPL families upto 2 lacks or the Tamil Nadu govt. partnership with Star Insurance or newly introduced Vajpayee Arogya Shree Schme in Gulburga in Karnataka, none of them spoke on the flip side of partnership with private sector namely the neglect of govt. services at the expense of the private sector.

While the members of SSAI did not make much of an intervention during the entire meeting, the stand of the association remained unclear to me. On the one side they seemed to say universalization of social security & on the other side the organization seemed to be 'think tank' that was primarily involved in research & closely associated with govt. at policy levels. The association even made a virtue out of the fact that its founding in 1991 was inaugurated by none other the current Prime Minister Dr. Manmohan Singh, the man who liberalized the Indian economy & firm advocate of spending cuts in social services!

**14. Final Meet**

It was last meeting of our CHLP programme. Though much of the time was meant for settling bills & completing our report, it was something more than that. It was meant for sharing & looking forward were our paths are headed next. During the sharing of experiences, it was more than anything else how much each of us had evolved in this 9 month journey & what impact this fellowship had made a differences in our various paths.

During our final meet, we had a 2 day alumni workshop meet on 25th & 26th of November, 2010 of the 3 year CHLP programme which included how CHLP had made a phenomenal difference to many would social activists like Karibasappa, Varsha & others. It even included sharing of experiences from those from the previous fellowship prior to CHLP that included Premdas, Ameer Khan, Sathyashree, Naveen Thomas & others.

*The Truth About Me – A Hijra Life Story*

The high point of this whole alumni was the sharing of experiences by two members belonging to the transgender community (from the sexual minorities NGO – Sangama) who had been especially invited to share their life experiences. We were all given a copy of the book 'The Truth About me – a Hijra Life Story' written by one of them – A. Revathi.

This is the English version of the Tamil orginal & a first of its kind by an Indian transgender. The book takes us into the often traumatic & terror filled life of Revathi who was born a male (Doraisamy) in a upper caste Gounder family in a small village near Namakal town (Salem dist. Tamil Nadu) in 1970.

As Revathi begins to grow, he starts to develop feminine ways such as playing games played only by girls, trying on his sister skirt or feeling shy to go to boys toilet in school & so on. And this does not go unnoticed, Revathi had to endure scolding & beating by his school master, parents & brothers for no fault of his own & also had to face taunts by his fellow class mates as 'number 9' or 'girl boy', even having his pants forcibly removed to check whether he was boy or girl.

By 15 years of age, unable to bear the burden of a female trapped in a male body, Revathi runs away with a group of fellow travelers like herself (trapped in male bodies) to be eventually inducted into the Hijra community as a chela (disciple) to a gurubai (head). Revathi also describes in some detail the complex relationship within the Hijra community with the different houses of Hijras, its hierarchies, its rituals & the performing of nirvanam (sex change operation).

Virtually treated as outcasts, the life of an Hijra in India is not easy as their only source of livelihood is either demanding money from shops, in trains, in traffic signals or doing sex work. After initially begging on the streets of Delhi for sometime, Revathi soon realizes her growing need for a sexual relationship with a man, which lands her into doing sex work near train stations of Mumbai.

The book describes in moving detail the daily travails faced by Hijras of braving police & rowdies by constantly bribing them or face violence in their hands & even threat to their very lives. She also describes the intense competition within Hijras themselves for clients & the exploitation suffered in the hands of gurubais often leading to fights among one another. Despite the various problems within the different groups of hijras, it should be noted that there is no caste or religious differences

observed among Hijras, with most of them on par with one another.

Disowned by society at large including their family & relatives, having virtually no rights whatsoever & even criminalized by law, the book tells us that the desires of hijras are no different from the rest of us, of wanting lead normal lives, running families & households & going to work as rest of us do. Written in a simple, jargon free style describing every aspects of her private life (including sexual), this book is not only about the life of Revathi, but about the most marginalized & most stigmatized communities in India. Nor is it just a narrative but also a critique of the dominant stereotypic culture & attitudes of the ruling elite.

The turning point in Revathi's life occurs when she shifts to Bangalore to join a hamam (bath house), where after an initial period of facing the same problems as elsewhere, she is introduced to the sexual minorities NGO – Sangama & eventually leading her to join the NGO as an office assistant. Here, she is introduced into the world of rights, denials of basic rights (including option of sex change operation in public health care) & discrimination faced by sexual minorities & they too can stand up for their rights (within the limitations of an NGO framework).

One might conclude that Revathi was lucky in a way of having landed into an NGO job & later success story through her acting & writing career, but if one were to picturize this with the entire hijras population at large or even sexual minorities, their life continues to be same as before. Nor does the troubles haunting Revathi since her childhood end by her joining the NGO, which continues to manifest itself but in qualitatively different forms, leading her even to contemplate thoughts of suicide. But despite all odds staked against her, she realizes the need to continue her struggles & decides to write an autobiography of her life.

**15. Appendix- Articles written for the newspaper– Dudiyora Horaata (Workers' Struggle)**

**A. Antibiotic Superbug Scandal (18th August, 2010)**

The recent news on a study published by Lancet Infectious Diseases ("Emergence of a new antibiotic resistant mechanism in India, Pakistan & the UK: a molecular, biological & epidemiological study" by Karthikeyan K Krishnasamy et.al) on a drug resistant bacterial gene, the so called super bug, named New Delhi metallo – beta – lactamase – 1 (NDM-1), tracing its possible origins to India has raised a furore among the Corporate hospitals like the Appollo & the Indian Health ministry.

All the hue & cry was not so much about antibiotic resistance, but a possible link to the medical tourism industry (now a booming sector in India) being responsible for the spread of resistance to developed nations such as the EU & that Indian hospitals not being safe for treatments. This is just an instance which proves beyond doubt that when profits are concerned, neither the corporate hospitals nor its mouth pieces in the health ministry will spare any effort at dealing with issue at hand, but go to any extent of shifting blame even taking on a anti imperialistic rhetoric claiming the report to be 'western plot' to undermine Indian medical tourism industry.

It should be borne in mind that the so called medical tourism is a shame rather than a pride of India. A nation in which public health system is all but dysfunctional, with 80% of the health expenses borne by out of pocket expenditure & health related expenses being the major cause of rural indebtedness (according to govt. published statistics), the very mention of India being a medical tourism hub is an insult to the majority of the people who have no such access to the highest

standards of care.

Whatever be the rights or wrongs in the study, it is beyond doubt that antibiotic resistance has emerged as a serious public health concern. One of the common causes of this is the overuse & abuse of antibiotics especially in developing countries like India. The chief reason for this includes the unethical promotion of the drugs by the pharmaceutical companies (doctor – company relationship), unregulated sale without prescription at drug stores, use of antibiotics for virtually every kind of infection (including viral), expectation from the patients to be prescribed an antibiotic & thus a trend has set in that extends from the pharmaceutical company to the doctor down to the patient, that virtually sees antibiotics as 'magic bullet' for any disease.

With no new antibiotics on the pipeline & researchers having reached a dead end as far as research into newer antibiotics is concerned, health system is finding it increasingly difficult to cope with emerging newer antibiotic resistant strains of bacteria. The problem has been completely blown out of proportion with the presence of over 80,000 brands of drugs in the Indian market, many of them irrational combinations which includes antibiotics. Whereas World Health Organization (WHO) mandates only 250 essential drugs which could treat over 90% of the diseases concerned, but given the clout of the pharmaceutical industry whose influence extends from the govt. to drug control authority to the judiciary, all talk of rational use of drugs has been thrown into the air.

The problem is made all the more worse with the unhealthy & unregulated proliferation of private & corporate hospitals that looks at health sector as nothing more than a lucrative market waiting to be exploited. All this flows from the distorted model of health care system followed in India, which has been exasperated by the onward march of capitalist globalization, with strong emphasis on individualistic, medically oriented, technologically driven, with strong professional control & institution based enterprises.

A system that addresses only curative aspect of health care, without addressing overall political – economic - social causes which are primarily responsible for the ill health of the population, cannot solve the health problems of the people. Health is not merely about absence of disease, but the overall physical, social & mental well being (WHO), health care is only an aspect of it. Thus health is also access to nutritious food, safe drinking water, good housing, clean environment, social equity etc., which are equally responsible for the healthy living standards of the people. So a struggle for health is a struggle against capitalism which is solely responsible for unequal distribution of wealth, exploitation of people & resources, environmental destruction & much more.

What is is required is an overall socio – economic transformation of society, meaning Socialism, by nationalization & working people control over the big pharmaceutical companies, private medical hospitals, medical education & research. It is equally important to radically change the content of these services to a health care system based on the comprehensive primary health care model that starts from the ground up, to a pharmaceutical industry that is geared towards producing drugs which are affordable, rational & based on people's needs, medical education that is re-oriented towards service of the people & research that is socially relevant & based on ground realities.

And finally, we need to reexamine the way we look at microbes or any infectious diseases for that matter, unlike modern medicine that has been riddled with terminologies of war & look at microbes as terrorist that need to be wiped out. Apart from changing the social system that we live in presently, we need to find alternative approaches of dealing with infectious diseases without seriously hampering the delicate ecology of our planet.

**B. Garment Industry – Special Exploitation Zone (8th September, 2010)**

The garment industry in Bangalore with about 1200 registered units employing over a half a million workforce & one of the biggest sources of exports in the country, but hardly is there any mention in the media on the living & working conditions of the workers who are the real makers of some of the top brand clothing in the world.

Earning anywhere between Rs. 3200 to Rs. 4000 a month, which is pathetic sum especially given the sort of profits being made by the contracting company & the brand companies. And this at the cost being borne by the worker who is being made a victim of both company & the pro – capitalist policy of the govt. that have resulted in prise rise of all essential commodities making the lives of these workers ever more miserable.

Comprising of mainly unskilled or semi skilled women workers & mostly hailing from rural, lower class - caste backgrounds, between the age group of 20 – 40 years, most of these workers are hardly aware of the benefits (which is piecemeal) that they are entitled, giving the company management & labor department a free hand in denying them their basic rights.

But the biggest problems that is faced by these workers is the lack of organized unions in every factory to fight for increasing their wages & their basic rights as human beings. Although coming under the factories act, governed by minimum wages, covered by Employment State Insurance (ESI) scheme, most of the companies hardly adhere to these laws given the laxity in implementation by the govt. & loopholes in the laws that allow the companies in denying the workers their benefits.

A common practice followed by the company management is the denial of gratuity benefits & pension benefits after 5 yrs of employment by a worker in a company by asking the workers to rejoin as fresh employees & thus denying them this benefit. A second ploy used by the company is the non payment of Provident Fund to the concerned labor department & using this money to build as capital, while the workers remain seemingly unaware of this denial until the day of their resignation from the company. Another important right concerns health care services covered by the ESI which continues to be a regularly denied unless by bribing the officials of the concerned department.

All these is besides the regular harassment faced by workers by their male supervisors to meet their production targets & most workers having to work overtime without compensation, working anywhere between 9 – 10 hrs a day. All these is besides lack of provisions of some of the basic amenities in many of these units such as drinking water facilities, proper rest time, inadequate lunch hours, toilet facilities, besides domestic violence commonly witnessed in their homes, all of which has a general bearing in terms of deterioration of their health.

The picture may sound dismal, but garment workers are increasingly beginning to question the denial of their most basic rights. Given the low levels of information of the existing rights & provisions, lack of fighting unions the majority of these workers in these special exploitation zones are either suffering the denial of rights silently or many a times "led" by yellow unions or extortionist mafia outfits.

It should be noted that the Bangalore industrial scene has not having witnessed any major victorious battles of the working class, let alone the garment & textile workers. Many of the so

called unions are NGO sponsored who basically take a "Industrial peace line" & thwart any attemps of radicalization among the rank & file. These do-gooder NGO's focus more on conflict management by "training" the leaders than build combative unions. Their approach to dispute it to go & talk to the "brand" people than to fight & increase the class consciousness of the workers.

But all this is changing with the enthusiastic participation of the garment women workers belonging to the GATWU & KGWU in the September 7th General Strike indicates the growing radicalization among these low paid workers. But at the same time given the fault lines of the global economy & its impact on India, the stage will be set for a major conflict between capital & labor as was witnessed recently in the successful strike of the Bangladeshi garment workers.

**C. Capitalism Systemic Malaise – Beggar's Death in Bangalore (28th Aug, 2010)**

The death of over 28 inmates at the Beggar's Rehabilitation Center (popularly known as Beggar's Colony) in Bangalore and the subsequent drama that unfolded over the past two months has brought into focus the rotten state of affairs in the Karnataka state's social welfare department. The inmates of the center were living in conditions to what amounted to a concentration camp in extremely miserable and filthy conditions. It was a well known "Secret", but no media or political parties ever bothered about the plight of the inmates. With already over 287 deaths at the center since January, it was only a disaster waiting to happen.

Bangalore is known across the world as an IT city, a city of technology as well as of affluence. What is unfortunate is that the affluence of the city has not been shared with all. In the deaths and inhuman treatment of the Beggars, one sees the other face of Bangalore. While the poor are being hounded all over the country, with an anti-beggary law, the Karnataka state has imprisoned the poor behind bars. Instead of addressing deep-rooted issues of inequity, illiteracy, unemployment, a skewed distribution of resources and poverty, the government and its strong arm, the police, have been picking the poor and the innocent citizens and admitting them into the beggary home. It is difficult to imagine the justification the state could offer in forcibly admitting into the Beggars' Colony people who are not beggars.

The deaths and the subsequent hospitalization of many of the inmates of the center was triggered from what has now become infamously known as the independence day lunch (auspicious gift indeed for a people who were virtually held as captives at the center!) by a donor whose name continues to be criminally withheld by the government. For over two days, despite continuous vomiting and diarrhea, all the inmates were left to fend for themselves by the staff and only after they began to die that the cases were referred to the medical officer at the primary health center in the colony.

*BJP's Contempt for poor*

Even more scandalously, the dead bodies were bundled off to the crematorium without proper investigations relating to the circumstances that led to the tragedy. The authorities backed by their political bosses the Chief Minister B S Yeddyurappa, the Home Minister V S Acharya, and Police Commissioner Shanker Bidari (notorious for his human rights record) virtually ruled out any possibility of foul play and decreed it as a natural state of affairs due to old age and susceptibility to communicable diseases! This attitude of the BJP government of Karnataka suits very much with the ideology of the communal, pro-upper caste and pro-upper class BJP, which is the political arm of

RSS which has a pathological contempt towards all that is considered low and downtrodden in the society.
While the government has ruled out food poisoning as the cause of death, it has put the blame on gastroenteritis, lack of hygiene and malnourishment as possible causes of death(this itself is an indictment of the BJP Govt.) Even if we go by the government's words, even a knowledgeable lay person would know that gastroenteritis is not an highly complicated disease and can be easily treated by provided an adequate fluid balance is maintained in the body caused due to dehydration by vomiting and diarrhea.

*Criminal Negligence*

All that was required was an anti-emetic drug to control the vomiting and oral re-hydration fluid for diarrhea, which can be prepared at any reasonably clean place by mixing a pinch of salt and four teaspoons of sugar to a liter of clean drinking water, this is an effective and simple solution to the problem, but yet diarrhea is the No. 1 cause of death among children in India. Lack of intervention at a proper time could have further complicated the situation given the low immunity and ailing conditions of many inmates at the center.

The beggar's colony presented a picture where everything was wrong. Firstly, the number of inmates at the center was grossly high at over 2500, as compared to the capacity of the center to handle only up to 900 inmates. With the inmates packed as herds of sheep in the dormitories which remained unclean and not disinfected for months together, toilets overflowing with faeces, stench of urine being everywhere, the conditions were not fit for even animals let alone humans. Whatever funds allocated in the budget for the rehabilitation, the funds were grossly mismanaged, underutilized or siphoned off to other priority (pocket) areas and the inmates were left to rot and die.

None of the recommendations made by a legislature committee with regards to the maintenance of the center were ever implemented by the Social welfare department of Karnataka. No segregation was carried out on the basis of health issues, instead all of them were packed into the same rooms, no dietary changes were made and the primary health center at the colony was extremely understaffed functioning with only a single doctor, whereas the committee had recommended posting five doctors at the center. The horrifying stories that were given to the fact finding committees by the inmates indicates that the authorities treated them more like they treat criminals rather than people unfortunately driven to destitution.

*PPP is an alibi to privatse!*

Another aspect which has not received much attention is that the primary health center was being run under public – private partnership (PPP) with the NGO Karuna Trust, headed by Dr. H Sudarshan (winner of Right to Livelihood or Alternative Noble), a known votary of NGO partnership with government in running primary health centers. Well nothing much seems to have changed under the management of Karuna Trust, primary health center which continues to be understaffed, ill-equipped and is not able to discharge all the obligations of a health center that includes ensuring preventive measures to stop the spread of infectious diseases and continuous monitoring of the health status of the inmates.

If the tragic deaths of the inmates is anything to go by, that the PPP of the social services is not the solution to the problem. But if the government's thinking is, it is for more such PPP model and this

time it is to address nutrition by tying up with the notorious ISKCON (International Krishna Consciousness) for providing meals to the inmates.

The tragedy has given an ideal opportunity for the corrupt neo-liberal BJP government, to demonstrate that the state's services are bound to be inefficient and thereby it is time to abdicate all the moral obligations of the government to the welfare of the beggars and allow NGO's/ charities to step in.
This calamity is a direct result of government's [including the previous Congress and JD(S)] deliberate strategy of starving the center of funds and running an extremely inefficient system that was bound to fail. Whatever changes that government has promised with regard to improving the center will only be cosmetic and the situation will continue to rot. How can the government change the situation overnight when the problem is systemic and the rot flows from the top, not from below. While the establishment has promised posting more doctors at the center, the question is where will the doctors come from, when the health department of the state is itself understaffed for doctors and super specialists.

*Neo- liberalism is the culprit*
The disaster has once again reiterated the consequence of neo-liberal economics with least priority to social services, especially towards the downtrodden, socially exploited and vulnerable groups such as beggars who are not even considered as humans beings let alone welfare beneficiaries. It is apt to remember that the tragedy took place in the so called IT capital (which boasts of huge GDP contribution) of the country and shows how much development has trickled down to the poor and the marginalized. If anything , development has come at the cost of further marginalization of the oppressed classes rather than the other way around.

*Capitalism breeds destitution- dump it!*

The so called development at any cost leading to loss of land, homes and livelihoods across the country will only exacerbate, and not eradicate beggary. In the last instance, beggary is only a deeper symptom of a larger malaise in the society under capitalism whose sole worship of profit is sure to trample on and continue to deprive all the basic rights and necessities of the poorer sections of the society.

**D.The Condition of Agarbatti Workers in Karnataka (6th Aug, 2010)**

The incense stick (or popularly known as Agarbatti in India) used in every devout Hindu households for religious purposes, is today a highly marketed commodity both in India & abroad. But not much thought seems to have gone into how these agarbattis are produced or manufactured. With limited infrastructure such as a wooden board, availability of raw materials & with little amount of skill, virtually any unskilled worker can make agarbatti in any household or sheds.

The fact that manufacturing can be any household or a shed involving a few workers, is something exploited by the companies that sell agarbattis under various brands. Although agarbatti industry falls under the Factory Act in Karnataka, many of the manufacturing units are poor households in slums which do not come under the purview of any labor laws as many of the units are unregistered units. It is estimated that there are around 250,000 workers engaged in the Bangalore – Mysore region alone, which is the highest in the country.

In a place called Ullal in the outskirts of Bangalore, all the workers are women & even involving

children, belonging to either poor Muslim or dalit households. Most of these women have taken up this profession due to their extremely miserable conditions & trapped by traditions to be confined within the house to do household chores or look after children.

Earning anywhere between Rs. 20 – Rs. 22 for every 1000 sticks (piece rate basis) & depending on the type of agarbatti they produce, a single worker can earn anywhere between Rs. 100 - Rs. 120 a day if she labors for 9 – 10 hrs. a day. Given the highly inflationary situation in the country at present, the amount these workers earn is pittance compared to the rate at which it is sold in the market ar Rs. 1.00 – Rs. 1.50 to even Rs. 50 a piece (!) depending on the type & flows directly from the highly skewed model of development under capitalist globalization that pushed many poor households into such higly informal home based work due to lack of employment in the formal sector.

While companies do not directly contract the work to the workers but is usually done through middlemen, there is distinct lack of employee – employer relationship & most women are are under no obligation to meet targets or deadlines with enough freedom to produce according to their capacities. But given their poverty ridden conditions, most women labor as any other factory worker as this is their only means of livelihood that is sustaining their families today.

The problems of these workers are not confined to wages & lack of social security alone, their working conditions remain extremely dismal. Confined to dark dingy rooms without proper ventilation & lack of provision of safety gear, health hazards pose a serious risks. The common health problems that these women face include body pain & pain in the limbs due to the repetitive nature of work, skin & dust allergy allergy, gynecological problems such as abdominal pain, irregular menstruation, urinary problems & white discharge. But studies are yet to determine clear linkages between working conditions & health risks.

The agarbatti production process does not end in the households, which in fact 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 & marketing of the brand, most of the non household based work are confined to factory premises, which are governed by labor laws.

The conditions of those workers working in licensed agarbatti manufacturing units is no better. The only difference being women receive a fixed salary & are entitled to namesake social benefits such as Provident fund (PF), Employee State Insurance (ESI) scheme, bonuses, pension etc. Most of these social benefits hardly meet the criteria for decent living standards. ESI continues to be corrupt institution with workers assessing benefits only by bribing the staff & treatment services provided under ESI run hospitals or clinics are at best second rate.

No doubt the consciousness of the workers remain low especially those working in household or unregistered units, as most of them are not even considered workers but as housewives doing part time work, by not only the govt. but also the major trade unions. Any attempt to demand increase in wages or social security results in either the middlemen threating to shift the unit elsewhere as there no dearth of labor available & desperate situation of these women leads most of them to succumb to the middleman's threats. Also middlemen act as kind of moneylender providing loans to the workers & many workers fear losing the good graces of the middleman, as many of them remain perpetually indebted to him.

Given the significantly large number of population engaged in home based work, with estimates

upto 50 million workers engaged in the entire South Asia, it becomes imperative to look into alternative method of organization of these home-based workers' rather formation of unions in the factory premises of the traditional sense. While fighting for every minimum demands such as minimum wages, provisions of social security net as stipulated by the govt. it becomes important to question the minimum wages or social security measures being currently given by the govt. A radically different social measures are required that not only addresses the povety stricken conditions of these workers but radically redefines who controls the institutions of labor, welfare & governance, & puts them firmly under the control of workers & trade unions, which is the only guarantee to achieving a decent employment, a living wage & social security.

**16. Organizations Visited**

- **Headstreams (Badami)**
- **Spandana (Belgaum)**
- **Saki (Hospet)**
- **Punyakoti Foundation (Hospet)**
- **Jagruti/ Drug Action Forum – Karnataka (Dharwad)**
- **Nirmana (Bydagi, Haveri)**
- **Sathi (Pune)**
- **Center for Studies on Ethics & Rights – CSER (Mumbai)**
- **Basic Needs India (Bangalore)**
- **Association of People with Disabilities APD (Bangalore)**
- **Karuna Trust (Bangalore)**
- **Sangama (Bangalore)**
- **FEDINA (Bangalore)**
- **BGVS (Bangalore)**
- **Action Aid (Bangalore)**
- **Cividep/ Garments And Textiles Workers'Union - GATWU (Bangalore)**
- **FRLHT (Bangalore)**
- **Environmental Support Group - ESG (Bangalore)**
- **All India Democratic Women's Association - AIDWA (Bangalore)**
- **Regional Ocupational Health Center – ROHC (Bangalore)**