MAPPING THE TRAJECTORY OF COLLECTIVE ACTION IN HEALTH

From pre-Independence to post structural reforms

Dissertation submitted to Jawaharlal Nehru University in partial fulfillment of the requirements for the award of the Degree of

MASTER OF PHILOSOPHY

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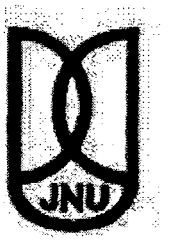

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CERTIFICATE

This is to certify that the dissertation titled **"Mapping the Trajectory of Collective Action in Health: From Pre-Independence to Post Structural Reforms"** submitted by **Chandni Nair** in partial fulfillment of the requirements for the award of the degree of **Master of Philosophy** of this University is her original work according to the best of our knowledge and may be placed before the examiners for evaluation.

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The fact that health activism has not received much of academic attention did pose as a challenge for research in the area, especially in M.Phil. where time is a constraint. Despite that, the process has been exhilarating and intellectually stimulating. I realized the multi-disciplinarity of the task I had taken on as I moved from one social science discipline to the other in the course of gaining an understanding of the topic. I also came to appreciate the significance of science as a tool for political action in health. History in health activism is continuously in the making, and exciting times lie ahead.

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Contents

List of abbreviations

ACASH	:	Association for Consumer Action on Safety and Health
AIDAN	:	All India Drug Action Network
AIDS	:	Acquired Immune Deficiency Syndrome
AITUC	:	All India Trade Union Congress
ANM	:	Auxiliary nurse midwives
BFHI	:	Baby Friendly Hospital Initiative
BGVS	:	Bharat Gyan Vigyan Samiti
BPNI	:	Breastfeeding Promotion Network of India
CAHP	:	Coordinating Agency for Health Planning
CDP	:	Community Development Programme
CHC	:	Community cealth centre
CPA	:	Consumer Protection Act
CPI	:	Communist Party of India
CRHP	:	Comprehensive Rural Health Project
DCC	:	Drug Consultative Committee
DTAB	:	Drug Technical Advisory Board
FERA	:	Foreign Exchange and Regulation Act
FPAI	:	Family Planning Association of India
FRCH	:	Foundation for Research in Community Health
HDEP	:	High Dose Estrogen Progesterone
HIV	:	Human Immunodeficiency Virus
ICMR	:	Indian Council for Medical Research
ICSSR	:	Indian Council for Social Science Research
ILO	:	International Labour Organisation
IMA	:	Indian Medical Association
IMF	:	International Monetary Fund
IMR	:	Infant mortality rate
IMS	:	Indian Medical Service

IUD	:	Intra uterine Device
JSA	:	Jan Swasthya Abhiyan
KSSP	:	Kerala Shastra Sahitya Parishad
LOCOST	:	Low Cost Standard Therapeutics
MKSS	:	Mazdoor Kisan Shakti Sangathan
MFC	:	Medico Friend Circle
MNCs	:	Multi-national companies
MRTP	:	Monopolies Restrictive Trade Practices
NGO	:	Non-governmental organization
NNPC	:	Neighbourhood Network in Palliative Care
NPPF	:	Non-party political formations
NPC	:	National Planning Committee
NRHM	:	National Rural Health Mission
OPD	:	Out-patient department
PHC	:	Primary health centre
PHM	:	People's Health Movement
PNDT	:	Pre-natal diagnostic techniques
PUCL	:	People's Union for Civil Liberties
SAP	:	Structural Adjustment Programme
SHRC	:	State Health Resource Centre
UNICEF	:	United Nations Children's Education Fund
VHAI	:	Voluntary Health Association of India
VHW	:	Village health workers
WHO	:	World Health Organization
WSF	:	World Social Forum
WTO	:	World Trade Organization

Chapter 1

Collective action: an introduction

Humanity has a universal potential for change. Society evolves by transformation and change. The sources of social change range from contact with other societies to technological changes to changes in demographic variables to production of new ideas. Social change is also spurred by social, economic and political processes and by conflict. Singh (2001) observes that 'social contradictions and conflicts inhere in the very nature of the founding of human society and social organization'. At the root of such conflict are inequality, injustice, domination and subordination, which in turn produce resistance, opposition and encounters.

Collective action that involves conflict is an inherent feature of the social, political and economic landscape of societies. While academic interest in the phenomenon was awakened in the latter half of the twentieth century, such action has existed for as long as human society has, in various forms such as riots, revolt, rebellions, revolutions and movements. The hope that 'another world is possible' is an echo from the past that keeps reinventing itself to the changing discourses and paradigms of society, politics, culture and economics. From the bread riots[1] in Europe in the eighteenth century to the French Revolution of 1789 to the political and social turmoil of the Sixties[2] up until the anti-globalization voices, the history of mankind is the history of collective action. Thus, we are provided with a vantage point from which to study the course of history of humankind.

Collective action is also an intellectual process that seeks to establish a new order of life and change through ideas and aspirations. It is interesting to note how people come

[1] Bread riots were riots by the poor in response to deregulation and rising prices of food. These have been recorded as early as 1709 and occurred throughout the eighteenth century. Bread riots have been studied by Edward Thompson in 'The Moral Economy of the English Crowd in the Eighteenth Century' written in 1967.

[2] The Sixties was a period characterized by radical and subversive events in nearly every part of the world; this was the period of the counter-culture revolution and the entry of the 'flower children' and 'hippies', new genres of music, the anti-war / peace movement, the civil rights movement, the rise of the New Left in America. In Africa, 32 countries gained independence from colonial rule.

together around issues and at critical times with a sense of solidarity to challenge the status quo. Singh (2001) writes of social movements that these 'are not made, much less are they launched or led by leaders. Whenever opportunities permit or human disenchantments exhaust the limits of human perseverance, movements decoil (unfold) automatically and reveal themselves in the actions of the awakened conflictual consciousness of the collectivity'. Indeed, history is replete with such opportunities and disenchantments that have brought people together to struggle against conditions, norms, values and institutions.

In India, from pre-Independence days, 'organized societal actors' have played key roles at critical policy junctures by mobilizing and organizing, one the earliest examples of a social movement being that of peasant uprisings that pre-date even British rule (Ray and Katzenstein 2005). These actors and constituencies range from the Dalit and backward classes to industrial workers, students and women to homosexuals, peace activists, environmentalists and anti-globalization activists.

While arguing that public protests have a certain functional utility in a parliamentary form of government, Shah (2004) observes that before and after Independence, a large number of the people felt that the institutional means of redress for grievances, frustrations and wrongs were inadequate. The parliamentary form of government as a political institutional device has proved to be inadequate to continue or expand concrete democratic rights of the people. When the civil and democratic rights of the people are not protected by the Constitution, the movements for their protection increase (Desai 1962 cited in Shah 2004).

Social movements, one of the most powerful forms of conflictual collective action, have the potential of 'transforming the social system and bringing about change in society for the greater democratisation and justice for the deprived groups' (Shah 2004). Social movements, protest actions and political organizations unaligned/unaffiliated with political parties have become synonymous with democracies (della Porta and Diani 2006). Gaventa has argued, "through community organizations, social movements, issue

campaigns and policy advocacy, citizens have found ways to have their voices heard and to influence the decisions and practices of larger institutions that affect their lives (Gaventa 2001 cited in Mayo 2005).

1.1 Political trends affecting collective action

While scholars have made a distinction between social and political movements, the history of conflictual collective action shows how the larger socio-political context shapes and determines collective action. The view that collective action is conditioned by the political and institutional context is confirmed by various scholars. An article that explores protests against privatization of electric services and foreign direct investment in Peru suggests that the transition from Alberto Fujimori to Alejandro Toledo created a more conducive environment for new forms of collective action and resistance, greater levels of mobilization and greater chances to achieve positive goals. During the time that Fujimori was the President of Peru (1990-2000), a heavily centralized political authority was created with very little space for political dissensions even within his own Congress party. He reversed the decentralization initiatives taken earlier, thereby closing space for any political challengers. The period of the Fujimori regime was characterized by a general decline in strike activity, largely because the political environment delegitimated the use of protest and the economic conditions eroded and weakened collective action. (Moises 2008)

In contrast to Fujimori's authoritarian regime, the democratic government of Toledo provided an environment that facilitated greater levels of mobilization. Under Toledo (2001-06), most of the dissensions came from within his own party, Peru Posible. In 2002, President Toledo restarted the process of decentralization and power was dispersed from the central government to the regional governments. Toledo also attempted to undo some of the problems created by the neo-liberal reforms. As compared with the authoritarian regime of Fujimori, the Toledo government was more willing to accommodate societal and regional demands. All these attempts and processes enabled new challengers to mobilize against the government and resist neo-liberal reforms. Peru

had never been a witness to as many protests and strikes as it was when Toledo's government was in power (Ibid.).

In the Indian context, Ray and Katzenstein (2005) build their thesis on how social movements have responded to the shifting master frame of the state - from state to market; from secular and social democracy to regionalism coupled with liberalisation. These responses range across three phases, which they see as distinct cohorts of movement activism. During the period from 1947 to the late 1960s (or the Nehruvian era, as it is called), 'poverty alleviation' was the frame of reference against which policy proposals and political claims were measured. Movement activism was also directly accountable to the discourse of poverty alleviation. The second phase, 1964-84, was the phase in which the institutional vehicle expected to carry out the project of poverty alleviation, i.e. the Congress, was crumbling. Social movements sought to function more autonomously and with new agenda. However, the movements did continue, although to different levels, to keep their commitment to the master frame of poverty alleviation. In the third phase, i..e., from the late 1980s to the present, the discourse has changed, with the market and religious nationalism[3] emerging as the dominant voices. In this new paradigm, there has been a massive 'NGO-ification' of civil society and the agenda of poverty alleviation seems to have taken a backseat, according to the authors.

1.2 The trajectory of movement activism: The Indian context

In the context of the Independence movement or the freedom movement, we know that what began as a social reform movement in the nineteenth century acquired a political character in the early twentieth century under Mahatma Gandhi's leadership. The Indian national movement against British rule and colonialism was a mass movement that is most diffuse and varied in nature. It consisted of several agitations, campaigns, movements, boycotts, riots, lockouts, strikes, revolts and every possible form and tool of collective action. It was also a movement that incorporated a multitude of ideologies, communist, socialist, radical, moderate, Gandhian, and Hindu and Muslim fundamentalism.

[3] The VHP and the RSS were the most powerful social movements, according to the authors.

Following Independence, the movement groups that emerged traced their lineage in the socialist, communist, Gandhian and social reform movements of the pre-Independence years. However, in the Nehruvian era of institutional politics[4] and the dominant state and Congress party, these movement voices were overpowered as their ideologies were sharply different from Nehru's ideas of a developmentalist state. Nehruvian social democracy[5] deflected and appropriated the agendas of these groups, which stuck out as non-party political groups. They worked quietly in small stagnant spaces available at the periphery of party politics (Sheth and Sethi 1991 cited in Sheth 2004). The period from 1947 to the late 1960s saw the development sector as partners of the state rather than as adversaries. The development agenda was dictated by the state, and it is a well-known fact that social development got residual funding and that the social sectors were neglected.

By the late 1960s, however, institutional politics declined. The objective of poverty alleviation could not be achieved. An agricultural crisis, drought, famine and the resulting migrations, an economic recession and wars with China and Pakistan all led to chaos, confusion and a breakdown of the state. There was disillusionment with Nehruvian policies of development, regional and sectoral inequalities had grown, and there were no reductions in inequalities of wealth, health or consumption in the course of the first two decades of Independence (Ray and Katzenstein 2005). The decline of institutional politics, which began in the late 1960s, gave rise to several mass-based movements of protests (Kothari 1988b cited in Sheth 2004). The issues of protests varied from price rise to corruption. Political parties such as the Socialists, communists, the right wing, Jan Sangh and smaller regional parties like the Lal Nishan Party and the Peasants and Workers Party claimed the participation of peasants, landless and workers in large numbers in their land grab campaigns, price agitations and strikes (Shah and Gandhi 1991) The protest movements became extremely intense in the mid-1970s with the

[4] Institutional politics is explained in a later chapter. Briefly, it refers to electoral politics, political parties and other institutions of the state such as legislature, executive, judiciary.

[5] According to Encyclopaedia Britannica, social democracy refers to a political ideology that advocates for a peaceful transition from capitalism to socialism using established political processes. Social democrats aim to reform capitalism democratically through state regulation and the creation of programs that work to counteract or remove the social injustice and inefficiencies they see as inherent in capitalism.

politically high-intensity movement led by Jayaprakash Narayan (popularly known as the JP movement). Thus, as a result of decline of institutional politics, new social and political spaces opened up for movement groups and new social activists (Kothari 1988b cited in Sheth 2004).

The decline of institutional politics gave rise to new 'micro-movements' between mid-1970s and 1980s (Sangvai 2007). These 'micro-movements' took up issues and constituencies that had been neglected by the state. These constituencies included workers from the unorganized sector, women, rural areas etc. These micro-movements were led by young men and women, many of whom left their professional careers to work towards these causes. These were neither political parties nor pressure groups, but civil associational groups who took up political struggles that were articulated by the affected people themselves. 'The key concept they worked with was democratising development through empowerment of the people' (Sethi 1984 cited in Sheth 2004). The micro-movements took upon themselves not only the proper implementation of programmes or distributive justice but the questioning of the model of development being pursued. 'The questions asked were fundamental: development at whose cost and at what cost, and what constituted development itself.' Some examples of these micro movements are the Chhattisgarh Mukti Morcha for the rights of mine workers, Girni Kamgar Sangharsha Samiti, in Mumbai to save the livelihood and housing rights of textile mill employees; the National Fishworkers' Forum upholding the rights of over eight million fishworkers and against big Indian and multinational trawler owners, the Kanoria Jute Mill workers' struggle in Kolkata combining agitation and constructive work in the context of an anti-capitalist, anti-imperialistic politics, the Mazdoor Kisan Shakti Sangathan (MKSS) in Rajasthan, raising the issues of displacement, environmental and economic destruction (Sangvai 2007).

Since the mid-eighties, India has rapidly integrated with the world economy. The globalisation of India was speeded up under the Structural Adjustment Programme (SAP) designed by the World Bank to reform India's economy. A large part of the middle class

has certainly benefited from the SAP and related initiatives but overall poverty has not declined - if at all, it has added to the misery of the already impoverished masses.

It is this new discourse of globalization that becomes the new frame of reference for collective action since the 1990s. The gap between rich and poor nations has widened, as have inequalities within countries, between social classes, between men and women and between young and old. The World Social Forum (WSF) was born as a response of the growing international movement to neo-liberal globalisation and the effects of neo-liberal economic policies being pursued in most countries. This Forum has made clear the power and capability of civil society in opposing this new form of imperialist domination. A new paradigm has, thus, emerged for collective action. This collective action, which is becoming global by the day, can be seen to fall under one large umbrella, i.e. the anti-globalization movement.

1.3 Collective action in health

In a paper presented in Atlanta, USA, Brown et al (2003) conceptualized health social movements as addressing (a) access to, or provision, of health care services; (b) disease, illness experience, disability and contested illness; and/or (c) health inequality and inequity based on race, ethnicity, gender, class and/or sexuality. According to the authors, health social movements can be subdivided into three categories: health access movements that seek equitable access to health care and improved provision of health care services; embodied health movements that address disease, disability, or illness experience by challenging science on etiology, diagnosis, treatment and prevention; and, constituency-based health movements that address health inequality and health inequity based on race, ethnicity, gender, class and/or sexuality differences.

Activism around health issues has been a force for social change. Health activism brings together science and political action. One of the earliest examples of health activism can be seen in the formation of the Health of Towns Association, a public health pressure group. It was formed in 1844 following the publication of Edwin Chadwick's seminal *Report on the Sanitary Condition of the Labouring Population.* The Association

advocated for environmental public health interventions in Victorian Britain. The association existed only briefly, from 1844 to 1849. Its aim was to "substitute health for disease, cleanliness for filth, order for disorder, economy for waste, prevention for palliation, justice for charity, enlightened self-interest for ignorant selfishness, and to bring to the poorest and meanest - Air, Water, Light". Today it is remembered chiefly as the vital pressure group in the campaign to promote sanitary reform in the rapidly growing cities of industrial Britain. Its work was to arrange public meetings and lectures; publish the *Journal of Public Health*; organise regional groups to further its cause; and lobby Members of Parliament, doctors, and opinion formers. The campaign culminated in the legislative milestone, the Public Health Act of 1848 (Berridge 2007).

In more recent times, advocacy and activism around issues of health have been numerous and this kind of health activism or health advocacy is focused around a single issue. However, they are linked to each other in many ways and do come together for support, inspiration and strength. Some of these are the breast cancer advocacy movement in the USA, advocacy for the rights of the disabled and the anti-psychiatry movement in the USA. The rest of this section throws light on various movements in health, both in India and globally.

Breast cancer: Campaigning and advocacy around breast cancer is an example of collective action organized around a specific health condition. It is sometimes considered as a part of the global women's movement. Like the anti-tobacco campaign, it is also considered as an advocacy[6] movement. For most part of the 20th century, breast cancer was considered as a disease that was not to be spoken about. Women who were detected with breast cancer had to undergo radical mastectomy. They were not asked for their opinions and the doctor would take the decision. The breast cancer advocacy movement took place in the United States of America in phases. The first phase began to take shape in the 1970s along with the women's movement. The events that led to the breast cancer movement include the publication of the book *Our Bodies, Our Selves* by Boston

[6] Although in this study, the term 'health advocacy' has not been used, it refers to 'a methodology to create an awareness among consumers and make the health (care system) a politically sensitive subject in order to motivate the political leadership (to take remedial action). (Bal 1996)

Women's Health Collective in 1974, which provided valuable information about women's health and gave women a sense of control over their bodies and their health. In addition, prominent women like Betty Ford (widow of former US President Gerald R. Ford) and Shirley Temple Black[7] spoke publicly about their diagnoses. The third most important event that influenced the first wave of the breast cancer movement was the advocacy of the two-step surgical procedure for treatment by Rose Kushner, first the biopsy, and then surgical treatment a few days later, giving women time to come to grips with their diagnosis and to have some input into treatment decisions. Kushner wrote about this in her seminal book titled *What to Do...If You Find Something That Suggests Breast Cancer*, then rewritten and retitled as *If You've Thought About Breast Cancer....* first published in 1979 by the American Cancer Society, District of Colombia Division, and subsequently by the Women's Breast Cancer Advisory Center. The overriding sense during this first wave was that women had the right to be active participants in their treatment decisions, and that women with breast cancer could speak out as survivors rather than stay hidden as victims. The second wave of the breast cancer movement was inspired by the political activism around HIV/AIDS, which emerged as the dominant public health issue in the 1980s. Gay rights activists advocated better treatment and increased funding for HIV/AIDS research. All this made breast cancer activists sit up and take notice. Several breast cancer organizations and breast cancer support organizations were set up in the US during the 1990s. Funding for research also increased through the lobbying efforts of the National Breast Cancer Coalition. These efforts led to Congress channeling more than $1 billion for breast cancer research through the Department of Defense. The publication of Susan Love's book titled *Breast Book* in 1990 was a key event in this phase. This book was a primary source of information for an entire generation of women diagnosed with breast cancer. For the first time, individuals were truly empowered to understand their diagnosis, their treatment options, and what to expect in the future. The breast cancer movement has had several achievements, such as the improved kinds of surgical treatments, the concept of peer support and study of environmental and other causes of breast cancer.

[7] Black was a US politician and a diplomat. As a child, she had acted in American films.

Disability: The disability rights movement advocates for improving the quality of life of the mentally and physically disabled populations. Their issues include access to education, employment, safety of women, access to public places such as buildings, public transport etc. In the United States, the disability rights movement began in the 1970s, encouraged by the examples of the African-American civil rights and women's rights movements, which began in the late 1960s. One of the most important developments was the growth of the Independent Living movement[8], which emerged in California. The Vocational Rehabilitation Act 1973 and the Americans with Disabilities Act 1990 are the most important disability rights legislation in the United States. The Americans with Disabilities Act 1990 ensures equal access to employment opportunities and public accommodations for people with disabilities. In the UK, following extensive activism by disabled people over several decades, the Disability Discrimination Act 1995 was passed. This makes it unlawful to discriminate against people with disabilities in relation to employment, the provision of goods and services, education and transport. It is a civil rights law. Other countries use constitutional, social rights or criminal law to make similar provisions. The Equality and Human Rights Commission provides support for the Act. Equivalent legislation exists in Northern Ireland, which is enforced by the Northern Ireland Equality Commission. In India, it was after a long period of collective struggle that the Persons with Disabilities (Equal Opportunities, Protection of Rights and Full Participation) Act was passed in 1995. This is a major step in enabling the disabled to become an integral part of the mainstream society. Other legislative provisions include the Mental Health Act 1987, Rehabilitation Council of India Act 1992, and the National Trust for Welfare of Persons with Autism and Cerebral Palsy, Mental Retardation and Multiple Disability Act 1999. Apart from protective legislation, the disability movement in India also attempts to change the attitudes of people towards the disabled through the media and the education system. Also, disability was included as a category in Census 2001 after a massive public campaign.

[8] The Independent Living movement advocates that the disabled have a right to live an independent adult life, which implies that they have a right to be equal participants in society.

Anti-psychiatry: Beginning in the 1960s in the US, the anti-psychiatry movement challenges the fundamental claims and practices of psychiatry. It was internationally promoted through the efforts of its four seminal thinkers, Michel Foucault in France, R. D. Laing in Great Britain, Thomas Szasz in the United States, and Franco Basaglia in Italy. The term "anti-psychiatry" was first coined in 1967 by the South African psychoanalyst David Cooper. The key concept of the anti-psychiatry movement was that 'personal reality and freedom were independent of the definition of normalcy imposed upon by organized psychiatry'. The antecedents of the movement can be traced to the early 1950s when divisions between biological psychiatry[9] and psychoanalytic psychiatry started developing. Psychoanalytic psychiatry was challenged by biological psychiatry on the grounds that it was unscientific, costly and ineffective. Conversely, biological psychiatry was criticized by psychoanalytic psychiatry on the grounds that it abused in the name of science and mental patients were compulsorily admitted to state institutions where they would be forced to take high doses of neuroleptic drugs and undergo convulsive and psychosurgical procedures. The anti-psychiatry movement was the organized opposition by a group of sociologists and psychoanalysts to the exploitation and mistreatment and abuses by biological psychiatry. Foucault wrote extensively tracing the social context of mental illness in *Madness and Civilization: A History of Insanity in the Age of Reason* in the early 1960s. R.D. Laing too did the same in *The Divided Self: An Existential Study in Sanity and Madness*. In 1965, he along with Cooper set up over 20 therapeutic communities throughout England where staff and patients assumed equal status and any medication used was voluntary. In 1957, Szasz wrote the seminal paper titled '*The Myth of Mental Illness*' in which he expressed his belief that the classification of schizophrenia as a disease was a fiction perpetrated by organized psychiatry to gain power. The state, searching for a way to exclude nonconformists and dissidents,

[9] Psychiatry is a branch of medicine that is concerned with the prevention, diagnosis and treatment of mental illnesses. Biological psychiatry, or biopsychiatry, is an approach to psychiatry that aims to understand mental disorder in terms of the biological function of the nervous system. It is an interdisciplinary science that draws on sciences such as neuroscience, psychopharmocology, biochemistry, genetics and physiology. Biological psychiatry has been particularly important in developing and prescribing drug-based treatments for mental disorders. Psychoanalytic psychiatry is the branch of psychiatry that applies the principles of psychoanalysis to the diagnosis and treatment of mental illness. Psychoanalysis is a body of ideas developed by Freud and his followers, which is devoted to the study of human psychological functioning and behavior.

legitimized psychiatry's coercive practices. In the 1970s, the Italian psychiatrist Basaglia mobilized an anti-psychiatry movement in Italy that led to the enactment of the Italian National Reform Bill 1978 that banned all asylums and compulsory admissions and established community hospital psychiatric units, which were restricted to 15 beds. This resulted in a process of deinstitutionalization in which hundreds of psychiatric institutions were closed throughout Europe, New Zealand, and Australia, including many in Ireland and Finland, where the highest number of asylum beds were located (Rissmiller and Rissmiller 2006).

Palliative care: The palliative[10] and chronic care movement in Kerala is a movement that provides an alternative to the clinical model of palliative care. The movement is localized (as it is confined to the state of Kerala), institutionalized and does not involve protest or confrontation of any kind. The movement, also called the Neighbourhood Network in Palliative Care (NNPC), emerged with the realisation that patients with chronic and incurable diseases need long-term psychological, social and emotional attention alongside medical and nursing care. It was felt that the existing hospital-centered services were designed mainly to look after people with acute illnesses and that medical institutions alone could not take up the responsibility of looking after chronically ill patients for very long. Moreover, even the limited services available are not accessible to most, especially the poor. The NNPC is an attempt to develop a sustainable, community-led service focusing on the long-term home-based total care of patients with chronic and incurable diseases. The NNPC is a volunteer-driven movement that is attempting to empower local communities to take care of their chronically ill patients. Doctors play only a secondary role in NNPC. In this sense, the movement offers a social model of palliative care as opposed to the hospital-based clinical model. The movement is community-based and community-led. Thousands of trained volunteers from different backgrounds spend at least two hours a week on home care visits, running out-patient clinics, organising family help, and raising funds. Besides dressing wounds and sores, they sit with patients and

[10] The World Health Organization defines palliative care as "an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual".

listen to their problems and fears. They also listen to the concerns of family members and train them in simple nursing tasks like catheterisation. All NNPC volunteer groups are supported by trained doctors and nurses. The NNPC has grown into a huge network of 150 palliative clinics, supported by 10,000 active trained volunteers, 85 doctors and 270 nurses who look after around 25,000 patients at any point of time. Most funds come from the community itself through small donations. Recognising the importance of palliative care, the Kerala government - in a first for any government in Asia - came out with a palliative care policy in April 2008. The policy emphasises a community-based approach to palliative care and considers home-based care the cornerstone of palliative care services. It also highlights the need to integrate palliative care with primary health care[11] (Suchitra 2009).

1.4 Collective action in health: The Indian context

Social movements involving health issues have been instrumental in effecting social change. This phenomenon needs to be explicitly addressed by social scientists. Health as an issue has also been integrated into the agenda of larger social movements. The history of collective action in health can be traced to the labour movement in the mid-1800s when the first mills were set up and railway lines laid. Collective action as a form of struggle for better health services can also be traced to the days of the nationalist movement when some of India's most eminent professionals, such as BC. Roy, Dr A.R. Ansari, Dr Khan Saheb, Hakim Ajmal Khan, Dr Jeevraj Mehta and Dr N.M. Jaisoorya, demanded a more egalitarian health service system and made this demand an important plank in the anti-colonial struggle (Banerji 2004). The women's movement was the first to bring up the issue of medicalization of health and illness. Feminist critiques of India's initial health policy during the first post-Independence decades highlighted its strong urban bias and the fundamental inability of the system of primary health centres to serve vast rural populations. When the third phase of the women's movement emerged from the 1970s onwards, one of the first areas that grew in tandem was the awareness of the significance of women's health and the first discoveries by demographers such as Pravin Visaria and Asok Mitra of a secular declining trend in the female-male sex ratio since the

[11] www.infochangeindia.com

beginning of the twentieth century (Ray and Katzenstein 2005). Women's groups continue to register protests against sex determination tests, compulsory family planning practices and the state policy on reproductive health and population policy (Shah 2004). Similarly, outcomes of environmental degradation in terms of health have been on the plank of environmentalists and environmental movements. Health impact assessments have been a component of the larger environmental impact assessment. In the current paradigm of neo-liberalism, health is an area that is seriously threatened by policies, such as privatization of health care services. Governments are spending lesser and lesser on social expenditure, and there has been a resurgence of communicable diseases such as tuberculosis and malaria and new diseases such as HIV/AIDS. The People's Health Movement is an example of a movement that was organized in 2000 on the principle that health is primarily determined by the political, economic, social and physical environment and should, along with equity and sustainable development, be a top priority in local, national and international policy-making.

1.5 Objectives

Historically, health has been an area which has not remained distanced from conflict, resistance and action. The trajectory of collective action in health can be seen to remain inextricably interlinked with historical, political and economic developments. This study attempts to map out a trajectory of collective action in health from the colonial era to the period following the adoption of the structural adjustment programme. In doing so, the study considers the socio-political and economic conditions around those periods in history that led up to, influenced, conditioned and shaped the struggles/protests. While mapping such a trajectory, the study shall also consider the historical evolution of public health in India. In brief, this study aims:

- To map the trajectory of collective action in health in India during the period from pre-Independence to post structural reforms
- To locate collective action in health in a historical and political context by tracing the historical and political conditions in which such action emerged
- To develop a typology of collective action in health

1.6 Conceptual framework

This study attempts to trace collective action in health in India from the 1800s to the 2000s. It begins with a detailed look at the workers' movement, the beginnings of which can be traced to 1875. It then moves to the nationalist movement. The colonial rule is the political backdrop for both these movements. The study then moves to the post-Independence period. With a brief look at the Nehruvian era, the next major case of collective action in health, i.e. the community health movement is studied. The period of community health movement inspired a phase of issue-based campaigns. Both these cases of collective action in health together span nearly two decades, from early 1970s to late 1980s. In addition, the study also includes the third phase of the women's movement which overlaps the period of the community health movement and continues till date. The study then moves to the period following the adoption of the structural adjustment programme where the major case of collective action in health is the People's Health Movement, which began in the year 2000. The study draws from the political process theory in order to analyse the trajectory of collective action in health. According to this theory, it is the political context which stresses certain grievances, and around it, movements organize. The actions of activists can only be understood when seen against the broader political context.

1.7 Methodology

The methodology adopted for the study includes desk review of literature from different disciplines and interpretation of published data. Review of historical accounts of the movements and documents and data has also been undertaken.

1.8 Rationale for the study

While health has been a component of major social movements, such as worker's movement, environmental movement and women's movement, and while struggles and campaigns on health issues are numerous, these have not been studied individually or even woven together using one conceptual framework. Thereby, the idea that health is an issue around which a movement can occur is overlooked and/or not taken seriously. Health is seen as a niche area that can only be taken up by specialists, perhaps because

there is knowledge about health that is specialized. However, historical and contemporary times negate this view. Health as an issue of struggle and resistance has been taken up at several points of time by constituencies as varied as industrial workers, political activists, women, development activists, health professionals and even communities.

It is time that health as a raison d'être for public protest is given its rightful place and that its study as a 'movement' gains academic recognition and legitimacy. This study is an attempt to trace the struggle for better health as distinct and as a component of other movements. It attempts to bring into focus the increasing need for such an attention in current times when good health is threatening to become private property and the state no longer promises equity or equality.

1.9 Chapterization

The study comprises five chapters. The opening chapter introduced the term collective action and threw light on the significance of collective action. It also explained the political context of collective action and, in detail, cited examples of collective action in health, globally and in India. This was followed by a historical look at collective action in health in India. The chapter also spelt out the objectives, conceptual framework, methodology, rationale and chapterisation for the study.

In Chapter 2, the term "collective action," as used in the study, has been defined and conceptual issues have been elaborated upon. Here, various theoretical perspectives used to study collective action have also been reviewed.

Chapters 3 and 4 provide a trajectory of collective action in health in India from the pre-Independence to the post structural reforms period. In doing so, these chapters refer to those historical and political developments that have either influenced or led to such activism and collective efforts.

Chapter 5 summarizes and discusses the trajectory of collective action in health. It is also the concluding chapter.

Chapter 2

Conceptual issues & theoretical perspectives

This chapter defines collective action for the purpose of the study. It also throws light on conceptual issues and theoretical perspectives of collective action. In sociology, collective action is synonymous with social movement. However, in this study, the definition of collective action has been broadened to include other kinds of struggle and activism. While this study looks at 'collective action', which encompasses campaigns and forms of activism that have not academically been regarded as 'social movements', for theoretical purposes, it draws heavily from social movement theory. The conceptual issues and theoretical perspectives for collective action have been borrowed from those of social movements.

In India, the study of social movements by sociologists began in the 1970s along with the academic interest in the processes of development and modernization. At the global level, it was in the same decade that the functional paradigm in sociology came to be increasingly replaced by the Marxist, the symbolic interactionist and the phenomenological paradigms. In India, the 1970s is a period of historical and political significance. This was the period when the state's idea of development started being questioned and a need and aspiration for change among the masses was obvious. All these developments also inspired the study of social change and social transformation. Thus, began the academic pursuit of understanding and studying social movements. Social movements are studied not only by sociologists but also by historians, political scientists and even anthropologists. There is a multidisciplinary approach to the study of social movements leading to an interdisciplinary character of these studies (Singh 1986).

2.1 Early studies of social movements

As mentioned above, social movement studies were rarely undertaken by academics before the 1970s. The exception was A.R. Desai who conducted a masterly study of the Indian national movement from a sociological perspective. His *Social Background of Indian Nationalism* published in 1954 became a classic both among sociologists and

historians. Stephen Fuch's studies on messianic tribal movements during the 1960s and T.K.Oommen's study of *Gramdan-Bhoodan* or the land-gift movement in Rajasthan, based on the Gandhian Sarvodaya (upliftment of all) philosophy led by Vinoba Bhave in the first years of the 1970s are other early examples of social movement studies (Ibid.).

2.2 Defining collective action

Collective action can in general be defined as the pursuit of a goal by a section of people in an organized manner. The study shall define the term 'collective action' by drawing from various definitions of social movements.

According to Shah (2002), there is no one precise definition of the term 'social movement' accepted by scholars of all disciplines or even scholars belonging to the same discipline. The term has been used differently by different political leaders, activists and scholars who have written on movements. Also, studies on social movements in India have not yet made a systematic effort to define the concept in the Indian context (Chandra 1977 cited in Shah 2002). The meaning given to the term 'social movements' has temporal and cultural contexts.

M.S.A. Rao (1978) defines a social movement as an organized attempt on the part of a section of society to bring about either partial or total change in society through collective mobilization based on an ideology. He identifies some of the basic features of a social movement as:

- collective action as distinct from individual action
- sustained collective action as distinct from a sporadic occurrence
- informal or formal organization
- oriented towards bringing about change, either partial or total, in the existing system of relationships, values and norms
- presence of an ideology

della Porta and Diani (1999) reflect that scholars from varying theoretical and territorial backgrounds share a concern for at least four characteristic aspects of movements[12]:

i. Informal interaction networks – which promote the circulation of essential resources for action (information, expertise, material resources)
ii. Shared beliefs and solidarity
iii. Collective action focusing on conflicts
iv. Use of protest

Singh (2001) refers to social movement as a sustained and continuous collective action over a long period of time and characterized by the presence of an ideology shared by the participants, a strategy employed to achieve the objectives, an organizational structure with a clear system of leadership and communication, an adversary, mobilization against the adversary and finally, the impact they have on society. Singh identifies the following set of "broadly generalized and relatively consistent 'normal-type'" characteristics of social movements:

i. Universalism
ii. Relativism
iii. Social optimism
iv. Social renewal and self actualisation

Herbert Blumer (1995) defines social movements as collective enterprises to establish a new order of life. According to him, social movements emerge from a condition of unrest, and derive their motive power, on the one hand, from dissatisfaction with the current form of life, and on the other hand, from the wishes and hopes for a new scheme or a system of living.

Charles Tilly (2004) defines social movements as a series of contentious performances, displays and campaigns by which ordinary people made collective claims on others.

According to Sidney Tarrow (1998), social movements are collective challenges (to elites, authorities, other groups/cultural codes) by people with common purposes and solidarity in sustained interactions with elites, opponents and authorities.

Richt (1999) defines a social movement as an action system comprising mobilized networks of individuals, groups and organizations, which based on a shared collective identity, attempt to achieve or prevent social change, predominantly by means of collective protest.

Goodwin and Jasper (2003) define a social movement as a collective, organized, sustained and non-institutional challenge to authorities, power holders or cultural beliefs and practices.

The above definitions of 'social movement' have certain common elements. Primarily, the common element is that of 'collective action'. Another element is that of conflict. This study looks at collective action that has as its roots the element of conflict. The conflict that is at the root of collective action arises from unequal power relations based on class, caste or gender, which then lead to denial, discontent, deprivation, inequity and inequality. Singh (2001) differentiates between conflictual and non-conflictual collective action. He defines conflictual collective action as the collective effort of a section of people to pursue certain shared objectives, goals, and values, even in the face of opposition and conflict. The introduction to the study has already mentioned non-conflictual collective action and described a few examples as well, such as the industrial workers' movement. Non-conflictual collective action can be defined as those kinds of collective action that emerge from voluntary acts of behaviour and do not contain the element of conflict.

For the purpose of this study, collective action is defined as having the following elements:

i. It is a collective and organized effort by a group of persons or organizations.

ii. The collective action is based on a certain ideology or principles or approach in which all the individuals and organizations have faith. It is fact that within a movement, there may be different strands that are ideologically different from each other. However, in this study, the actors share a belief in a common ideology/principles/approach and their efforts.

iii. The goals or the objectives are clear to all the persons or organizations involved.

iv. The efforts are directed towards bringing change in institutions, norms, values.

v. The effort is sustained at least till the time the objectives are achieved.

vi. At the heart of the collective action, there lies a conflict, such as between workers and capitalists, colonizers and colonized, rich and poor, elite and masses, etc.

vii. The action may be carried out by informal or formal organizations (for e.g. in the case of the workers' movement, the trade union is a formal organization whereas the women's movement was a loose coalition of women's groups).

The term 'collective action' has been used with specific intentions. It does not refer to a specific genre of collective action but represents a varied and complex phenomenon. For all purposes in this study, the term 'collective action' includes movements, campaigns and efforts of pressure groups and non-governmental organizations[13] (NGOs). The NGOs included in the definition for this study are empowerment NGOs and social action groups.

[13] Broadly, NGOs can be classified into four: grassroots, support, network and funding. Grassroots NGOs are of four types: welfare NGOs, development NGOs, empowerment NGOs and social action groups. Welfare NGOs are involved in charity, welfare, relief and rehabilitation. Development NGOs may be involved in providing development services such as credit, seeds, fertilizers, technical know-how etc. Social action groups focus on mobilizing marginalized sections around specific issues which challenge the distribution of power and resources in a society. Empowerment NGOs combine development activities with issue-based struggles. They may be involved in the provision of services such as savings and credit; but they utilize such activities for social, economic, political and cultural empowerment of the poor. While the first two types of NGOs often enter into collaboration with the government, the last two often confront state policies, legislations and practices. Support and network NGOs emerged to lend capacity enhancement support to grassroots NGOs and create a platform for NGOs to meet, share experiences and carry out coordinated action. Funding NGOs emerged to fund grassroots NGOs, support NGOs and people's organizations. (Rajasekhar 2003)

For the purpose of our definition, collective action excludes activities where the state is involved and in that sense, includes only non-state actors. It is important to mention here that collective action in this study also includes campaigns. Campaigns are seen to be sporadic and relatively limited in scale, intensity and impact, and yet not mobilizing large sections of people in resisting dominant structures (Monteiro and Lingam 1998). Campaigns and movements may either slide into each other or move from one into the other. For instance, campaigns may emerge from or link with movements or, at times, a campaign may take on a movement-like dimension. This was the case when issue-based campaigns emerged in the 1980s. These had been highly influenced by the community health activism of the 1970s.

Collective action in this study refers to non-institutionalised as well as institutionalised action. Non-institutionalised forms of action include non-violent and passive collective resistance, such as *dharnas* (sit-ins), boycotts, *hartals* (strikes), picketing and peaceful slogan-shouting protest marches to violent collective outbursts of people such as those in riots and revolts (Singh 2001). Institutionalised forms of action include petition in courts of law, articles in newspapers and journals, collective bargaining of trade unions with employees, legal recourse etc.

2.3 Classification of social movements

According to M.S.A. Rao (1978), social movements can be classified on the criterion of the consequences of the movement as reformative, transformative and revolutionary. Another criterion is the locus of a movement on which count movements can be classified into linguistic, religious, sectarian, caste, peasant, worker, tribal, ethnic, and student, etc. Movements may also be classified on the basis of their scale and spatial spread. While some may be all-India, other may be regional and local. Another criterion, according to Rao, of classification is the dominant issue of interest, such as women's liberation. Rao considers the criteria of ideology and the nature of consequences as critical in defining the nature and scope of a movement, the criterion of locus helps identify the section of society which is involved in the movement.

Singh (1986) refers to T.K.Oommen's typology of social movements – one which could be evolved by making a methodological distinction between the 'problem related to the scale of the movement and the issues related to the units and levels of observation'. He views social movement as institutionalized collective action that is guided by ideology and supported by an organizational structure. Hence, the essential tension in movements is between mobilization and institutionalization.

Partha Nath Mukherjee, who made a comparative study of the Naxalbari, a Left revolutionary movement and the Sarvodaya, a Gandhian movement in Bihar, puts forward the idea that it is not the collective mobilization but the objectives that should define a social movement. Mukherjee defines a social movement as a collective mobilization that seeks a change *of* structure either through institutional or non-institutional means. All other mobilizations that seek changes *in* social structure are quasi-movements. He schematizes various types of social movements based on the nature of the change that they pursue and the degree of the institutional appropriateness of the means employed. According to his definition, most agrarian, social and cultural movements in India would qualify only as quasi movements. Both the Naxalbari and the Gandhian movements in his view fall within the category of social movements proper, as they seek transformation of the social system as such (Singh 1986).

Yet another typology distinguished four kinds of social movements: transformative movements that aim to change the entire social structure, often by violent means, reformative movements that aim at partial change, typically to offset prevailing injustices and inequalities, redemptive movements that aim to change radically the (decontextualized) individual, emphasizing personal betterment, and alternative movements that aim to counter conventional cultural norms in favour of more self-sufficient and/or sustainable lifestyles (Wilson 1973 cited in Shah 2004).

Blumer (1995) deals with social movements by treating them as three kinds – general social movements, specific social movements and expressive social movements. Expressive movements are simply expressive behaviour of people that may have

profound effects on the personalities of individuals and on the character of the social order. Examples of expressive movements are fashion movements and religious movements. General social movements are those aim to bring about a shift in the ideas of people, in the perceptions that people have of themselves and of their rights and privileges. These are also called cultural drifts. Examples of such cultural drifts in our own recent history are the increased value of health, the belief in free education, the extension of the franchise, the emancipation of women, the increasing regard for children and the increasing prestige of science. Examples of general social movements are labour movement, youth movement, women's movement and peace movement. Specific social movements are those that have well-defined goals and objectives, an organization and structure, leadership and a definite membership, a guiding set of values and a philosophy.

2.4 Approaches to the study of social movements

Analysts use either of two frameworks for the study of social movements, Marxist or non-Marxist. According to the Marxist approach, the cause for social movements can be located in the economic structure of society. The unequal distribution of wealth and the unequal power relations in a class-based society consisting of haves and have-nots creates friction and opposition. The unequal power relations are manifested in the domination and exploitation of the labour classes by the propertied classes through various means, such as the coercive power of the state and other institutions such as religion, education, mass media etc. Collective action is the organized attempt by the labour class against the dominant class. It is their effort to bring about revolutionary political change by overthrowing dominant classes in power. Though to Marxists, structural causes of conflicting economic interests are central to their studies, a number of Marxist scholars have begun to pay attention to ethnic, religious and other cultural factors. According to Marxist scholars, members of the same class not only have common interests vis-à-vis the other classes, but also share a common consciousness regarding their position in society and the common interests they share. This facilitates their collective action against the ruling classes and state. Marxist scholars of social movements believe in bringing in change through revolution (Shah 2002).

Broadly, in the non-Marxist approach to the study of social movements, 'mass movements are the product of mass societies that are extremist and anti-democratic'. Non-Marxist analysts attribute the cause of social movements to individual psychological traits, some focus on elite power struggle and their manipulation and some others emphasize the importance of cultural rather than economic factors. Some non-Marxist scholars do not favour revolutionary change in the political and economic structure but advocate 'political change' that is confined to a change in government and political institutions. Those who do believe in revolutionary change lay emphasis on political institutions and culture. Non-Marxist scholars accuse Marxist studies of being 'reductionist', 'mechanical' and 'over determining' economic factors (Ibid.).

Monteiro and Lingam (1998) write that 'studies and writings on social movements have unequivocally related them to social change'. They then go on to understand social movements using the three approaches to social change, i.e. the structural-functional approach, the Marxist approach and the symbolic interaction school of thought. According to the structural-functional approach, social movements are 'temporary aberrations' that emerge from stresses and strains in the system. They are mechanism that help society adapt to the changes required. Once adapted, the change gets institutionalized (Oommen 1990 cited in Monteiro and Lingam 1998). According to the Marxist approach to social change, social movements occur as a result of exploitative relations between those who own the means of production and the labour class and as a response to this class conflict. The symbolic interaction school of thought attributes the cause of social movements in terms of behavioural aspect of individuals who act together, to transform established social relations. This school of thought emphasises the 'behavioural aspects of individuals in collectivity'.

2.5 Theoretical perspectives

The way in which social movements are viewed has changed enormously over the past couple of decades. Up until the 1960s, social movements were looked upon as dangerous crowds and mobs of violent people who would do anything that their leaders asked them to do and engage in all kinds of unreasonable activities and pursue unreasonable goals

that they were not supposed to. It is important to mention here the fact that nineteenth century Europe was a witness to several crowds who took to the streets to demand better working conditions, right to vote and other such rights. Political action that was attempted outside of institutionalised channels was feared by scholars, elites and society in general.

These attitudes changed in the 1960s with the main reason being the civil rights movement, which emphasized the repression faced by Blacks in America. 'For one of the first times in history, large numbers of privileged people (those in college and with college education) had considerable sympathy for the efforts of those at the bottom of society to demand freedom and material improvements. It was hard to dismiss civil rights demonstrators as misguided, immature, or irrational.' Scholars too then began to take a closer look at collective action as a phenomenon that was worthy of study (Goodwin and Jasper 2003).

Social movement theories have undergone several conceptual turns. The essence of the main theories of social movement is presented below:

- Collective behavior/collective action theories

The term "collective behavior" was first used by Robert E. Park, and employed definitively by Blumer (1995) to refer to social processes and events that do not reflect existing social structure (laws, conventions, and institutions), but which emerge in a spontaneous way. Collective behavior might also be defined as action which is neither conforming (in which actors follow prevailing norms) nor deviant (in which actors violate those norms). The social movement is seen as a form of collective behavior. These episodes are less fluid than the other forms and do not change as often as other forms do.

- Relative deprivation theory

Relative deprivation is the experience of being deprived of something to which one thinks one is entitled. Schaefer (2008) defines it as "the conscious experience of a

negative discrepancy between legitimate expectations and present actualities." It is a term used in social sciences to describe feelings or measures of economic, political, or social deprivation that are relative rather than absolute. The critique of this theory has pointed out that this theory fails to explain why some people who feel discontent fail to take action and join social movements (Kendall 2005).

- Value-added theory

Value-added theory (also known as social strain theory) was first proposed by Neil Smelser (1963) and is based on the assumption that certain conditions are needed for the development of a social movement. Smelser saw social movements as side-effects of rapid social change. He argued that six things were necessary and sufficient for collective behavior to emerge and that social movement evolves through those relevant stages:

a. Structural conduciveness - things that make or allow certain behaviors possible (e.g. spatial proximity); also, awareness of the problem among people the opportunity to act
b. Structural strain - something (inequality, injustice) must strain society, and existing power holders are unable (or unwilling) to deal with the problem
c. Generalized belief - The problem should be clearly defined and this definition widely agreed by the participants.
d. Precipitating factors – There should be a spark to ignite the flame.
e. Mobilization for action - People need to become organized.
f. Failure of social control - High level of social control by the power holders (politicians, police) often makes it more difficult for social movement to act.

Critics of this theory note that it is based on functionalism and views all strains on society as disruptive (Kendall 2006, della Porta and Diani 2006).

The European new social movement theory and the North American resource mobilization theory emerged in reaction to previous analyses of social movements. The resource mobilization theory was propounded as a response to the psychological reductionism of prior theories of collective action in the United States, i.e. that social

movements are the outcome of frustration, alienation etc.. The new social movement theory was born of a disenchantment with an outmoded style of class analysis. It was propounded on the belief that there are social conflicts that cannot be explained in class terms and that in a postmodern or postindustrial society, there are multiple and diverse social conflicts and not just those based on class issues.

- Resource mobilization

Resource mobilization theory stresses the ability of movement's members to acquire resources and to mobilize people towards the furtherance of their goals (Kendall 2006). Costain (1992) describes the theory as being based on the idea that successful movements acquire resources and creating advantageous exchange relationships with other groups as they achieve success in fulfilling their goals. According to the resource mobilization theory, it is a core group of sophisticated strategists that works towards harnessing the disaffected energies, attracting money and supporters, capturing the media's attention, forging alliances with those in power, and creating an organizational structure. However, this theory assumes that without such resources, social movements cannot be effective and that dissent alone is not enough to bring about social change (Kendall 2006).

- New social movement theory

The new social movement theory attempts to explain several new movements that emerged in various Western societies roughly since the mid-1960s (i.e., in a post-industrial economy). These movements do not have a clear class base and they do not have a special interest appeal to any one group. There are two central claims of the new social movement theory. First, new social movements are a result of the development of the post-industrial economy and, second, these movements are unique and different from previous social movements of the industrial economy. New social movements concentrate not on issues of economic well-being but on less materialistic qualities of life, such as gay rights and pacifism (Buechler 1999).

- Frame analysis theory

Sociologists have utilized framing to explain the process of social movements. In this theory, scholars have studied the need for organizers to create 'symbols', i.e. people need to be convinced that they have grievances and establish a feeling of solidarity among each other. In order to attract people to join and remain committed to a movement, its issues must be presented or "framed" so that they fit or resonate with the beliefs, feelings and desires of potential recruits. Certain meanings are created for the participants and for the opposers. Frames may take the form of appealing stories, powerful clusters of symbols, slogans and catch words or attributions of blame for social problems. Social movement leaders and recruiters find the right frames, ones 'aligned' with the understandings of potential recruits. The process is considered "successful" when the frames projected align with the frames of participants (Snow and Benford 1988).

- Political process theory

It is argued that the new social movement theory and the resource mobilization theory had ignored the political context in the form of the state. Tarrow (1998) propounded a model in which collective action was connected to politics. He called this the "political process model". The state was an important component of the analysis. In this model, the collective identity of the social movement and its strategic intent need to be analysed in interaction with the political environment, especially with the institutions of the state. Social movements vary in character and organization with the kinds of political authority they challenge. Social movements are, thus, a form of mass politics. Also, it is the socio-political context that forms the conditions for the emergence of and success of movements. The political process theory argues that movement activists do not chose their goals at random. It is the political context which stresses certain grievances, and around it, movements organize.

The notion of political opportunity structure was later introduced in the theory according to which the political opportunity structure conditions the emergence, strategy and likelihood of success of social movements. The emergence of social movements is a result of 'opportunities' provided by the state (such as a lessening of repression or a

division among economic and political elites). The political opportunity theory argues that the actions of the activists are dependent on a broader context (in other words, on the existence, or the lack, of a specific political opportunity). The actions of activists can only be understood when seen in the broader context of political opportunities. Tarrow (1998) explains political opportunity as "consistent - but not necessarily formal or permanent - dimensions of the political struggle that encourage people to engage in contentious politics".

2.6 Disciplinary domain of study of movements

M.S.A. Rao (1978) argues that a study of social movements belongs mainly to the domain of history and not sociology because of the retrospective nature of the task. According to him, the field work cannot be carried out because the researcher will not be aware of the movement or because it is difficult to carry out fieldwork especially when a movement is violent in nature. The debate of whether social movements should be the domain of political science or sociology is interesting. Andre Gunder Frank and Marta Fuentes (2002) make a distinction between social and political movements in the context of new social movements as these do not raise economic issues, are not concerned with state power and are primarily concerned with protecting and enlarging the autonomy of civil society. New social movements also raise issues that cut across the interests of classes and in that sense, are social and not political. According to them, the objective of social movements is social transformation whereas political movements strive for state power (Shah 2004). However, Shah argues that this is problematic since power is not located in the state alone. Also, movements involving issues concerning the sense of social justice have political implications. Dhanagare and John (2002) assert that Frank and Fuentes are "committed to a process of de-politicisation of the social regime".

In this chapter, the term 'collective action' was defined, drawing from various definitions of social movements and campaigns. This chapter also spelt out the ways in which social movements are classified. It dwelt briefly upon the two major approaches to the study of social movements. The theoretical perspectives on social movement were also explained.

Finally, the chapter discussed the debates regarding the disciplinary domain of the study of social movements.

Chapter 3

The trajectory of collective action pre-Independence

This chapter attempts to map the trajectory of collective action in health in the period before Independence by chronologically reviewing those movements, campaigns and other forms of collective action as defined for the purpose of the study which undertook health issues in a significant way. The attempt would be to understand the context, issues and outcomes of such collective action. It would do so against the background of the political and economic conditions at the time, both in general and with regard to health. The trajectory of collective action in health in this study is reviewed from the time of the emergence of modern industrialization, beginning with the workers' movement, followed by the nationalist movement.

Industrialization began in India in the middle of the nineteenth century with the building of the railways and the emergence of textile and jute mills. The changing pattern of production and an expanding workforce had its own implications for the health of workers. The labour movement, which effectively began in 1875 and transformed in the 1920s into the trade union movement, was instrumental in introducing laws for the betterment of the living and working conditions of the workers and included several provisions related to health.

The Indian national movement was a movement that sought for autonomy for the Indian populations from British rule. On the agenda were health issues that gained clarity through the recommendations of the National Planning Committee (under the chairmanship of Jawaharlal Nehru).

This was an overview of the chapter. The rest of the chapter details the above.

3.1 The Industrial Workers' Movement[14]

The workers' movement has been at the forefront of the struggle for better health services for workers. The trade unions have been instrumental in bringing about several legislations related to the health of workers. In addition to presenting information related to these initiatives and outcomes of the struggle, this section will also describe the political and economic conditions that led to the birth of the workers' movement.

The Industrial Revolution began in India in the middle of the nineteenth century when the first railway lines were laid and textile and jute mills established. By the end of the 1800s, the major employers of the labour force were the cotton and jute mills, the railways and the coal mines. By 1929, the pattern of industry had changed, with cotton, jute and the railways remaining as very large employers but plantations of tea, coffee and rubber also becoming major employers. Steel, general engineering, paper, cigarettes, armaments and foundries began to be manufactured. Besides, a construction sector had begun to emerge to support the industrialisation process. There was also an upcoming 'unregulated' sector comprising traditional activities in *bidi*, shellac, carpet, wool, mica, and match manufacture (Qadeer and Roy 1989).

Employment and industrial production grew with the Second World War as new industries were coming into existence. While the plantations, cotton, jute and the railways were all still big employers, the manufacturing industry had grown beyond steel and engineering, etc., into cement, sugar, shipbuilding, chemicals, dyes and beverages. The composition of the unregulated sector was about the same, but it too had grown enormously to meet the war demands. Thus, on the eve of Independence, India had a small but significant industrial sector.

Industrial growth in the post-Independence period has had its own ups and downs. From 1955 onwards, newer industries like chemicals, fertilizers, metals, power, petroleum and coal, machinery and minerals, which had just started in the fifties, became prominent.

[14] In this dissertation, the terms industrial workers' movement and the trade union movement have been used interchangeably.

The changing pattern of industrial production and expanding work force had its own implications for the health of the workers. Industries like textiles, jute and mining had mechanical and dust hazards and these dangers were combined with the insanitary conditions in which workers were forced to live. The introduction of machinery, especially high-speed machines, created higher risks of accidents while the chemical, fertiliser and petroleum industries introduced the risk of genetic diseases, chronic poisoning and ecological destruction (Ibid.).

The total work force also expanded as industry diversified and their associated hazards increased. In 1892, the total number of workers employed in industry was 316, 816, as per the report of Labour Investigation Committee. By 1929, 1,166,000 workers were reported to be working in the industries, as per the report of Factories Act. With the demands on production caused by the Second World War, employment opportunities expanded further and the work force increased to 2,436,312 by 1946. By 1968, it was estimated to be 16,330,000 and the 1981 Census estimates the total work force at 222.3 million. This increasing population was constantly being exposed to increasing and varied health hazards (Ibid.).

The industrial workers' movement is being used here to refer to both the labour movement and the trade union movement. The labour movement began in 1875, when a number of measures through legislation, administration and welfare work were taken by the Government, management and social workers to improve labour condition. The trade union movement commenced in 1918 when workers formed their own organizations to improve their conditions. [15]

The period of the labour movement can be divided into two. The early labour movement was from 1875 to 1890. From 1853 to 1860, the British government in India adopted some crude legislation such as the Apprentices Act, Fatal Accidents Act, Merchant

[15] The labour movement is *for* labour, whereas the trade union movement is *by* labour. This distinction is worth noting because till the workers organized themselves into trade unions, there were attempts, mainly by social reformers, to improve the working and living conditions of labour. These measures undertaken by non-workers for workers, may form a part of the labour movement and not of the trade union movement.

Shipping Act, Workmen's Breach of Contract, and Employers and Workmen (Disputes) Act. However, these laws were more in the interests of employers than of labour. In 1875, when the First Bombay Factories Commission for the investigation of the factory conditions was appointed, Indian labour problems came to be publicly discussed. This was followed by other events, such as setting up the Second Bombay Factory Commission in 1884 and the submission to the Government of another memorandum signed by about 17,000 workers in 1890. The second phase of the labour movement from 1890 to 1918 was marked by the establishment of a number of associations for labour, such as the Bombay Mill-hands Association (1890), the Amalgamated Society of Railway Servants of India and Burma (1897), Kamgaar Hitwardhak Sabha (1909), the Printers' Union, Calcutta (1905), the Bombay Postal Union (1907) and the Social Service League, Bombay (1910). The leaders of these labour associations were primarily social reformers belonging to the moderate school of politics (Punekar et al. 1984).

The labour movement, till 1918, was strictly constitutional and relied mainly on moderate methods, such as investigations, memoranda, petitions, legal enactments, committees and commissions. The labour movement was moderate in character. However, it paved the way for the birth of the Indian trade union movement by publicizing the labour problems and by creating a social welfare climate (Ibid.).

3.1.1 Conditions for the birth of the workers' movement

The immediate post-war period (1918-20) saw the birth of the Indian trade union movement. The factors that favored its birth and infancy include the demand for political and economic freedom and better wages, intense industrial and economic unrest owing to the failure of earnings to keep pace with prices and profits, the impact of the Russian Revolution (1917), the role of International Labour Organization (1919), the All India Trade Union Congress (1920) and the Swaraj Movement (1920-22). The contributions of these factors to the Indian trade union movement, as spelt out by Punekar et al. (1984) are the following:

i. *Demand for political and economic freedom, better wages*

When the First World War ended successfully, Indians too began demanding self government. Several Indian employers also established a number of industries. Some soldiers who had taken part in the War joined the industries as workers. These soldiers had been in contact with their counterparts in other countries and knew about trade unionism and spread this among their co-workers. In addition, at the end of the War, prices and profits went up but wages remained the same. This led to discontent among workers who began demanding more wages. A number of strikes took place by workers in various mills, railways, and seafarers, some of which were successful. This encouraged the strike committees to convert themselves into trade unions. Thus, there was a general air of discontent among people for political and economic justice.

ii. *The Russian Revolution (1917)*

The trade union movement in its early stages was influenced by communism and Soviet Russia. The Communist Party of India (CPI), which had inspiration and instructions from Moscow, captured the All India Trade Union Congress (AITUC) in 1925. The Russian Revolution of 1917 introduced into the minds of workers the ideal that exploitation of labour could be stopped through political means.

iii. *The International Labour Organisation (1919)*

The International Labour Organisation (ILO) came into existence as the result of the Peace Treaty of Versailles (1919) for 'the well-being, physical and intellectual, of industrial wage earners'. The ILO has considerably influenced India's labour movement, labour legislation and labour policy.

iv. *The All India Trade Union Organization 1920*

The All India Trade Union Organization, established in October 1920, owes its immediate origin to the ILO's procedure. The workers' delegate to the ILO

is to be nominated by the Government, in consultation with the most representative organization of workers. When the first ILO conference was held in 1919 in Washington, there was no central federation of Indian trade unions and hence the Govt of India nominated a delegate without consulting trade unions. This action led to some dissatisfaction among the labour ranks. On October 30, 1920, representatives of 64 trade unions, claiming a membership of 1,40,854, met in a conference in Bombay and established the AITUC under the chairmanship of Lala Lajpat Rai. The AITUC was the central federation of Indian trade unions developed by the trade union movement. The ILO also encouraged the movement by providing training, literature and other resources including an international platform for trade union leaders from various countries.

v. *The Swaraj movement (1920-22)*

Mahatma Gandhi's first Civil Disobedience Movement started on August 1, 1920. In this movement, there were a large number of young, energetic and dedicated persons who joined the trade union movement that had just begun. This also introduced the political element into trade unionism (Punekar et al. 1984).

3.1.2 Ideology

The Marxian approach to trade unions[16] is based on the concept of class struggle between the capitalist employers and their workers. To get more and more profits, the employers exploit the workers who, because of their common interest to get more wages, unite in trade unions and then resist the employers. If the struggle continues, workers may

[16] The most popular definition of a trade union is the one given by Sidney and Beatrice Webb: "a continuous association of wage earners for the purpose of maintaining or improving the conditions of their working lives". To achieve their goal, trade unions may achieve a variety of means. These methods can be divided into four types:

i. method of mutual insurance or welfare work
ii. method of collective bargaining
iii. method of legal enactment; and
iv. method of direct action

overthrow the employers, getting the ownership of the means of production. The trade unions may even capture the government by joining the labour party (Ibid.).

3.1.3 Struggle for health by the workers' movement

In India, the trade union movement is over 50 years old. Despite its slow growth and ups and downs, it has been the major tool helping workers to get them their rights. The number of trade unions has increased from 2,766 in 1946-47 to 35,750 in 1979.

The industrial workers' movement has addressed several issues related to health of workers. These have taken the form of legislations. In the following pages, those legislations that are related to the health of industrial workers are detailed. The following legislative measures have been adopted by the /govt of India by way of social security schemes for industrial workers.

Table 1: Protective legislation for industrial workers

S. No.	Legislation	Provisions related to health
1.	Workmen's Compensation Act 1923	Cash compensation, generally lumpsum, in cases of injury caused by accident arising out of, and in the course of, employment. Compensation is also payable for certain specified occupational diseases.
2.	Mica Mines Labour Welfare Fund Act 1946	The activities sponsored by the Fund are as under: i. improvement of public health and sanitation, the prevention of diseases and the provision and improvement of medical facilities The Fund is maintaining a central hospital, regional hospitals, dispensaries, mobile medical units, maternity centres, child welfare centres. The Fund also provides treatment facilities for TB patients and leprosy patients. ii. Provisions for improvement of water supply and facilities for washing iii. Provision and improvement of educational facilities. The Fund is running multipurpose institutes imparting adult education, schools for children, crafts training for families etc. iv. Improvement of standards of living, including housing and nutrition, amelioration of social conditions. The fund has programmes for housing such as subsidy scheme, subsidy-cum-loan scheme, new subsidized housing scheme, departmental housing, low cost houses, and 'build-your-own-house' schemes Provision of recreational facilities such as sports, exhibition of films, arranging of dramas etc.
3.	Factories Act 1948	- Washing facilities - Seats for occasional rest for workers obliged to work standing - Canteens, if employing more than 250 workers - Shelters or rest rooms and/or lunch room, if employing over 150 workers

		- appointment of Welfare Officers in factories ordinarily employing 500 or more workers to look after the welfare of the workers Managements are to comply with the health provisions in the Act relating to cleanliness, disposal of wastes and effluents, elimination of dust and fumes, artificial humidification, overcrowding, lighting, drinking water facilities (arrangement for cool drinking water in summer in factories employing over 250 workers), urinals, latrines, spittoons, First Aid boxes (one for 150 workers) and ambulance facilities (in factories employing over 500 workers)
4.	Employees State Insurance Act 1948	Medical care and cash benefits, generally paid once a month, in cases of sickness, maternity and disablement and death due to employment-injury. Grants to meet funeral expenses of the diseased workers are another cash benefit. Artificial limbs, dentures etc are also provided, when necessary, either free or at a nominal cost. The rate of cash benefits for sickness and temporary disablement is equal to half the assumed average daily wage. Maternity benefit is granted at the rate of twice the sickness benefit rate with a minimum of Re. 0.75 per day. The rate of dependants' benefits varies according to the relationship of the dependant to the deceased worker. Sickness benefits are given for a maximum period of 56 days in a year, and maternity benefits are given for a period of 12 weeks.
5.	Plantations Labour Act 1951	Every employer is required to provide and maintain for every worker and his family residing in the plantation, the necessary housing accommodation. The standards and specifications of the accommodation, procedure for allotment and rent chargeable from workers, etc are to be prescribed in the Rules by the State governments. Other obligations of the management are: a) provision of medical aid to workers and their families. The workers are also entitled, subject to any rules framed by

		the State governments, to sickness allowance and maternity allowance b) provision for a canteen in plantations employing 150 workers c) appointment of Welfare Officers in plantations employing 300 or more workers to look after the welfare of the workers
6.	Mines Act 1952	- Provision of shelters for taking food an rest if 150 or more persons are employed - provision of canteen in mines employing 250 or more persons - appointment of Welfare Officers in factories ordinarily employing 500 or more workers to look after the welfare of the workers - provision in coal mines of (a) pit head baths equipped with shower baths, (b) sanitary latrines, and (c) lockers, separately for men and women workers - maintenance of first-aid boxes and first-aid rooms (in mines employing more than 150 workers)
7.	The Merchant Shipping Act 1958	Provisions in the Act relating to health and welfare cover: i. crew accommodation ii. supply of sufficient provisions and water iii. supply of necessities like beddings, towels, mess utensils iv. supply of medicines, medical stores, surgical and medical advice etc v. maintenance of proper weights and measures on board, grant of relief to distressed seamen aboard a ship vi. every foreign-going ship carrying more than the prescribed number of persons, including the crew, is required to have on board as part of her complement a qualified medical officer vii. appointment of a Seamen's Welfare Officer at such ports in or outside India as the Government may consider necessary

		viii. establishment of hostels, clubs and canteens, libraries etc ix. provision of medical treatment and hospitals
8.	The Motor Transport Workers Act 1961	Motor transport undertakings are to provide: i. canteens of prescribed standard, if employing 100 or more workers ii. clean, ventilated and well-lighted and comfortable rest rooms at every place wherein motor transport workers are required to halt at night iii. uniforms, raincoats to drivers, conductors and line checking staff for protection against rain and cold iv. a prescribed amount of washing allowance to the abovementioned categories of staff v. a First Aid box and such medical facilities for workers at such operating centres and halting stations as may be prescribed by State govts.
9.	Dock Workers (Safety, Health and Welfare) Scheme 1961	A comprehensive Dock Workers (Safety, Health and Welfare) Scheme 1961 has been framed for all major ports and is administered by the Chief Advisor, Factories (Factory Advice Service and Labour Institutes). It is framed under the Dock Workers (Regulation of Employment) Act 1948. Amenities provided in the port premises include provision of : i. urinals and latrines ii. drinking water iii. washing facilities iv. bathing facilities v. canteens vi. rest shelters vii. call stands viii. First Aid arrangements
10.	Iron Ore Labour Welfare Cess Act 1961	The Fund provides amenities such as: i. improvement of public health and sanitation, the prevention of diseases and provision and improvement of medical facilities ii. the provision and improvement of

		water supply and facilities for washing iii. the provision and improvement of educational facilities iv. improvement of standard of living, including housing and nutrition, the amelioration of social conditions and the provision of recreational facilities
11.	Coal Mines Labour Welfare Fund Act 1974	The Act provides, inter alia, for the setting up of a fund called the Coal Mines Labor Housing and General Welfare Fund. The activities of the Fund are broadly classified under 'Medical', 'Housing' and 'General Welfare'. The Fund provides medical facilities such as the following: i. Central Hospitals at Dhanbad and Asansol ii. Regional hospitals iii. Maternity and Child Welfare Centres iv. Facilities for TB patients v. Dispensaries (allopathic and ayurvedic) vi. Treatment of leprosy vii. Treatment of cancer viii. Treatment of mental cases ix. Health promotion centres x. Family planning xi. Supply of artificial limbs xii. Welfare for the visually handicapped xiii. Free supply of spectacles and dentures xiv. Anti-malaria operation xv. Filaria survey In addition, the Fund provides for housing facilities and water supply among others.

Source: Punekar et al. 1984

The collective action by trade unions had a major role to play in bringing about these legislations. Qadeer and Roy (1989) write that the debates in the Legislative Assembly between 1922 and 1948 provide information on the 'social forces which determined the evolution of labour legislation in India'. One of these was the struggles by the trade unions. The laws that were proposed by the Government were those that had already been conceded by the industries or the states at the local level. Thus, workmen's compensation, maternity benefits, and health facilities for workmen were legislated for in the Assembly well after these rights had already been fought for and achieved by unions in different places within the country.

The workers' movement has achieved many benefits for the workers despite several problems, such as the splits in the Communist Party of India in the 1960s, low bargaining powers of workers, unorganized nature of a large majority of workers etc. The Jharia coal mine strike, the general strikes of Bombay textile workers and plantation workers in Assam between 1920 and 1921 were some of the earliest struggles which focussed upon the poor living conditions of the workers. Following these struggles, the Bombay Mill Owner's Association was persuaded to agree to some of the workers' demands which included compensation for employment injuries and medical aid during working hours. The Labour Bureau provides information on disputes resulting in closures and lock-outs and cases compensated under the Workmen's Compensation Act 1948. In both of these, trade unions play an important role. Data from the National Labour Year Books shows that over the period from 1951 to 1980, against every conviction under the Factories Act 1948, at least 50 compensations were won under the Workmen's Compensation Act. Data from the National Labour Year Book 1983 shows the main issues related to industrial disputes are wages, bonus, retrenchments, hours of work and leave. Since a separate category of 'health' is not present in the data, it has to be seen as part of 'others' or 'unknown', but an assessment may not be possible because the data is clumped together (Ibid.).

The trade union is a powerful institution. It has played a pivotal role in building a large social movement. Trade unions have a long history of organizing workers, have a firm

ideological base and have a widespread network. The issue of health taken up by the trade union movement has resulted in extremely significant reforms for industrial workers and is a step ahead towards the goal of social justice.

3.2 The Nationalist Movement

The nationalist movement refers to the various national and regional campaigns, agitations and efforts of both non-violent and militant philosophy and involved a wide spectrum of political organizations, philosophies, and movements which had the common aim of ending the British colonial authority. Although the nationalist movement came to include several political parties, organizations of students, workers, peasants, capitalists, princes, landlords, women, depressed classes, states' peoples, socialists and communists, it was really the Indian National Congress that led the movement from the early 1900s. They used moderate methods of 'prayer, petition and the press' until the beginning of the early 1900s when they took a more radical approach towards political independence. With the entry of Mahatma Gandhi into the nationalist movement in 1915, it took on a mass character. The nationalist demands of the Congress resulted in the increased role of Indians in the administration and governance of the country, such as the Government of India Act 1919 and the Government of India Act 1935 (Chandra 1988).

3.2.1 Socio-political conditions for need to take up health as an issue

The drain of wealth by the colonizers resulted in a disrupted economy and a country that was ridden with poverty. The poor health status of the people of India during the colonial rule was an impact of the political and economic policies imposed by the British. The discriminatory attitude of the British towards health services translated into policies that neglected the health of the civilians and created inequities in health status and health services whose effect continues till date. The British never seriously pursued any policies related to public health for civilians. Their health services were aimed at their officials and troops and confined to the cantonments. Public health was, thus, confined to a certain section of the public. The indigenous systems of Indian medicine too were neglected by the British (Jesani 1998).

The first hospitals set up by the English East India Company in Madras, Bombay and Calcutta were done so exclusively for the British population, especially the armed forces. The Indian Medical Service (IMS) was founded in 1764, keeping in mind the increasing needs of the British population. The IMS catered mostly to the needs of the armed forces. By the early 19th century, hospitals for the general population were established in chief mofussil towns, besides the Presidency headquarters (Crawford 1914 cited in Duggal 2001). The expansion of medical facilities followed the devolution of the imperial government especially after 1880 with the setting up of Municipalities and District Boards. However, these medical facilities had a distinct racial and urban bias. Separate provisions were made on employment and racial grounds, though in some places non-official Europeans were allowed access to hospitals designed for civil servants. In General Hospitals, wards for Europeans and Eurasians were separated from those for the rest of the population (Jeffery 1988). These facilities, at least till the Montague-Chelmsford Reforms of 1919, were located in urban areas in the military and civilian enclaves of the English.

Another aspect, which received early attention, at least in the cantonments, was public health measures. The continued high mortality of British soldiers despite good access to medical services led to the appointment of a Royal Commission to enquire into sanitary conditions of the army in 1859. The Royal Commission submitted its report in 1864, recommending setting up of Sanitary Commissioners in each Presidency. Preventive health care consequently began to get some importance at least in the cantonments. Within 30 years of creation of such Commissioners, the death rate in the army declined from 69 per 1000 in 1857 to about 16 (Jaggi 1979 cited in Duggal 2001). However, in the general population, mortality due to diseases emanating from insanitary conditions continued to be extremely high. For instance, just four diseases – cholera, smallpox, fevers and bowel complaints - in 1886 claimed over 368,000 lives in Madras Presidency alone (Ibid.).

Following the Government of India Act of 1919, health was transferred to the provincial governments who then began to take some interest in rural health care. In fact, it was

when the Rockefeller Foundation entered India in 1920 that rural health care expanded. The focus of their activities was on developing health unit organizations in rural and semi-rural areas, in addition to support for malaria research and medical education (Bradfield 1938 cited in Duggal 2001). This intervention of the Rockefeller Foundation is historically very important for development of health care services and health policy in India, especially for rural areas. It may be considered a watershed that paved the path for the ideology that rural areas need only preventive health care and not hospitals and medical care clinics, i.e., they need "public health" and not medical care. The result of this was that medical care activities of the State were developed mainly in the urban areas and rural areas were deprived the devolution of medical care within their reach. This is an important historical fact to note because these same differential treatments for urban and rural areas have continued even after Independence (Jeffery 1988).

With regard to public health also, these racial biases were evident. Only the European areas received the benefits of public health measures. The same was true in the case of medical education in India. Europeans and certain western oriented Indian communities like Christians in Bengal and Parsis in Bombay largely monopolized it, at least until 1920 (Ibid.).

The Imperial government in India adopted measures that were totally inadequate to deal with the problems at hand because of the racial and urban bias. These were conditions that led to the demand for better health services becoming an issue in the nationalist movement.

3.2.2 Health initiatives in the nationalist movement

In contrast to the colonial state, the Indian nationalists envisioned a 'thoroughly regulated, state-directed transformation of health conditions'. In 1938, the Indian National Congress established a National Planning Committee (NPC) under Jawaharlal Nehru to plan for the development of the nation. The Committee was set up to plan for the economic development of the country. In its Terms of Reference, it was spelt out that the problems of poverty, unemployment, national defense and of economic regeneration

could not be solved without industrialization. Therefore, it was really for the industrial development of the country that the NPC was set up. A comprehensive scheme of national planning was to be formulated, which would provide for the development of heavy key industries, medium scale industries and cottage industries. While this was the original intention of the nature and scope of work to be done by the Planning Committee, it conceived its task in a broader spirit and expanded its scope and definition of planning to include not only economic development and standard of living but also 'cultural and spiritual values and the human side of life' (Report NPC 1949). It was to fulfill this part of the task that the Committee constituted 29 sub-committees with specific Terms of Reference.

A sub-committee on national health was one of the 29 sub-committees. The sub-committees that made resolutions on areas that would have a direct impact on health were the sub-committees on women, labour and population. In a note for the guidance of the sub-committees, the Committee had the following suggestions as the indices of progress of standard of living:

- an increase in agricultural production for improvement of nutrition from the standard of an irreducible minimum requirement of proteins, carbohydrates and minerals (as well as necessary protective foods) having a calorific value of 2,400 to 2,800 units for an adult worker
- an increase in industrial production for improvement of clothing from the present consumption of about 15 yards on an average to at least 30 yards per capita per annum.
- the dimunition of unemployment
- the increase in per capita income
- the liquidation of illiteracy
- an increase in public utility services
- provision of medical aid on the basis of one health unit for 1,000 population
- increase in average expectation of life (Report NPC 1949, p 48-49)

The sub-committee on national health was chaired by Col. S.S. Sokhey. It envisaged a future India where "organised, systematic, collective enterprise to provide the necessary advice and treatment for guarding or improving the health of the individual is made available, not as a matter for the affected individual to obtain for himself, or even as a matter of spasmodic charity ... but as a matter of right to the individual through an organised public service discharging a common obligation of society towards its members" (NPC National Health, p 27).

The NPC's vision of a state-run health service funded by a system of national social insurance was inspired by 'the maternalist welfare schemes of continental Europe, from the liberal welfare state of New Zealand and the Soviet Union' (Koven and Michel 1990 in Amrith 2007). The British invested more money on the study of tropical diseases than on providing public health services with the belief that the diseases prevalent in the country were due to the tropical climate. None of the countries from whom the NPC took inspiration were tropical countries. In fact, the NPC challenged this view of the British rulers and adopted the universal standards of the League of Nations' nutrition committee to declare that "the needs of the people... in this country are not different from the corresponding needs of the people in other temperate countries" (Amrith 2007).

According to Amrith (2007), there were distinct but overlapping concerns that led to national health being considered as a problem that required a singular response in the form of a national health policy. He traces three discourses, i.e. the concerns of India's elite with racial purity and degeneration; the concern of social reformers with the misery of India's villages, and the concern of modernists with using the state to transform society and economy. These concerns led to the idea of looking at health as a right. "As a result of the confluence of these discourses, the idea that health as a right of national citizenship became thinkable, even natural, by the 1940s". The nationalist movement took up the agenda of health with the broader agenda of caring for the people. They framed the issue in such a way that a healthy body symbolized a healthy nation.

The NPC, appointed in 1938, began its work early in 1939. Twenty-nine sub-committees, formed into eight groups, were set up with special terms of reference to deal with all parts and aspects of the national life and work in accordance with a predetermined Plan. The Sub-committees submitted reports in 1940. These reports went into cold storage when World War II began and remained so for the duration of the war. The sub-committee reports were revised in 1945 after the Second World War had ended.

The sub-committee on National Health was appointed to consider the following terms of reference:

a. prescribing standards of dietary and nutrition for all classes of population
b. consideration of the nature and incidence of the various epidemics which take a heavy toll of life, and suggestion of ways and means for guarding against these scourges
c. investigation into the volume and causes of infant mortality as well as mortality among women; and suggestion of ways and means of reducing such mortality
d. provision of the necessary health units, comprising physicians, nurses, surgeons, hospitals and dispensaries, sanatoria and nursing homes
e. health insurance
f. medical training and research
g. compilation of vital statistics, including those of birth and death rates
h. cultivation of the necessary drugs and production of medicines to provide the necessary preventive or curative aid, scientific and surgical appliances and accessories of the National Health Services
i. any other questions connected herewith (NPC National Health 1948, p 17)

Its report, published in 1948, was sketchy compared to the Bhore Committee Report - it was not as well studied and it lacked in detailed analysis of the existing health situation as well as of the future plans. In fact, it borrowed its analysis of the health situation from the Bhore Committee and also concurred with most of its recommendations. On the basis of

an interim report of the National Health sub-committee presented to the NPC in August 1940, the NPC adopted certain resolutions, some of which are:

a. Dietary standards to be raised, made adequate and better balanced for the purpose of raising the standard of public health
b. Adoption of a form of health organization, in which both curative and preventive functions are suitably integrated, and administered through one agency. This should be the responsibility of the state.
c. Medical and health research for the investigation of the indigenous and other methods for the maintenance of health and the prevention and cure of diseases
d. Appointment of one qualified medical man or woman for every 1,000 population, and one (hospital) bed for every 600 of population. Within the next 10 years, the objective aimed at should be one medical man or woman for every 3,000 of population, and a bed for every 1,500 of population. This should include adequate provision for maternity cases.
e. Establishment of large numbers of training centres
f. Training of large numbers of health workers
g. The medical and health organization should be so devised and worked as to emphasize the social implications of this service. With this object in view, the organization should be made a free public service, manned by whole-time workers trained in the scientific method.
h. Adequate steps be taken to make India self-sufficient as regards the production and supply of drugs, biological products, scientific and surgical apparatus, instruments and equipment and other medical supplies... No individual or firm, Indian or foreign, should be allowed to hold patent rights for the preparation of any substances useful in human or veterinary medicine (Ibid. p 224-226)

The sub-committee on women also produced its report titled Women's Role in Planned Economy. Some of the significant resolutions adopted by the NPC related to health were the following:

a. An organized health service, with special maternity arrangements for women, shall form an integral part of planned economy. Indigenous *dais* shall be gradually replaced by trained midwives as soon as possible.
b. A planned scheme of national economy should provide for a scheme of social insurance, made available in cash and kind, for all citizens. This should include benefits in the case of disability, sickness, accident, pregnancy and child birth in the case of women, and assistance for the care and nursing of the newborn child.
c. During the transition period, due provision should be made in the leave rules applying to women workers to get leave on the grounds of the sickness of the child. The burden of this may be borne by the community. (Report NPC 1949, p 214-222)

The sub-committee on population chaired by Dr Radha Kamal Mukherjee passed the following resolutions:

a. The problem of the size of the population of India has been fundamentally caused by the lack of all-round economic development. There is a disparity between population and standard of living, which can be bridged by economic development.
b. There is a deficit in food supply estimated at about 12 per cent of the requirements of the population, and chronic undernutrition and imbalanced diet of the masses. The prevalent undernutrition and malnutrition should be tackled by systematic crop planning, stressing the production of heavy yielding, energy producing and also protective foodstuffs. A Central Nutrition Board should be set up with regional boards, for developing a national nutritional policy in coordination with the Departments of Agriculture and Public Health. There should be nutrition research institutes functioning under these Boards.
c. Adoption of a family planning policy by the state. Knowledge of cheap and safe methods of birth control should be spread, birth control clinics should be

established and other necessary measures taken in this behalf and to prevent the use or advertisement of harmful methods.

d. Gradual raising of marriage age and discouragement of polygamy are desirable in the interests of the limitation of the size of the family.
e. Maintenance of vital statistics, and the carrying out of periodic demographic surveys on comprehensive lines are necessary; and appropriate machinery should be devised for the purpose. (Ibid. p 147-149)

The sub-committee on labour, which was chaired by N.M. Joshi adopted the following resolutions pertaining to health:

a. In view of the specially technical nature of the problems of health and safety, a special committee should be appointed to make detailed investigations and recommendations for improving provisions for the health, safety and conditions governing night work, in all regulated undertakings.
b. A wage fixing machinery should be established early in all provinces, in order to secure for the workers a living wage, fix minimum wages, consider other questions relating to wages and obtain for them a decent standard of life, health and comfort.
c. Maternity benefit legislation should be undertaken on the general lines laid down by the Geneva Convention of 1919, in regard to the period before and after child birth, and payment being made out of a special public fund.
d. The system of compulsory and contributory social insurance for industrial workers should be established directly under the control of the state, to cover the risks of sickness and invalidity other than those covered by the Workmen's Compensation Act. Schemes for providing alternative employment to those involuntarily unemployed, old age pensions and survivors' pensions and social insurance to cover risks of sickness and invalidity for all, should be established directly under the State. These schemes should be extended by stages, priority being given to particular classes of workers, with due regard to the relative urgency of their needs, facility of application, and to the ability of the community to provide for them. (Ibid. p 153-157)

The resolutions of the National Planning Committee did not get implemented because in 1943, the Government of India (Central Government of British India Provinces) announced the appointment of the Health Survey and Development Committee chaired by Sir Joseph Bhore. The terms of reference of this committee was to survey the health conditions and health organization of the country and make recommendations for future development. (Duggal, 2001) Thus, the sub-committee on National Health was overshadowed by the Bhore Committee. However, the NPC laid down several significant recommendations, such as the introduction of the frontline health worker, social insurance that includes health-related benefits, raising the age at marriage, maternity benefit legislation and compulsory and contributory social insurance for industrial workers. Although the recommendations of the NPC did not get implemented, the recommendations related to health remain one of the earliest efforts to organize a universal system of health care that is affordable and accessible. Moreover, by having recommendations on health in the sub-committees on women, labour and population, the Committee asserted the need to look at health as requiring multi-sectoral effort. Also, the Committee was clear about the need for socio-economic changes to improve the health of the people.

Chapter 4

The trajectory of collective action post Independence

This chapter continues the exercise of mapping the trajectory of collective action in health. It details three movements, i.e., the community health movement, which went on to inspire a phase of issue-based campaigns, the women's movement and the People's Health Movement.

The political context for the emergence of community health movement and women's movement

The political context for the emergence of the community health movement and the women's movement is the same with some issues and developments exclusive to both. Both these movements emerged in the 1970s. In this section, the conditions common to the emergence of both movements are laid out.

The roots of the movement groups that existed post-Independence can be traced to the Gandhian, socialist, communist and social reform movements of the nationalist movement. These were groups that were party-independent yet political. They were political but not involved in electoral party politics. After Independence, it was the liberal, modernist English-educated elite that dominated all areas, be it politics, economics or society and these movement groups were pushed to the periphery (Sheth and Sethi 1991 cited in Sheth 2004). However, within three decades of Independence, new social and political spaces opened up for them as well as for several new groups of social activists. This became possible, ironically, with the decline of institutional politics, which began in the late 1960s.

Decline of institutional politics: By the late '60s and '70s, as has been mentioned earlier in the study, the decline of institutional politics brought the Nehruvian era to an end. Institutional politics refers to the conventional mainstream politics of legislatures, elections, political parties and trade unions. Political parties failed to convert the

economic demands of the poor and the deprived into effective political demands. Instead, some of them took to ethnicizing and communalizing economic issues for electoral gains. The parties also lost their 'movement' character because the process of including the marginalized into the mainstream of Indian politics halted. The political parties only approached them for votes before elections. Thus, political parties increasingly became just electoral machines. The trade unions failed to expand their activities in the growing informal and unorganized sector of the economy. Trade unions' incomes grew with the frequently raised membership fees and the union leadership got used to a cushy lifestyle and the political parties to which they were affiliated did not have any reason to complain. The legislatures also reflected this change in the wider politics. The Parliament became a puppet in the hands of the Executive, with the ruling party not leaving any space for debates on any issues. As a result, the Executive became the most powerful branch of governance and the judiciary a final arbiter of all political disputes. 'The political discourse began to be increasingly informed by narrow constitutionalist positions held by the executive and often endorsed by the law courts rather than being informed by issues emerging from democratic politics. The Indian Constitution which was held not only as an instrument of governance but also as an agenda for social transformation, became a document sanitized from the flesh and blood of social and political movements which enriched democratic politics' (Rana 2001).

Thus, within two decades, the failure of planning became evident. The strategy of the Bombay Plan in any case supported private accumulation of capital by public financing. The colonial legacy of rural-urban divide in planning continued, social development got residual funding and was thus neglected. As mentioned in the introductory chapter of this dissertation, the objective of poverty alleviation could not be achieved. An agricultural crisis, drought in Bihar, an economic recession and wars with China and Pakistan all led to the breakdown of the state. There was disillusionment with Nehruvian policies of development, regional and sectoral inequalities had grown, and there were no reductions in inequalities of wealth, health or consumption in the course of two decades of Independence (Ray and Katzenstein 2005).

Within a few years after Nehru's death in 1964, the Congress only won the parliamentary elections by a bare majority. The Communist Party of India, which also aimed for poverty alleviation, split twice, in 1964 and 1969, thus weakening the voices demanding poverty alleviation. Under Indira Gandhi, the Congress party became personalistic. By the 1970s, poverty had increased sharply (Ibid.).

All this gave rise to several mass-based movements of protests. The issues of protests varied from price rise to corruption. Massive rebellion of the rural poor swept the country. This period was characterized not only by the turmoil in India but also in the international sphere in the developed countries, the post-war boom of the economy had ended and radical students and working masses had come out into the streets forcing numerous changes in the world[17].

In 1970, in Dhulia district in Maharashtra, following a shootout between landlords and *bhil advisasi*s (tribals), and the ineffective class cooperation policies of the Sarvodaya[18], many young volunteers left to help the *adivasis* set up the Shramik Sanghatana. This organization took a more militant approach, initiated a landgrab, demanded minimum wages and held *shibir*s or camps for the landless (Gandhi and Shah 1991).

Within the Left also, a militant strand emerged, the Naxalites, which criticized the way in which the government implemented the land reform programme. Radical Maoist students organized armed struggles of tribals and peasants in Naxalbari and Debra Gopalibravur areas in Bengal, Muzaffarpur in Bihar, Srikakulam in AP and Kerala between 1967 and 1970 (Ibid.).

The economic and social crisis deepened. Every section of society was in turmoil. In Gujarat, in 1973, students who had up until then seemed apolitical agitated against

[17] Mention has been made earlier in the Introduction (Ch.1) to this study of the movements of the Sixties.
[18] Sarvodaya (*uplift of all*) was Gandhiji's philosophy and a programme of upliftment of the rural population by the sharing of resources, education, rural industry (mainly spinning) and the improvement of the status of untouchables. In 1951, the central tenet of the Sarvodaya movement was the concept of *Bhoodaan*. In 1952, it was supplemented by the concept of *Gramdaan*. Two of the most charismatic leaders of the Sarvodaya movement and ardent followers of Gandhiji were Vinoba Bhave and Jayprakash Narayan.

inflation and forced the resignation of the State government. Inspired by their success, Bihari students invited Sarvodaya leader Jayprakash Narayan to launch an anti-price rise and anti-corruption movement in 1974. Political parties such as the Socialists, communists, the right wing, Jan Sangh and smaller regional parties like the Lal Nishan Party and the Peasants and Workers Party claimed massive participation of peasants, landless and workers in their land grab campaigns, price agitations and strikes (Ibid.).

The unrest, confusion and migrations caused by drought and famine had, in 1969, added momentum to the mass struggles. In this period, alliances between political parties and trade union alliances took place. The Bihar bandh was supported by 400 trade unions. Twenty to thirty thousand people attended the Lal Morcha in 1974 in Bombay, which was organized by a front of Left parties and unions. In Gujarat, students found themselves being supported by peasants and later, Sarvodaya members. 2,00,000 railway employees belonging to different unions came together under the National Committee for Railwaymen's Struggle in 1975 (Ibid.).

In 1975, under siege from grassroots movements all over the country and other political developments, Indira Gandhi announced the imposition of Emergency. A number of senior political leaders, political activists and leaders of grassroots NGOs were imprisoned (Ray and Katzenstein 2005). The protest movements, however, acquired a big momentum in mid-1970s, the largest and politically most high-intensity movement among them being the one led by Jayaprakash Narayan (popularly known as the JP movement).

Thus, the movement groups of the past found new social and political spaces in the 1970s. The late 1970s and early 1980s also saw the rise of new organizational forms, namely Non-Party Political Formations (NPPFs) and non-governmental organizations (NGOs). The issues raised were political but they maintained distance from party politics and established a relatively autonomous identity (Monteiro and Lingam 1998).

The anti-emergency movements gave rise, especially in the period between the mid-1970s and 1980s, to several 'micro-movements' (Sangvai 2007). The issues and constituencies espoused by these 'micro-movements' were those that had been neglected by the state. These included workers from the unorganized sector, women, rural areas etc. These micro-movements were led by young men and women, quite a few of whom left their professional careers to work towards these causes. These were neither political parties nor pressure groups, but civil associational groups who took up political struggles that were articulated by the affected people themselves. 'The key concept they worked with was democratising development through empowerment of the people' (Sethi 1984 cited in Sheth 2004). The issues were not only proper implementation of programmes or distributive justice, but about the crisis of development itself. These micro-movements questioned the model of development and debated at whose and what cost development was taking place. Some examples of these micro movements are the Chhattisgarh Mukti Morcha for the rights of mine workers, Girni Kamgar Sangharsha Samiti, in Mumbai to save the livelihood and housing rights of textile mill employees; the National Fishworkers' Forum upholding the rights of over eight million fishworkers and against big Indian and multinational trawler owners, the Kanoria Jute Mill workers' struggle in Kolkata combining agitation and constructive work in the context of an anti-capitalist, anti-imperialistic politics, the Mazdoor Kisan Shakti Sangathan (MKSS) in Rajasthan, raising the issues of displacement, environmental and economic destruction (Sangvai 2007).

4.1 Community health movement and issue-based campaigns

In the 1950s and 1960s, the health sector in India focused on how to manage epidemics. Mass campaigns with a technocentric approach were launched against malaria, smallpox, tuberculosis, leprosy, filaria, trachoma and cholera. These were vertical programmes and cadres of workers were trained to run these (Banerji 1985 cited in Duggal 2001). The policy of having mass campaigns was in continuation of the policy of colonialists according to which health could be looked after if the germs causing disease were eradicated. The underlying cause of disease, i.e. inadequate nutrition, clothing, and housing, and the lack of a proper environment were ignored. The policy regarding

communicable diseases was dictated by imperialist powers and the policy framework, programme design, and financial commitments etc were decided by experts in international agencies (Duggal 2001).

India was the first country in the world to adopt a policy of reducing population growth through a government-sponsored family planning programme in 1951. In the first two Plans, the programme was mainly run through voluntary organizations, under the aegis of Family Planning Association of India (FPAI). By the Third Plan period, government agencies began to actively participate in it. Family planning even became an independent department in the Ministry of Health. The heavy emphasis on population control was a result of the influence and pressure of developed countries such as the USA (Ibid.)

During the first two Five-Year Plans, the basic structural framework of the public health care delivery system remained unchanged from what it was pre-Independence. Urban areas continued to get over three-fourth of the medical care resources whereas rural areas received "special attention" under the Community Development Program (CDP). The Mudaliar Committee set up in 1959 reported that basic health facilities were inavailable to half the population of the country and that the primary health centre (PHC) programme had not been given the importance it should have been given. Not only were the number of PHCs less, most of these were also understaffed, with large numbers being run by auxiliary nurse midwives (ANMs) or public health nurses in charge (Mudaliar 1961 cited in Duggal 2001). One of the reasons for this was that doctors were increasingly moving into private practice after having received training at public expense. The emphasis given to individual communicable diseases programme was given top priority in the first two Plans. However, due to lack of support to primary health centers, the gains could not be achieved (Batliwala 1978 cited in Duggal 2001). The rural areas had very little or no access to PHCs. The condition of the secondary and district hospitals was the same as that of the PHCs with the majority of the beds and various facilities located in urban areas.

The third Five-Year Plan launched in 1961 highlighted inadequacy of health care institutions, doctors and other personnel in rural areas as being the major shortcomings at the end of the second Five Year Plan. However, no steps were taken to increase auxiliary personnel whereas funding for medical education increased (Ibid.).

In 1966, the epidemiological trend in communicable diseases was noted to have reversed with a rise in the incidence of malaria (GOI 1982 cited in Duggal 2001). Family planning continued to remain an obsession. In the Fifth Plan, it was acknowledged that despite advances in terms of decline in infant mortality rate and rise in life expectancy, the number of medical institutions, functionaries, beds, health facilities etc., continued to be inadequate in the rural areas (Duggal 2001).

Thus, the model of development pursued by the state had affected the health sector too. As Jeffery (1988, p. 228) points out, one of the reasons attributed to this was the 'slavish adherence to models derived from the colonial period and based on structures copied from the West'. There began a critique of the 'professional model' of health services. Ivan Illich's book *Medical Nemesis: The Expropriation of Health* published in 1976 was such a pioneering critique. In addition, the success of the barefoot doctors of China also received attention for its community-based model. Thus, the community health movement envisioned deprofessionalised and demystified health care. This was an effort to look for alternatives for health care of the masses and there were several strands to this debate.

Ideology and characteristics of the community health movement

Community health activism was a meeting point for those who wanted to engage in social activism along with serving the immediate needs of the people. Thus, community health combined service with activism. Thus, this health work was not just medical relief provided by the professionals to people, but it was health work of professionals with the people. The following are some principles and characteristics of community health activism:

- This activism was highly disillusioned by the developmental model adopted by the government and at least initially did not believe that the government could fulfill the task of development on its own.

- While many of the individuals in these groups of NGOs[19] came from various political movements, they strived hard to establish non-party affiliated health care work. In fact, they often downplayed politics and affiliation in order to survive their activities in the rural areas. In many ways, this was useful, for that provided them a neutral space in the rural sociopolitical structure to negotiate contradictions and develop their health care work.

- Many of these NGOs disliked the concepts of philanthropy and welfare. One of the premises they worked on was that the community has the capacity to look after itself, provided skills are generated and support provided. Philanthropy and welfare make them dependent.

- Many of these NGOs embraced the community health approach. They saw the problems of health care delivery in the high level of bureaucratization and professionalisation of services. Thus, their motto was to demystify medical care and de-professionalise the work of health care providers. At another level, some of them hoped that such activities would integrate health care functions within the community and make it possible for people to look after themselves. Above all, it was believed that de-professionalisation would create a pressure on the professionals to reorient themselves.

In order to make health care available to rural masses, the above ideas were put into practice in an innovative way. The village level health workers were trained, newer and cheaper methods of tackling common problems were devised and innovations were introduced in the methods of delivering primary health care (Jesani 1998).

[19] A description of the kind of NGOs referred to in this dissertation in the context of collective action is discussed in Chapter 2, page 21.

Innovative projects like the Comprehensive Rural Health Project (1971), in Jamkhed, Maharashtra, the Mandwa Project (1972) and Banwasi Sewa Ashram in Sonbhadra district, Uttar Pradesh (1968) came to be implemented. There was a realization that "....health was not a matter of merely delivering medical services, it was closely bound to the poverty of the people, their lack of food. Gradually the programmes expanded to improving agriculture and economic backwardness through the granting of loans, setting up of night schools and women's groups" (Nair 1985 cited in Antia and Bhatia 1993). These projects looked at health in its socio-economic context and methodologically emphasized the development of village-level health workers who emerged as alternative paramedics in this period (Jesani 1998).

One of the most significant of these community health projects was the Comprehensive Rural Health Project in Jamkhed, Ahmednagar district, Maharashtra, started in 1971 by Dr Rajnikant Arole and Dr Mabelle Arole. Jamkhed is a drought prone area where people are primarily dependent on agriculture as marginal farmers or daily wage labourers. The nearest health facility was the district hospital, which was several kilometers away. The Aroles started their clinic in an old veterinary dispensary with staff accommodation and inpatient facilities provided by Jamkhed residents. They started by fulfilling the immediate and strongest need, i.e. providing curative care. Soon, they were able to organize the villagers to form clubs wherein discussions centered on agriculture, livestock development and suchlike. These later became the Health Committees where health issues started being discussed. In the nearby villages too, curative clinics began with facilities provided by the villagers. These were used as springboards to introduce preventive health activities. Village health workers (VHWs) were selected by the villagers from among themselves. These were women from poor families and backward castes. The VHWs underwent rigorous training in providing health services. This training was given entirely by hospital doctors and nurses. They also discussed with the people the role of water and sanitation, nutrition and immunization, and also identified the economic and social problems of the people. The CRHP Health System consisted of a three-tier system. The first tier consisted of the VHW and the village volunteers. The second tier consisted of a mobile health team consisting of a social worker, two

paramedical workers and a trained nurse. The third tier consisted of OPD and hospital services. No prescriptions were given and all requirements of drugs, injections, saline or blood were met right at the hospital. The family members of hospitalized patients stayed with the patients, helped in cleaning the ward, making beds etc. hospital costs were also reduced since the family members took over many of the nursing functions. Besides health activities, several economic activities such as provision of tube wells, soil and water conservation, afforestation, loans for income generating activities, training of veterinary workers and provision of veterinary services and building of housing units were also undertaken as part of the project. Meeting with bank officials regarding various loan schemes were also held. A notable improvement in the health status of the community was seen from 1971 to 1989. For instance, the birth rate (per 1000) declined from 40 in 1971 to 24 in 1989 and infant mortality rate (IMR) fell from 180 in 1971 to 25 in 1989. An alleviation in the status of women was also a key outcome of the project. The scope of the project thus encompassed not only health care but also socio-economic development. The most important tool of the project was the participation of the people in deciding about the programmes and their implementation (Arole 1993).

The success of the Jamkhed project was widely projected by WHO and UNICEF and it also inspired to a certain extent some proposals on the future of medical education in the Srivastava Committee Report 1975 (Jeffery 1988). The Srivastava Committee also recommended and advocated the community health approach which led to a community health workers' scheme launched in 1977. The Alma Ata declaration signed in 1978 embodied many of the ideas developed in the community health projects. While many of the experiences of community health projects were adopted in health policies, but tardily implemented, the most important contribution made by them was the idea and practice of deprofessionalised and demystified health care. They produced one of the best critiques of the profession-centered medical care model. The control exercised by the professionals, the vulnerability of people due to mystification of medical care perpetuated by them and above all, the over-medicalisation and iatrogenesis that accompanied the commercialized medical care system were highlighted (Jesani 1998). The sixth Five-Year Plan was to a great extent influenced by the Alma Ata declaration of Health For All by

2000 AD and the ICSSR - ICMR report 1981. The plan conceded that "there is a serious dissatisfaction with the existing model of medical and health services with its emphasis on hospitals, specialization and super specialization and highly trained doctors which is availed of mostly by the well to do classes. It is also realized that it is this model which is depriving the rural areas and the poor people of the benefits of good health and medical services" (Draft FYP VI, Vol. III, 1978, 250 cited in Duggal 2001).

There were a number of mass movements centered on the issues of health, environment and science. In Kerala, a unique mass-based movement called the Kerala Shastra Sahitya Parishad (KSSP) established in 1962 began towards the mid-seventies to take radical steps to bridge the ever-growing gap between science and society. It began as a forum of science writers with the limited objective of publishing science literature in Malayalam, the local language and popularizing science. However, it soon realized that if science had to reach the common people, this was not enough. KSSP became convinced that a privileged minority was monopolizing the benefits of science and technology and it resulted in their enrichment at the expense of the majority. It was with the objective of arming people with the tools of science and technology that in 1972, KSSP decided to become a People's Science Movement and adopted 'Science for Social Revolution' as its motto.

Inspired by the Kerala experience, the People's Science Movement in Maharashtra and Bharat Gyan Vigyan Samiti or All India People's Science Network aimed at creating a rational, scientific temper among people by demystifying science. These and many smaller groups also functioned as pressure and propaganda groups on the issues of environment and health.

Even as these groups worked hard and successfully at implementing basic health care in rural areas by community programmes, there was a more radical stream that critiqued the former of uncritically working within the confines of the existing health care system. 'Their attempts were seen as merely providing cosmetic changes and without challenging the unequal structural factors at local, national and international levels' (Nair 1985 cited

in Jesani 1998). The inability of the health system to effectively cater to the health problems during natural disasters like floods and droughts, endemic in the late seventies added to this questioning of the existing system.

In 1974, a coalition of doctors, health functionaries and concerned individuals came together to raise issues and problems related to health, mainly through conferences and newsletters. This was the Medico Friend Circle (MFC). The MFC group felt that the existing system of health care was not geared towards the needs of the majority of the people: the poor. It required fundamental changes. This would occur as a part of the total social transformation in the country since the medical system is only a part of the total system. Some of the demands of MFC were that medical and health care should be made available to everyone irrespective of her/his ability to pay, medical intervention and health care should be strictly guided by the needs of our people and not by commercial interests, the pattern of medical and health care should be adequately geared to the predominantly rural health concerns of India, the medical curriculum and training should be tailored to the needs of the vast majority of the people in India, the public health system should be sensitive and comprehensive and cater to all health-needs of the people, and that there should be active participation by the community in the planning and carrying out preventive and promotive measures. The MFC bulletin (first published in 1975) was the main medium through which experiences, ideas and information were communicated. It carried articles which usually represented varying points of view of our membership within the broad MFC perspective.

In addition, there were several grassroots and community organizations and activists who were quietly involved in training health workers, dispensing medicines at low prices, providing different health services and information, creating consciousness regarding health, working out alternatives etc.

The government's emphasis on family planning, the manufacturing policies of the pharmaceutical companies, industrial disasters, such as Bhopal, and more theoretical

issues such as the ideology of health care, its delivery systems and sexism in medicine came in for discussion.

Institutions like VHAI New Delhi and FRCH Bombay incorporated different perspectives in their research and dissemination of information on health. The Voluntary Health Association of India (VHAI) began in 1969 as the Coordinating Agency for Health Planning (CAHP) when 25 leaders of Christian hospitals across the country met to discuss the problem of delivering health care to millions of rural people. By 1974, VHAI emerged as a federation of State Voluntary Health Associations that was geared towards promoting the community health movement (Ray and Katzenstein 2005).

Foundation for Research in Community Health (FRCH), which was established in 1975 as a non-profit voluntary organization in the field of health care, carried out field studies and conceptual studies primarily in rural India to gain a better understanding of the factors, which affect health and health services.

Low Cost Standard Therapeutics (LOCOST) began to supply medicine in bulk at cost price to groups working in the area of health. This successful venture has shown that health care need not be dominated by the high profit making pharmaceutical companies and their policies on the manufacture and distribution of certain types of drugs. LOCOST is a public, non-profit charitable trust registered in Baroda. It was founded in 1983 and has been serving the urban and rural poor by making only rational, essential, quality drugs at the lowest possible prices. LOCOST is a response to the difficulty faced by those working in remote areas to access good quality medicines at affordable prices. It has been supplying drugs to over 100 civil society organizations since its inception.

The Drug Action Forum in Calcutta and the Delhi Science Forum in New Delhi, the Association for Consumer Action on Safety and Health in Bombay, the AIDAN etc. acted as vigilante groups wanting a uniform, rational drug policy in India. The health journal, *The Radical Journal of Health*, established in 1986 was launched as a platform

for a Marxist critique of health care systems, population and other related subjects (Gandhi and Shah 1991).

Issue-based campaigns

Activism in the field of health gained momentum around the late '70s coinciding with India signing the Alma Ata Declaration in 1978. The contribution of health activism was to demystify and de-professionalise the medical model of health care with focus on the poor; preventive rather than curative strategies; indigenization of health knowledge and health practices; and recognition of patients as consumers and not as beneficiaries. It is based on this ideology that health campaigns, which addressed issues ranging from consumer rights/patients' rights to women's health and status, emerged.

In the late 1980s, there was a shift in the investment patterns. The focus shifted away from primary health care, which was also due to increased focus on drugs and equipment industry and professionals' demand for the use of hi-tech medical care. Specific campaigns on drug prices, the campaign for rational drug policy, the campaigns against the misuse of medical technologies and so on, which were highly influenced by the works and ideas popularized by the community health activists, took off. Campaigns against ecological degradation, nuclear radiation, industrial accidents and initiatives for sanitation, conservation, revitalizing indigenous health knowledge and practices and building awareness on medical ethics also raised issues from the vantage point of people's health (Nadkarni et al 1998).

Some of the key campaigns of the 1980s are described below:

a. Essential drugs campaign

The essential drugs campaign gained momentum around the 1980s as a result of insufficient supply of essential drugs, an overabundance of non-essential drugs of disputable therapeutic value and the prevalence of rampant malpractices related to the manufacture and distribution of drugs.

In India, after Independence, drug production increased quite rapidly and dependence on foreign companies was reduced especially after the Indian Patent Act 1970. However, the progress in weeding out hazardous, irrational and ineffective drugs has been very slow. The Hathi Committee Report, which was submitted in 1975, recommended measures to reduce the irrationalities in drug production and use. It made a list of 117 'essential' drugs – a list which was shorter than the first model list of essential drugs prepared in 1978 by WHO. However, the government failed to take any steps to operationalise the recommendations of the Hathi Committee. The Committee had recommended that to begin with, 13 essential drugs should be made available only under generic names and that all new drugs should be registered only under generic names. However, German and US drug companies got stay orders from the High Court as regards their products and, hence, only five drugs were made generic. Thus, the Hathi Committee failed to make any impact on the production and use of irrational drugs. In 1979, a Drug Price Control Order was brought out by the government, but it was not accompanied by a compulsion on drug companies to produce a minimum quantum of essential and life saving drugs. As a result, there was an increase in production of not only less essential drugs but also of irrational drug combinations and that too at the expense of some essential drugs (Phadke 1998).

In the 1980s, there was a rise of drug action groups all over India. Health activists from various parts of the country met to discuss various issues including that of drugs and called for some form of co-ordinated action. The all-India seminar on 'The Drug Industry and the Indian People' in November 1981 organized by Delhi Science Forum brought together health activists and health professionals from different parts of the country. In July 1984, the All India Drug Action Network was formed, which till date coordinates various health, science and drug action groups from various parts of the country (Ibid.).

The essential drugs campaigns in India took the form of the campaign against irrational drugs and the campaign for a rational drug policy.

Campaign against irrational drugs

In May 1980, a sub-committee of the Drug Consultative Committee[20] (DCC) recommended a ban on 23 types of drugs on the grounds of being irrational or hazardous. This list was modified by Drug Technical Advisory Board[21] (DTAB). The Drugs Controller of India further modified this list in 1983, banning 21 categories of drugs. This final list did not contain eight important and very widely used categories of irrational drug combinations, which were in the original ban list prepared by the DCC. This list included mostly obsolete drugs or minor drugs which were any way not being used extensively. However, even this ban was not implemented (Ibid.)

In 1983, Vincent Pannikulangara, an advocate, filed a writ petition in the Supreme Court demanding a ban on the drugs identified by DCC in 1980. Pannikulangara's petition did not yield the desired result as the Supreme Court ruled that the banning of drugs was a policy decision that the government needed to make. However, following this, there was further pressure on the government to ban more irrational and hazardous drugs. Four more categories were banned in 1984 and three in 1988, including high dose Estrogen Progesterone combinations. By April 1992, a total of 45 categories of drugs had been banned by various Gazette notifications. However, it was not publicized well and many of the banned drugs continued to be sold. Also, many of the drugs that needed to be banned remained untouched (Ibid.)

In November 1993, another drug action group, Drug Action Forum, Karnataka, filed a public interest litigation along with AIDAN in the Supreme Court with the complaint that the DTAB was moving very slowly in the matter of weeding out irrational drugs. A short list of drugs that needed to be urgently banned was submitted. The demand that all drugs not recommended by the standard medical textbooks be banned was also raised. These

[20] The DCC is a statutory body of the Parliament, which advises the Drugs Controller of India on drug policy issues.

[21] The DTAB is a statutory body of experts, which advises on technical matters arising out of the administration of the Drugs and Cosmetics Act 1940. The DTAB comprises mostly government bureaucrats – Director-General of Health Services, the Drugs Controller of India, two state Drug Controllers, directors of various government Drug Research Laboratories and other government officials. In addition, there is one representative each of the drug industry, Medical and Pharmacy Council, IMA and ICMR.

efforts resulted in the banning of a total of 11 categories of irrational drugs widely used all over India (Ibid.)

Campaign for a rational drug policy

In order to understand the objectives of the campaign for a rational drug policy, it is important to understand the problems with the past and present drug policies of the government. The first Drug Policy was announced in 1978, the year of the Alma Ata declaration. Drug companies lobbied against this policy despite making profits. In December 1986, the government announced the New Drug Policy in which 82 drugs were de-licensed in 1984 and 12 more in 1985. This means that the government gave up control in the production of these 94 drugs, most of which are essential drugs. Delicensing means freedom for multinational companies (MNCs) to acquire monopoly in the market and their entry into the marketing of these drugs. These MNCs also import drugs more freely because of the liberalization in imports. They import much more than they produce in India. This reduces self reliance and increases the deficit in foreign trade. Price controls were loosened. Instead of three categories, only two were to be under price control – Category I including 27 drugs used in national health programmes and Category II including 139 essential drugs. Thus, the number of drugs under price control came down from 343 as per the 1977 Drug Price Control Order to 166. The mark-up[22] for Categories I and II were also increased. In addition, the government announced that price control would only be for drugs with an annual turnover of more than Rs 4 crore and for only those drugs in case of which there is monopoly or oligopoly. This reduced the basket of price-controlled drugs from 166 to 70. The mark-up for all these 70 drugs was uniformly set at 100 per cent, which resulted in another round of price rise (Ibid.).

For companies to be registered under the Monopolies Restrictive Trade Practices Act (MRTP Act), the limit was increased to an annual sales turnover of Rs 1,000 million. As a result, none of the pharmaceutical corporations came under this Act. Moreover, due to loopholes and liberal interpretation of the Foreign Exchange and Regulation Act (FERA), all foreign companies except two, are now legally Indian companies but their control

[22] Maximum Allowable Post Manufacturing Expense

remains foreign. Not only this, the margin for the wholesaler and the retailer has been increased to 10 per cent and 20 per cent, respectively, in 1996 as compared with 8 and 11 per cent, respectively, in 1994 (Ibid.).

A massive drug campaign was initiated with the leadership of the All India Drug Action Network (AIDAN) to formulate a rational drug policy. It suggested modifications that included the setting up of a National Drugs and Therapeutics Authority; elimination of irrational and hazardous drugs; an independent study to assess the production cost, profitability and validity of the drug industry and the purchasing power of people; a systematic effort to identify the genuine drug needs in the country; and to strengthen drug control procedures (VHAI 1990 cited in Nadkarni et al 1998). This campaign for rational drug policy was triggered by many health and consumer organizations across the country, such as Aarogya Dakshata Mandal, Kerala Shastra Sahitya Parishad, MFC and Media Collective. This resulted in radical modifications of the New Drug Policy of 1986. The revised Drug Policy announced in September 1994 included many of the suggestions made by the health and consumer activists. Yet, it was argued that the provisions in the revised policy, as well as the Drugs Price Control Order of 1995 defeated the purpose of the drug consumer lobby because they would increase the drug prices substantially (Rane 1995 cited in Nadkarni et al 1998).

During both campaigns, the methods adopted by the health and consumer activists focused on public awareness regarding the harmful nature of many marketed drugs, lack of ethics in drug manufacture and inadequacy of government regulations. The methods ranged from organizing *morchas*, street plays, distributing pamphlets, to publishing articles in newspapers and journals. Substantial efforts were undertaken to win the support of professionals, experts, trade unions and politicians, including senior parliamentarians (Ibid.).

b. Campaign for patients' rights

With increasing commercialization of the medical health system, there is a rise in the tendency to exploit, or in other words 'to make profit from', the doctor-patient relationship.

Breach of code of medical ethics

Unethical practices and complete breach of the code of ethics by medical professionals have been documented. For instance, receiving non-practising allowance as a government servant, and continuing to indulge in private practice; treating hospital cases in private clinics and thus overcharging patients (Dang 1996 cited in Nadkarni et al 1998); advertising one's services (Ambulgekar 1996 cited in Nadkarni et al 1998) 'cut practice', that is paying a commission as a percentage of the expenses incurred by the patient for treatment (Kale 1996 cited in Nadkarni et al 1998); unnecessary hospitalization, tests, drugs, surgery; complicity on the part of doctors to prescribe 'reformulated and repackaged drugs' and receive 'perks' ranging from free samples to expensive dinners and lunches to personal gifts (Nadkarni et al 1998).

In order to protect the patient, several voluntary organizations have organized campaigns against unethical practices, medical negligence as well as the functioning of the Medical Councils and taken recourse to the Consumer Protection Act (CPA) 1986 (Ibid.).

Campaign Against Unethical Practices and Patient's Rights

The biases in the medical system and health care services against the weak have been recognized in the context of the right to health. It has been acknowledged that doctors, and the entire health care system are accountable to all patients. A Supreme Court judgment of November 13, 1995, was passed in favour of the inclusion of the medical services for payment under the Consumer Protection Act. The implementation of the Act for seeking protection for patients as consumers was strongly opposed by the medical profession. This was a landmark judgment as it recognized the change in the status of the medical profession from a 'service' to a transaction. It facilitated the functioning of alternative grievance mechanisms that were speedier than the Medical Councils and the

Judiciary (as defined by the Civil and Criminal Court systems). It increased the accountability of the medical profession not just to itself but to the civil society, defined as it is by the increasing market economy (Nadkarni et al 1998).

The CPA provides redressal beyond the purview of the doctor-provider relationship. It also provides relief to consumers utilising allied systems in the private sector like pharmaceuticals, blood banks, ambulance services, hospital industry and the medical equipment manufacturers (Ibid.).

c. Campaign for promotion of breastfeeding

The decline in breastfeeding became a concern in the 1970s both at the global as well as the national level. This trend was noticed in urban as well as rural areas. Myths, ignorance, increased urbanization processes that do not accommodate the needs of feeding mothers, increased hospital deliveries where medical personnel do not actively promote/encourage breastfeeding are some reasons that were identified for this decline. In addition, the aggressive marketing of breastmilk substitutes by commercial interests and promotion of breastmilk substitutes by medical personnel has seriously challenged traditional breastfeeding practices. The seventies witnessed global campaigning by citizens' groups, for controls on advertising and marketing of baby foods. In India, active movements were started by voluntary and consumer groups, including the Consumer Guidance Society of India and the VHAI. These groups came together in a network called the National Alliance for the Nutrition of Infants. Pressured by these groups, in 1983, the Govt of India adopted the International Code of Marketing for Infant Formulas, which had been earlier passed by the WHO in 1981, on the persuasion of the International Organisation of Consumers Unions and the UNICEF. The Breastfeeding Promotion Network of India (BPNI) was formed in 1991. It is primarily involved in training medical personnel, observing the World Breastfeeding Week with the World Alliance for Breastfeeding Action, publications, development of training materials, research, video production, monitoring and implementation of the 1992 Act and the introduction of topics on breastfeeding in medical schools. In 1992, the Infant Milk Substitutes, Feeding Bottles and Infant Foods (Regulation of Production, Supply and

Distribution) Act was passed by the Govt of India. It prohibits distribution of free samples to mothers, advertising to the public, promotion in health care facilities, distribution of gifts or samples to health workers and various other forms of promotion. Manufacturers are now adapting their promotion strategies in several ways to evade action under the law. It is significant to note that the Govt of India authorized four voluntary organizations to monitor the Act, namely, the Central Social Welfare Board, the Indian Council for Child Welfare, the Association for Consumers Action on Safety and Health and the BPNI. Another initiative of the international community, namely the Innocenti Declaration, 1992, has had a significant bearing on the direction of the campaign in India. The Declaration gave the concept of Baby Friendly Hospital and recommended the adoption of various strategies to protect, support and promote breastfeeding. India was one of its first supporters of the Baby Friendly Hospital Initiative (BFHI). In 1993, it set up a National Task Force for the BFHI with representatives from voluntary and other professional bodies (Nadkarni et al 1998).

4.2 The Women's Movement in India

The socio-political context in which the third phase of the women's movement emerged has been detailed in the beginning of the chapter.

Phases and ideology

The women's movement is divided into three phases. The first phase emerged as a part of the social reform movement in the 1800s. The broader agenda was to bring about change in a society that was ridden by differences on the basis of caste, gender and other kinds of inequalities. Issues relating to women were tackled within this broader agenda. Opinion was mobilized against oppressive traditional practices by Arya Samaj and Brahmo Samaj, the Hindu revivalist and reformist organizations, and by individuals such as Jyotiba Phule, Raja Ram Mohan Roy, Veeresalingam, and Ishwar Chandra Vidyasagar. Social activists sought reform through legislation. Sati was banned by law in 1829 following Raja Ram Mohan Roy's campaign. The Widow Remarriage Act of 1856 came into being after the cause of widows was widely advocated by Vidyasagar. Education was also seen

as a panacea for improving the status of women and there emerged a number of women doctors, social workers, teachers and scholars (Khullar 2005).

The second phase of the women's movement dates from 1930s to 1947 with the entry of women into the nationalist struggle for freedom. Mahatma Gandhi called women to join the nationalist struggle for independence. There was mass participation of women in the Non-cooperation and Civil Disobedience movements. Women now demanded adult franchise and gender equality as a Constitutional Right. The movement became political with the shift from social reform to equal rights approach (Shah and Gandhi 1991).

In the 25-30 years following Independence in 1947, a few attempts were made to improve the status of women, key among these being the constitutional guarantees for equality. The third and contemporary phase of the women's movement emerged in the 1970s. The United Nations' mandate given to governments of all member countries to critically assess the status of their women led to a major exercise in action research, carried out by the specially appointed Committee on Status of Women in India that included activists, academics and members of Parliament. The report titled *Towards Equality*, which was published in 1975, was a major eye-opener and highlighted the stark inequalities of gender evident in imbalanced sex ratios, major differentials in male-female mortality, discriminatory legal frameworks and practices, economic practices that did not recognize the contribution of women, educational system inaccessible to women etc. (Khullar 2005) This was a major factor that led to the third wave of the movement. In addition, in the aforementioned alternative development activities, mass struggles and agitations, middle class and working class women participated in great numbers and with militancy. The leadership, circumstances and manner of involvement of women was mainly initiated by men and political parties; nonetheless, it helped women become aware of their militancy and collective strength (Omvedt 1980 cited in Shah and Gandhi 1991).

The women's movement is a movement that embraces several ideologies, from liberal feminism to socialist feminism to radical feminism. The ideological strands in the movement are as varied as are the issues and the strategies.

Health initiatives

Health of women became a major issue in the third phase of the women's movement. This dissertation too shall focus on the third phase only. In this dissertation, the women's movement refers to the third phase of the women's movement unless specified otherwise.

The large body of information and understanding of the neglect of women's health has translated into health campaigns. On its part, the government has largely concentrated on women's reproductive capacities while women's groups and health groups have mainly reacted to or opposed and criticized state programmes.

Campaign against sex determination & sex pre-selection tests

The debate on the issues of misuse of medical technologies that aided sex determination or sex pre-selection began around 1983, when a series of investigative reports and research findings revealed the astronomically high number of female foetuses that were aborted following amniocentesis. Medical technologies like amniocentesis[23], chorionic villi biopsy[24] and ultrasonography[25] were devised for the detection of genetic diseases or to assist in delivery and not for sex determination (Ibid.).

Such campaigns, which originated in Mumbai, demanded a ban on all tests which lead to the selective abortion of female foetuses. They were led by activists belonging to the

[23] Aminiocentesis consists of the removal of about 15 cc of aminiotic fluid from inside the amniotic sac, which covers the foetus, for testing. The test is actually meant to detect over 70 genetic diseases such as Ducheen muscular dystrophy, mongolism, defects of the neural tube, RH incompatibility etc. Some disorders like haemophilia can be detected by determining the sex of the foetus. The mother faces the risks of infection and spontaneous abortion while the foetus could have hip dislocation and/or respiratory complications.

[24] Chorionic vill biopsy involves the removal of elongated cells (villi) of the chorion (tissue surrounding the foetus) through the cervix, which is then tested by DNA probes or by sex chromatin studies. It is a relatively painless and more accurate technique carried out between the 6th and 13th week of pregnancy.

[25] Ultrasonography makes use of inaudible sound waves to obtain a visual image of the foetus on the screen. Sex determination in this case can only be done at an advanced stage of the pregnancy.

Forum against Sex Determination and Sex Pre-selection: an umbrella body of several organizations of women, doctors, health activists, democratic rights activists and a research institution. These groups organized *morchas*, demonstrations, *dharnas*, exhibitions, seminars and workshops and drew people's attention to the rampant misuse of medical techniques through available media. As a result of this active campaigning, the Maharashtra Regulation of Use of Prenatal Diagnostic Techniques Act, 1988, was introduced by the Government of Maharashtra (Jesani 1988). Almost six years later, the Pre-natal Diagnostic Techniques (Regulation and Prevention of Misuse) Act was passed by the Central Government in 1994 (Ibid.).

Campaign against injectable contraceptives

In the 1970s, there was a raging controversy in the West about the injectable contraceptive Depo Provera and its carcinogenic effects. The USA, its country of origin, disapproved of the contraceptive and Britain permitted it only under a host of restrictions. In India, the ICMR shelved its plans of experimental trials but the contraceptive itself was not banned. A lack of clear government notification left the door open for ambiguity and litigation. Women's Centre (a women's organization) and Medico Friend Circle initiated legal proceedings against the licence to import the same (Ibid.).

However, the controversy around Depo-Provera was soon overtaken by one around Net-en[26]. Net-en was withdrawn from the market in 1971 after breast and pituitary nodules were found in experimental rats. Schering, the research organization, however reintroduced Net-en claiming that findings on rats were not applicable to humans. Clinical trials of the contraceptive were conducted on women in India by ICMR in the early 1980s without informing them about the risks of breast and cervical cancers, changes in menstrual cycle, excessive bleeding and possible effects on the foetus of the pregnant woman. Women's groups, such as Stree Shakti Sanghatana (Hyderabad), Saheli (Delhi) and Chingari (Ahmedabad), along with doctors and journalists filed a writ petition in the Supreme Court against ICMR and the Government demanding a halt to

[26] Net-en, a product of the German company Schering AG, is a bi-monthly injection that inhibits the production of gonadotropin, a pituitary gland hormone which, in turn, prevents ovulation.

Net-en trials, full and complete information about the contraceptive and the appointment of a team to investigate various other issues. The campaign against Net-en, which was the first to focus on preventive action in the field of women and health, presented an opportunity to combine action against a specific target with a questioning of the government's family planning methods. This was also the first time that information and experiences from different countries were fed into a campaign, an indication of the possibility of women and health groups forging links across the world. Groups and organizations such as Committee Against Long Acting Hormonal Contraceptives (Bombay), Indian Women's Scientific Association, Medico Friend Circle, VHAI, FRCH joined in condemning hormone-based contraceptives and their unethical testing on women. At the international level, the Feminist International Network against New Reproductive Technology and Genetic Engineering conference in Bangladesh resolved in a declaration known as Declaration of Comilla 1989 to demand knowledge and access to safe contraception, which does not harm women's bodies, reject any coercion in the name of population control policies and a stop to the use of dangerous IUDs, unsafe injectables, hormonal implants such as Norplant and other hormonal contraceptives as well as anti-fertility vaccines (Ibid.).

The Estrogen-Progesterone drugs campaign

The High Dose Estrogen-Progesterone formulations were brought into the market in the 1950s as a treatment for missed periods, and by the 1970s, the use of the drug became popular in a variety of gynecological problems and pregnancy testing. It offered an easy alternative to the cumbersome process of performing a urine test for ascertaining pregnancy. Documented evidence proves harmful effects of the drugs resulting in an increase in abnormalities, delayed side effects, abortions, still births, congenital heart disease in the foetus. Children exposed to such drugs had defects of the heart, trachea, oesophagus, vertebral column and the anus and other defects like harelips, cleft palates etc. Despite all these contraindications, the misuse of this drug is rampant. It is easily available over the counter without any prescription and is used for delaying menstruation and checking of pregnancies (Ibid.).

In 1982, VHAI called a meeting in Pune, Maharashtra, which was attended by health professionals, journalists, academics, church social workers and individual women activists. **This was the first time that such a group had got together to discuss the necessity of an essential drug policy.** The issues before them were the high cost of drugs, information misuse and overuse of drugs like anti-diarrhoeal tablets, tonics, antibiotics, analgesics, misbranded drugs and misleading advertisements. One of the important outcomes of this meeting was the launch of a campaign against HDEP drugs. On International Women's Day, women's groups took up this issue as one of their demands. Following campaigning by women's groups and publication of articles and letters in newspapers, in 1982, an order was passed by the ICMR asking drug companies to print warnings for the consumer's information. However, health activists argued that warnings were not enough and that a complete ban on High Dose EP formulations was the effective measure against widespread misuse. An article in *Onlooker* written by R.S. Anant in 1988 and published from Madras on the "very high incidence of congenital anomalies consequent to the administration of High Dose EP combination to pregnant women" generated a great deal of debate and found an echo in the Parliament. A petition was filed in the Supreme Court against the continued use of harzardous drugs including High Dose EP formulations. As a consequence of this opposition, the Government, on the recommendation of ICMR, granted a total ban (Ibid.).

Following the total ban, some pharmaceutical companies challenged the ban in the High Courts of Calcutta and Bombay. A stay order was granted by the court till a public enquiry committee conducted meetings in Delhi, Madras, Calcutta, Bombay (from February to July 1987) in order to give its opinion. This was the first time in India that the public, the government and the judiciary were holding a debate on a drug and its effects. Health activists and women's groups saw this as a positive response to the cooperation between health, women and consumers groups and it led to the creation of the All India Drug Action Network (AIDAN) in July 1984. Following the hearings by activist groups and on the basis of ICMR recommendations, HDEP formulations were finally banned by the government. However, it was soon discovered that the gazette notification issued only referred to the HDEP combination in the form of tablets and not

for injections. The Association for Consumer Action on Safety and Health (ACASH), a consumer group, immediately tabled a petition demanding a fresh notification of the order (Ibid.).

The campaign soon spread to other organizations: in Delhi, the Janwadi Mahila Samiti organized seminars and discussions along with its student group Students' Federation of India (SFI) and the science group, Delhi Science Forum. The campaign has received a good response from the media, the public and activist drugs.

4.3 People's Health Movement

Political and economic context for emergence

The People's Health Movement (PHM) emerged in response to the threat by neo-liberal policies of globalization, liberalization and privatization. A global movement was found necessary to address global determinants of health, which have adverse effects on lives of people across countries. A brief history of how the neo-liberal policies affect health is given below.

'Neo-liberalism, in theory, is essentially about making trade between nations easier. It is about freer movement of goods, resources and enterprises in a bid to always find cheaper resources, to maximize profits and efficiency. To help accomplish this, neo-liberalism requires the removal of various controls deemed as barriers to free trade, such as tariffs, regulations , certain standards, laws, legislation and regulatory measures and restrictions on capital flows and investment. The goal is to be able to allow the free market to naturally balance itself via the pressures of market demands; a key to successful market-based economies. The freedom is from the state, or government. Neo-liberalism also means reducing public expenditure for social services, such as health and education, by the government, deregulation to allow market forces to act as a self-regulating mechanism, privatization of public enterprise (things from water to even the Internet) and changing perceptions of public and community good to individualism and individual responsibility' (Martinez and Garcia 2004).

The neo-liberal political and economic policies are made by a small group of powerful governments and by international institutions such as the World Bank, the International Monetary Fund and the World Trade Organisation. These policies, together with the unregulated activities of transnational corporations, have had severe effects on the lives and livelihoods, health and well-being of people in both North and South. Following these reforms, which have taken place in phases in several parts of the world (Asia, Africa, Latin America), people's health, their access to health care and other social services has been adversely affected. Despite unprecedented levels of wealth in the world, poverty and hunger are increasing. The gap between rich and poor nations has widened, as have inequalities within countries, between social classes, between men and women and between young and old. A large proportion of the world's population lacks access to food, education, safe drinking water, sanitation, shelter, land and its resources, employment and health care services. These inequities and inequalities are affecting both the occurrence of disease and access to health care. The poor is disproportionately affected. Health services have become less accessible, more unevenly distributed and more inappropriate. Privatisation threatens to undermine access to health care still further and to compromise the essential principle of equity. There is a persistence of preventable ill health, resurgence of diseases such as tuberculosis and malaria, and emergence and spread of new diseases such as HIV/AIDS.

The Structural Adjustment Programme in 1985 led to the introduction of health sector reforms in India. The reform of the public services is premised on the view that the public sector is unable to act as sole provider of services within a context of economic recession. Advocates of this view claim that owing to the poor economic performance of the public sector, greater competition in the provision of services is the only means of providing better quality care and improving the efficiency of public services (World Bank 1987, 1993 cited in Sen 2004). The decline in the usage of public health care provisions has been held as the main indictor of growing consumer dissatisfaction with public services, which continues to be referred to as crucial in the argument for the privatization of health services (Mills 1993 cited in Sen 2004). The World Bank's World Development Report of 1993 titled '*Investing in Health*' advocated that the state or the public sector should

provide only essential services such as 'clinical packages' for the needy whilst the tertiary sector opens up to full global competition. The main aspects of the IMF-World Bank inspired reforms were cuts in health sector investments, opening up of medical care to the private sector, introduction of user fees and private investments in public hospitals and purely techno-centric public health interventions.

The WTO conference in Seattle of 1999 drew public opinion's attention worldwide towards the sustained challenge that broad coalitions were mounting against neo-liberal policies. (Della Porta and Diani, 1999, 2006). The World Social Forum (WSF) developed as a response to the growing international movement against neo-liberal globalisation. The forum was conceived as an open meeting space for democratic discussion of ideas, the formulation of proposals, the free exchange of experiences and the articulation of civil society organizations and movements that are opposed to domination by capital. The first edition of the WSF was organised in Porto Alegre, Brazil, in 2001, marking an opposition to the World Economic Forum[27] held in Davos. This Forum made evident the capacity of mobilisation that civil society has when faced with a new methodology, characterized by a guarantee of diversity and co-responsibility in the process of constructing the event. The People's Health Movement emerged around the same time, in the year 2000.

The movement: A background

The first global People's Health Assembly was held in Savar, Bangladesh, in December 2000, where the global People's Health Movement was launched and a global People's Charter for Health was adopted. In India too, in the same month, the first National Health Assembly (Jan Swasthya Sabha) was held in Kolkata after a year of extensive and intensive community mobilization at village, district and state levels across the country and the Indian People's Health Charter was adopted.

[27] The WEF has played a key role in shaping the ideas of those who promote and defend neo-liberal policies throughout the world.

The Jan Swasthya Abhiyan or PHM India was created as the India regional circle of the People's Health Movement. PHM is a growing coalition of people's organisations, civil society organisations, NGOs, social activists, health professionals, academicians and researchers that endorse both the Health Charters, Indian and global. There are 21 major national networks that constitute PHM India. The representatives of the networks form the National Coordination Committee and the National Working Group. The movement is organised through state-level and issue-based circles. The National Secretariat facilitates communication between members through advocacy and campaigns, a website and discussion group, media releases and publications and through the participation of PHM India in various conferences, policy dialogues and other events supported by PHM India volunteers all over the country.

Ideology, principles

The People's Health Movement is based on the principle that health is primarily determined by the political, economic, social and physical environment and should, along with equity and sustainable development, be a top priority in local, national and international policy-making. According to the PHM Charter, the principles of universal, comprehensive Primary Health Care, envisioned in the 1978 Alma Ata Declaration, should be the basis for formulating policies related to health. PHM promotes the primary health care approach, decentralized, integrated public health systems, with mechanisms for social control, community involvement in health decision making and action on poverty and the social determinants of health.

The PHM Charter also calls on the people of the world to support all attempts to implement the right to health, demand that governments and international organisations reformulate, implement and enforce policies and practices which respect the right to health, build broad-based popular movements to pressure governments to incorporate health and human rights into national constitutions and legislation and fight the exploitation of people's health needs for purposes of profit. The rights-based approach challenges the dominant global discourse of 'health care as a commodity' and 'safety nets for those left outside the existing packages of benefits' that result from health services

being increasingly marketized and from governments retreating from the provision of health care, limiting their role to supporting said 'safety nets' or other kinds of reduced public health services 'for the poor' (Shukla and Schuftan 2005). The right to health includes both the right to all the underlying determinants of health besides health care (such as water, food security, housing, sanitation, education, a safe and healthy working and living environment, etc.), and the right to health care (i.e., the right to the entire spectrum of preventive, curative and rehabilitative services plus health education and promotive activities carried out with the primary objective of improving health).

Health initiatives by PHM India

PHM India has been engaged in varied issues, such as critiquing the National Health Policy 2002 and calling for an increase in the budgetary allocations for health. It has also been instrumental in steering the focus of National Rural Health Mission (NRHM), which was launched in 2005, to decentralized, integrated, comprehensive primary health care and strengthening community participation and the role of local bodies through institutional mechanisms in the Mission. For this purpose, PHM India launched a People's Rural Health Watch, which has initiated work in eight states to follow implementation of the NRHM at community level. People's Rural Health Watch collects information on, assesses and analyzes the activities under NRHM, both at the state and national levels, communicates and disseminates all such documentation and information through reports and other means and provides feedback for improvement.

PHM India has collaborated with the National Human Rights Commission to conduct a series of public hearings in which cases of violation of citizens' health rights were documented. Based on this, a National Action Plan has also been developed. JSA has also taken leadership in advocacy with WHO for the primary health care approach. The WHO Commission on Social Determinants of Health was also launched following the demand by PHM for a Commission on Poverty and Health.

PHM India has been engaged in formulating state health policies in Karnataka and Orissa and is actively campaigning for the implementation of these policies. In Chhattisgarh,

PHM India has engaged itself with the activities of the State Health Resource Center (SHRC), which is engaged in training community health workers called *mitanin*s. The SHRC works closely with the government Department of Health and also works in partnership with a number of NGOs in the districts towards strengthening the health system. Support is also provided to other states with poorer health indicators including Madhya Pradesh, Jharkhand and others. In Maharashtra, PHM India members are involved in research-based health work including public hearings, regulation of the private nursing homes and hospitals through legislative action and budgetary analysis.

PHM India is also involved in the Right to Food campaign. In response to the Public Interest Litigation filed by Peoples Union for Civil Liberties (PUCL) Rajasthan in the Supreme Court and Bharat Gyan Vigyan Samiti (BGVS), one of the member networks of PHM India began to look critically at the issue of mid-day meal schemes from February 2002.

PHM India is also advocating for the formulation of a National Pharmaceutical Policy that addresses the critical issue of universal access to essential medicines and of national self-reliance.

Besides 12 networks/federations working in health related areas, there is strong participation from the women's movement, science movement and the National Alliance of People's Movements. The growing Dalit and environment movements and trade unions participate at times during events, though this varies in different regions. The disability movement is marginally involved. In terms of geographic spread, PHM India is present in 22 states with varying levels of activity at district and sub-district levels. The strength of the coalition is its diversity, spread, experience and willingness to work together. There is a plurality of perspectives and approaches in the movement, which is both its strength and weakness.

The emergence of this movement goes to prove that collective action in health is gaining a transnational character. While in India and Bangladesh, there is a very strong building

of People's Health Movement, country-level PHMs are being created in Italy, Sri Lanka, Philippines, South Africa, Egypt, Palestine, Australia and many countries of Central and South America such as Ecuador, Guatemala, Argentina, etc.

This chapter threw light on the political and economic context of the emergence of the community health movement and the women's movement. It described these movements in detail along with spelling out the health initiatives undertaken by these. The last section focussed on the People's Health Movement, a movement that emerged in 2000. Its background, principles, initiatives and other details were dwelt upon.

Chapter 5

Towards an understanding of 'health movements'

Summary, discussion and conclusion

5.1 SUMMARY

5.1.1 Political context and collective action in health

The trajectory of collective action that has been mapped in this study is reflective of the fact that there is a deep relationship between health and politics and that it is possible to locate movements related to health within the sphere of the political context. As we look back at the trajectory of conflictual collective action, we find that health was one of the issues around which such action was organized which in turn were influenced by the political context. Two of the earliest occurrences of such collective action were the industrial workers' movement and the nationalist movement. Post-Independence, in the seventies, the community health movement that inspired a phase of issue-based campaigns is a case in point of collective action organized around health that was a direct result of political conditions. The seventies also saw the re-emergence of the women's movement, which was also influenced by political events, and the need for which emerged from a long-standing neglect of women's status by the state. The introduction of the structural reforms package and adoption of neo-liberal policies provided the momentum for the growth of the People's Health Movement in the 2000 which organized to protest against the growing inequities in health and to reassert the need for primary health care, a promise that the state has steadfastly failed to keep.

The industrial workers' movement was an outcome of the exploitative conditions produced by the Industrial Revolution, which adversely affected the health of the people vis-à-vis the working conditions and other determinants of health. The economic transformation that took place – from agriculture to industry – led to the emergence of the capitalist class and the working class. The profit motive led to the exploitation of workers, not only economic but also physical. Trade unionism can be traced to the international call for solidarity among workers by the communist ideology. This was a

direct result of the growing exploitation of the worker class all over the industrializing world.

Several factors led to the birth of the trade union movement immediately after the First World War. While prices and profits went up, wages remained the same. Workers who had joined the factories after the war brought with them newfound knowledge of trade unionism and communism from their counterparts in other parts of the world. The Russian Revolution (1917-1919) and the Communist Party of India that received instructions from Moscow influenced workers and introduced the idea into their minds that exploitation of labour could be stopped by political means. The formation of the All India Trade Union Organization and the International Labour Organization were factors that encouraged the trade union movement and strengthened it. The link between the nationalist movement and the trade union movement was formed when young industrial workers who had participated in the first Civil Disobedience Movement led by Mahatma Gandhi in 1920 joined the trade union movement. All this served as the political background of the trade union movement. Thus, the trade union movement clearly began against the backdrop of these political events.

As Qadeer and Roy (1989) observe, 'workers' health is strongly affected by decisions about the choice of product, the choice of technology and the choice of work force to operate the technology on the one hand, and on the other, by social processes like welfare movements and legal interventions, all ultimately linked to the nature of social stratification and the demands of profit motive and private ownership'. The workers' struggle indeed reveals that health is a determinant of social, economic and political factors.

The nationalist movement began as a social reform movement in the 1800s. The Congress was formed in 1885 as the voice of the urban middle class who were secular, liberal and modern. It began to lead the movement from the early 1900s. While initially moderate methods were employed, the approach soon became radical, especially with the entry of Mahatma Gandhi in 1915 when it also took on a mass character. The desire for a

comprehensive plan for the economic development of an independent India led the Indian National Congress, the leaders of the nationalist movement, to come up with the NPC. Jawaharlal Nehru envisioned a mixed economy in this Plan. Although industrialization was the primary objective in the Plan, the issues of health, nutrition and general well-being found a place in the document. By including health aspects in the labour, population and women's sub-committees besides the health sub-committee, health came to be seen as multidimensional requiring multidimensional efforts.

Thus, the first efforts to design a pluralistic and people-centered model of health for the country began within the nationalist movement with the need for independence as the political context. In the words of the NPC Chairman's memorandum, dated 04 June 1939:

> "It is clear that drawing up of a comprehensive national Plan becomes merely an academic exercise, with no relation to reality, unless the Planning Authority, or those to whom it is responsible, are in a position to give effect to that Plan. If this authority is powerless or is circumscribed and restricted and its activities limited, it cannot plan ..."
>
> "... It follows, therefore, that the National Authority which plans must also have full power to give effect to its planning. An essential pre-requisite for planning is thus complete freedom and independence for the country and the removal of all outside control. This implies that the country possesses in itself full sovereign authority to take any measures, adopt any policies, and form any relations with other countries as may seem best to its governing authority in the interests of the country and its people ..."
>
> "... We have thus to draw up a full Plan which would apply to a free India and at the same time indicate what should be done now, and under present conditions, in the various departments of national activity."
>
> "The ideal of the Congress is the establishment of a free and democratic State in India. Such a full democratic State involves an egalitarian society, in which equal opportunities are provided for every member for self expression and self fulfillment, and an adequate minimum of a civilized standard of life is assured to

each member so as to make the attainment of this equal opportunity a reality. This should be the background or foundation of our Plan." (Report NPC 1946, pp 38-43)

The NPC laid down several significant recommendations, such as the introduction of the frontline health worker, social insurance that included health-related benefits, raising the age at marriage, maternity benefit legislation and compulsory and contributory social insurance for industrial workers. Although the recommendations of the NPC did not get implemented, the recommendations related to health remain one of the earliest efforts to organize a universal system of health care that is affordable and accessible. Moreover, by having recommendations on health in the sub-committees on women, labour and population, the Committee asserted the need to look at health as requiring multi-sectoral effort.

On the eve of Independence, a choice had to be made between the Bombay Plan, the People's Plan and the Gandhian Plan as a blueprint for the development of the nation. Inevitably, the Bombay Plan, which was the vision of techno-centric industrialists, was the choice that was made. The strategy of the Bombay Plan supported private accumulation of capital by public financing. The colonial legacy of rural-urban divide in planning continued, social development got residual funding and was, thus, neglected. Within two decades, the failure of planning became evident. The objective of poverty alleviation had not been achieved. An agricultural crisis, drought in Bihar, an economic recession and wars with China and Pakistan all added to the aggravating situation. There was disillusionment with Nehruvian policies of development, regional and sectoral inequalities had grown, and there were no reductions in inequalities of wealth, health or consumption in the course of two decades of Independence. It became clear that the Nehurivan model had got exhausted, and there was a upsurge of radicalism in India. The country was wrought with mass-based protests and movements on issues as varied as price rise and corruption. The emergence of the Naxalite movement and the students' movement was a part of this unrest. Different movement groups that had become submerged during the Nehruvian era rekindled. Although the radicalism began in the

political sphere, it soon spread among people from other backgrounds also. Young, educated people opted out of mainstream politics and went into the fields of alternative rural development, education, health, science popularisation. There were differing strands of ideologies among them – from Gandhians to Marxists to humanists. People without political backgrounds also joined the mass upsurge. The very idea of development was questioned in all spheres even as micro-movements emerged all over the country, such as Chhattisgarh Mukti Morcha for the rights of mine workers, Girni Kamgar Sangharsh Samiti, Mumbai, to save the livelihood and housing rights of textile mill employees and the National Fishworkers' Forum to uphold the rights of fishworkers against big Indian and multinational trawler owners.

In the 1950s and 1960s, the health sector in India focused on how to manage epidemics. Vertical programmes with a technocentric approach were launched against malaria, smallpox, tuberculosis, leprosy, filaria, trachoma and cholera. This policy was in continuation of the policy of colonialists according to which health could be looked after if the germs causing the disease were eradicated. The underlying cause of disease, i.e. inadequate nutrition, clothing, and housing, etc. were ignored. The policy was also dictated by imperialist powers and the policy framework, programme design, and financial commitments etc were decided by experts in international agencies. There was heavy emphasis on population control and the family planning programme started in 1951 became an independent department in the Ministry of Health by the Third Plan period (Duggal 2001).

During the first two Five-Year Plans, the basic structural framework of the public health care delivery system remained unchanged from what it was pre-Independence. Urban areas continued to get over three-fourth of the medical care resources. The Mudaliar Committee set up in 1959 reported that basic health facilities were inavailable to half the population of the country and that the primary health centre programme had not been given the importance it should have been given. Individual communicable diseases programme had been prioritized in the first two Plans. However, due to lack of support to primary health centers, the gains could not be achieved. The rural areas had very little or

no access to PHCs. The condition of the secondary and district hospitals was the same as that of the PHCs with the majority of the beds and various facilities located in urban areas. Despite the awareness regarding inadequacy of health care institutions, doctors and other personnel in rural areas, no remedial steps were taken. In 1966, the epidemiological trend in communicable diseases was noted to have reversed with a rise in the incidence of malaria. Family planning continued to remain an obsession. In the Fifth Plan, it was acknowledged that despite advances in terms of decline in infant mortality rate and rise in life expectancy, the number of medical institutions, functionaries, beds, health facilities etc., continued to be inadequate in the rural areas (Ibid.).

This then was the political backdrop for the emergence of the community health movement, which began in the late sixties as a result of the disillusionment with the development model that was being pursued. It attempted to look for alternatives to health care for the masses in light of the fact that even after two decades, the masses in the rural areas remained deprived of basic healthcare. It aimed to deprofessionalise and demystify the curative, urban-biased, profession-centered model of health care. There was one strand of the movement that attempted to bring about change by working uncritically within the then existing health care system. This strand consisted of health professionals who went into the rural areas and implemented community health projects such as the Comprehensive Rural Health Project in Jamkhed, Maharashtra, and combined social activism with health work. This health work was not just medical relief but viewed health as being determined by multiple factors. They emphasized the role of communities and that of village health workers. The other strand was radical and critiqued the former group of bringing about mere cosmetic changes by not challenging the unequal structural factors at local, national and international levels. This strand believed that structural changes were required since the medical system was just a part of the total system. Several groups challenged the system using various ways, such as research, advocacy, mass mobilization, mass education. Some of the prominent groups that identified with this strand were the Medico Friend Circle, the People's Science Movement, LOCOST, AIDAN and Delhi Science Forum. Coincidentally, the Alma Ata declaration signed in 1978 embodied several of the ideas developed in the community health projects.

The community health movement inspired a phase of issue-based campaigns. The ideological basis of the campaigns were the same as that of the community health movement, i.e. demystification and de-professionalisation of the medical model of health care with focus on the poor, preventive rather than curative strategies, indigenization of health knowledge and health practices and recognition of patients as consumers, not beneficiaries. The earliest and significant campaigns that were inspired by the community health movement were the essential drugs campaign, the campaign for patients' rights and the breastfeeding promotion campaign. These campaigns have been most effective and each of them has resulted in positive changes related to policy and legislations.

The third phase of the women's movement too began against the political backdrop of that of the community health movement. In the mass struggles and agitations of the seventies, women participated in huge numbers. It helped women become aware that they were a strong collective. The publication of the report of the Committee on the Status of Women titled *Towards Equality* in 1975 exposed the stark gender inequalities that were evident in imbalanced sex ratios, major differentials in male-female mortality, discriminatory legal frameworks and practices, economic practices that did not recognize the contribution of women, educational system inaccessible to women etc. (Khullar 2005).

With the community health movement and the Alma Ata declaration, people's knowledge and rural areas came into focus. However, Alma Ata was nipped in the bud by selective primary health care and a barrage of specific and vertical programmes. (Banerji 2001) The obsession with family planning continued and there was a resurgence of malaria. A large number of medical professionals were created but the quality of services declined. Demand for health services had grown but primary health care institutions and secondary referral level did not expand. The private sector grew.

During the 1980s, substantial health service infrastructure developed, but problems such as regional inequities, poor outreach and functional inadequacies remained (Priya 2005). Qadeer (2000) has pointed out a few aspects of the economy of the 1980s that led to

further distortions in the health services and health policies. The growth of the private sector was fuelled by the aspirations of the emerging middle class that lobbied for hi-tech hospitals conforming to international standards. The private sector grew from polyclinics to nursing home, private hospitals and the development of corporate hospitals. The private sector also benefited from government subsidies to medical education and import subsidies on equipment and drugs. Even though vertical programmes such as National Malaria Eradication Programme and Family Welfare Programmes were integrated into the general health services by the late 1970s, they retained their predominance in terms of policy planning and funding and the infrastructure was usurped by the family planning programme due to strong political and administrative backing. National and international population control lobby demanded that the use of infrastructural resources should be devoted exclusively to programmes that were directly or indirectly linked to population control. There was a shift in the investment patterns. The focus shifted further away from primary health care, which was also due to increased focus on drugs and equipment industry and professionals' demand for the use of hi-tech medical care. By the end of the 1980s, as Priya (2005) observes, the public health system was in a crisis with increasing demand for health care, increased but inadequate infrastructure (community health centres and PHCs), poorly functioning primary level institutions and a competitive expanding private sector.

The neo-liberal political and economic policies made by powerful nations and international institutions such as the World Bank, the IMF and the WTO were introduced in India from the mid-1980s. It began with the adoption of the structural reforms package in the mid-1980s followed by the economic crisis in the early nineties that led the Congress government to embrace the neo-liberal policies that led to the liberalization, privatization and globalization of the economy. The adoption of the structural reforms package in the mid-1980s also led to the introduction of reforms in the health sector. The main aspects of the IMF-World Bank-inspired reforms were cuts in health sector investments, opening up of medical care to the private sector, introduction of user fees and private investments in public hospitals and purely technocentric public health interventions. Privatization of health services has begun reflecting in the accessibility and

distribution of these. Public-private partnership is the vehicle on which health sector reforms are being carried out. Public health systems have deteriorated and universal access to health is a concept that is in the process of being wiped out. To make matters worse, diseases such as tuberculosis and malaria have begun resurging and new diseases such as HIV/AIDS have emerged and are spreading.

It is in such a political and economic environment that the People's Health Movement emerged with its emphasis on health and health care as a right. This rights-based approach to health is a strong assertion of the need to reverse the tide that is promoting the idea of health care as a commodity to health care as a right. The rights approach or the human rights approach is being considered necessary in light of the limitations of the basic needs approach. In addition, since the new UN policy is that of the human rights approach and since human rights principles are backed by international and national law, it is hoped that such an approach would be more effective. The PHM is a global movement and the transnationalisation of the movement is drawn from the fact that even the crisis in health and health systems is transnational in character.

The health system is a part of the larger socio-economic and political system. It, therefore, becomes inevitable that any changes in the larger system will affect the health sector. Moreover, when the state is the locus of power, movements and collective action for change that occur within the health system also tend to throb along with it. In other words, they are sensitive to and respond to the broad political trends. It is important to understand here that by political context, it is not only the traditional actor, i.e. the state, but also new political actors. In today's context, political actors include the World Bank, International Monetary Fund and the World Trade Organization. Movements not only challenge the state but also protest against the private sector, which is expanding and that too in an unregulated manner.

5.1.2 Evolving a typology for understanding collective action in health

Table 2 gives a comprehensive view of the trajectory of collective action in India from the pre-Independence days to the post-structural reforms period. The trajectory is

chronological except in the case of the community health movement and the women's movement, whose beginnings overlap.

Ideologically, the trajectory is varied. The workers' movement was inspired by the Marxist ideology. On the other hand, the nationalist movement was driven by a multitude of ideologies, from socialist to communist to moderate to Gandhian. The National Planning Committee though was led by Jawaharlal Nehru who believed that only industrialization of the economy could lead to development. The nationalist movement took up the agenda of health with the broader agenda of caring for the people. They framed the issue in such a way that a healthy body symbolized a healthy nation. The community health movement was based on the principle that health was determined by social, cultural, political and economic factors. As explained in Chapter 4, the entire movement was people-centered and was a revolt against the professionalized and medicalised health system. There were broadly two strands within this movement, one that worked within the confines of the existing system in order to bring about change and another a more radical one that demanded a change in the system in order to effect a change in the health system. However, there were also other strands, such as Gandhian and humanist ideologies. The women's movement, as written earlier, also consisted of several strands of ideologies, from radical feminism to socialist feminism to Marxist feminism. The strategy of the People's Health Movement is centered on the rights-based approach which asserts the prime role of the state and public health systems and their responsibility to provide health services for all.

The main actors in the industrial workers' movement were political activists and the industrial workers' themselves. Nearly every national-level political party had a trade union wing attached to it. Therefore, politicians played prime roles besides the leaders of the unions. The workers as a collective were powerful players in the movement. The nationalist movement had a mass character. Political activists, social activists, industrialists, medical professionals, students, and men and women from all sections of society all over the country participated actively in the movement to free the country.

Table 2: Trajectory of collective action in health in India from pre-Independence to post structural reforms

Collective action	Ideology / principles	Actors	Concern, action and reform in the area of health	Authority challenged
Industrial workers' movement	Marxist ideology	Political activists, industrial workers	Protective legislation to improve working conditions (Reduce occupational hazards, provide facilities of sanitation, water, housing, education, nutrition and medical, family planning, maternal health)	Capitalists, state
Nationalist movement	Nationalist ideology; 'Health body symbolizes a healthy nation.'	Led by political activists, social activists, health professionals, industrialists; the movement had a mass character	Policy and planning (nutrition, health system, medical and health research, hospital infrastructure, training for village health workers, drugs, social insurance, maternal health, maternity leave, family planning policy, raising of age at marriage, demographic surveys, minimum wage legislation)	Colonial authority
Community health movement and issue-based campaigns	People-centered approach; holistic approach to health; multiple ideological strands - radical Marxist, Gandhian, humanist	Led by health professionals; joined by social workers, activists, academics, researchers	Primary health care, access to health care, addressing determinants of health (water, sanitation, nutrition etc.), drug policy, patients' rights etc.	State, medical technology industry, drug industry, consumer products manufacturers
Women's movement	Feminist ideology	Women groups, journalists, social workers, church workers, lawyers, doctors, research institutions, NGOs	Reproductive issues, drug policy, mother and child health	State, medical technology industry, medical profession, drug industry, patriarchal values
People's Health Movement	Human rights approach	Led by health professionals; joined by people's organizations, civil society organizations, NGOs, social activists, academics, research institutions	Primary health care, universal access to health care, pharmaceutical policy, policy formulation and implementation, allying with other movements such as women's, disability, HIV, right to food campaign, etc.	State, transnational organizations, private sector

The community health movement was led by health professionals and they were soon joined by social workers, activists, researchers and academics. While the major actors in the women's movement were women, men too were involved in it. There were not only womens' groups but also other groups like NGOs and research organizations and journalists, social workers, church workers, lawyers, doctors etc participated in the women's movement (and continue to do so). The People's Health Movement was initiated by health professionals and they are joined by social activists, social workers, researchers, academics, and people's organizations and NGOs.

In health activism, the issues espoused are diverse and touch upon every area of health, from reproductive health to health policies to health legislation. The major achievements of the industrial workers' movement resulted in protective legislation. Provisions in terms of health include medical facilities such as hospitals and dispensaries and maternity centres, improvement of facilities for water supply and sanitation, food and nutrition, loan schemes for housing. The legislations also govern conditions at the workplace such as cleanliness, disposal of wastes and effluents, elimination of dust and fumes, artificial humidification, overcrowding, lighting. Cash compensation in case of sickness and disablement, maternity benefits etc. are also part of the protective legislation that the workers' struggle has been able to achieve. The health-related issues that the nationalist movement took up, as can be seen from the recommendations of the NPC, were also wide-ranging. These ranged from training of village health workers, nutrition, comprehensive health care system integrating curative and preventive functions, drug self sufficiency, mother and child health, social insurance for all, family planning, raising the age at marriage, demographic surveys, maternity benefit legislation, minimum wage legislation, etc. The community health movement was an inspiring period in the history of public health where health activism and social activism combined. The community health projects introduced values such as appropriate technology, social acceptability and cultural appropriateness in addition to emphasizing the importance of a people-centered, deprofessionalised approach to health care. These projects addressed issues such as primary health care, access to health care and a public health approach, i.e. addressing the underlying determinants of health (water, sanitation, housing, gender, education, nutrition

etc.) in addition to medical relief. The more radical strand was involved in critiquing the system and demanding a total transformation of the system. The issue-based campaigns also took up pertinent health issues such as drug policy, patients rights and promotion of breastfeeding. The women's movement has created a lot of impact in addressing the reproductive health issues of women. The campaign against injectable contraceptives and sex determination and sex pre-selection tests were significant in addition to the movement's vociferous opposition against the family planning policies of the state. Legislation and policy-related changes, such as the PNDT Act 1984, have been achieved as a result of the efforts of the women' movement. The People's Health Movement India has been involved in several issues related to universal access to health care, community participation in government programmes, advocacy for the formulation of a National Pharmaceutical Policy, engagement with states for state health policies, lobbying with WHO to bring back primary health care on the agenda etc.

Finally, if we take a look at the authorities or parties that these movements have challenged or opposed or stood up against, we find that these include the state, capitalists, colonial authorities, the medical and drug industry and even transnational organizations. The tools in health activism have included strikes, legal action, petitions, research, advocacy, community-based projects, media activism and even community mobilization.

5.2 DISCUSSION

5.2.1 'Health in social movement' and 'movement for health'

In the trajectory that has been mapped, the leaders, constituencies, health issues, all vary. The industrial workers' movement was led by industrial workers themselves (if we take into consideration the trade union movement only), the nationalist movement on the other hand had a multitude of people from all walks of life, politicians, doctors, teachers, industrialists, students, etc. The community health movement (followed by issue-based campaigns) was led by health professionals and attracted people from diverse backgrounds. It dealt with issues such as access to health services, equity in health services, democratizing the health system. It also dealt with science as it challenged the drug industry and other harmful medical technologies. It had a close involvement with

the profession of medicine. The originators of the women's movement were mainly women. However, soon, even non-women's groups got involved in it, as is evident from the campaigns and activism charted by them. The People's Health Movement began with the initiatives of a group of health professionals. It continues to be led by health professionals but it has grown into a coalition of people from the social arena and academics. The focus is completely on health as was with the community health movement. In the industrial workers', nationalist and women's movement, health was incorporated as one of the issues. The primary issues within the industrial workers' movement were the terms and conditions of work including wages, bonuses, retrenchment, leave and hours of work. Nearly all writings on the workers' movement focus on these issues and the politics behind the trade union movement. The nationalist movement too had freedom from colonial rule as its foremost objective. As its primary objective, the NPC had on its agenda industrial development, and health was included as one of the additional aspects. Similarly, the women's movement is a spectrum of issues related to women that it took up, such as employment, conditions of work, education, physical safety and security and health. However, the women's movement is different from the industrial workers' movement and the nationalist movement in that the health issues are a major part of the movement and the women's movement is also at times called a 'health movement'. The primary objective, of course, remained an improvement in the overall status of women.

Therefore, we have, on the one hand, those movements that took up health as 'one of the issues' with the 'main' issue being those other than health. The emphasis placed on health varied in these movements. On the other hand, there are those movements that have health as their central focus, which are the community health movement and the People's Health Movement, while not losing sight of the socio-political context. These movements, which were initiated and led by health professionals have been successful in producing a holistic critique of the health system even as they questioned the model of development pursued then and now. Clearly, bringing about a change in the 'health system' was/is a priority for these movements. For instance, in the community health movement, village health workers, locally selected and field trained were employed for

health services, reducing the dependency on medical professionals. Preventive and promotive health services involving community involvement like antenatal care, care of pre-school children, early detection and follow-up of communicable diseases were given importance besides including oral rehydration, immunization and the concept of essential medicine. An epidemiological basis to the analysis of health and a community orientation to the resolution of health problems was adopted (Jesani and Ganguly 1990 cited in Antia and Bhatia 1993). Primary health care has been an issue that was taken up by the community health movement and this concern continues in the People's Health Movement. The involvement of health professionals in both these as well as the issue-based campaigns has led to a certain kind of health activism, one in which science and political action combined to critique the health system.

5.2.2 Collective action in health: A merger of health and social activism

The 'dilemma' of a movement with health as the focus is the danger that it may become bio-medical, that the focus may become medicine and not health, that the 'individual' may become the focal point and not the 'social'. The workers' movement and the women's movement were limited in the constituencies that they served. They touched only that part of the health system that affected them. Their issues ranged from income to housing to education besides health.

The health-focussed movements, i.e., the community health movement and the People's Health Movement, have taken up the agenda of health with medical and health care issues. Despite that, their ideologies remain deeply entrenched in the spirit of participation and democracy. The argument in support of these movements is that in order to be effective, a movement must function with a high amount of focus on its own area. As Shukla (2007) of the People's Health Movement writes, tackling the right to the underlying determinants of health is as important for PHM as is the right to health care[28].

[28] The PHM differentiates between the right to health and the right to health care. The right to health includes both the right to underlying determinants of health and the right to health care. The right to health care implies the right to a set of basic public health services, which includes adequate physical infrastructure at various levels, adequate skilled humanpower in all health care facilities, availability of complete range of specific services appropriate to the level and availability of all basic medications and supplies.

There are initiatives that are already working towards the various determinants of health. Since each of these areas requires expertise, it is only right that health activists take the responsibility of the health care movement. This would give the movement a sharper focus, make it more effective and the health based arguments could strengthen the demands of claim to tackle these determinants from a rights perspective. Also, according to PHM activists, if health activists do not take the initiative on health care issues, then who will? It is however strongly asserted by these very activists that the struggle for health rights must move on to link with struggles for those rights that lead to improvement of health, such as right to food, water, education, housing, livelihood etc. Health activists, thus, have a 'dual' responsibility. They have a central responsibility for promoting the right to health care and they have the responsibility for co-initiating and participating to promote the right to the underlying determinants of health, i.e. water, food, education, housing etc.

5.3 CONCLUSION

This study has demonstrated that collective action in health emerges from a political and/or economic context. By doing so, it has also brought forth the fact that health is closely related to and dependent on politics and economics and, thereby, that health is a part of the larger socio-economic, political system. It also implies that achieving equity in health means that powerful interests have to be challenged and that political and economic priorities have to be drastically changed.

This study has traced those instances of collective action that have taken up health as an issue from pre-Independence to post structural reforms period. The trajectory of collective action in health, as mapped in this study, can be seen to have dealt with the following:

- Health inequities arising from adoption of certain models of development
- Health inequities arising from adoption of political and economic policies
- Health inequities based on caste, class, gender; region, nationality
- Inequitable access to health and health care services

- Health inequities from medicalization of health services
- Health issues arising from application of medical technologies, drugs
- Health issues related to incorrect practices, myths

After having mapped the trajectory, the study also leads us to define the term collective action in health in a specific context as the following:

"Collective action in health can be defined as the collective challenges by diverse groups of people and constituencies – medical and non-medical – with a well-defined ideology, in response to certain conflictual conditions emerging from certain political and economic contexts. These challenges may involve living conditions, work conditions, policies, policy implementation, legislations, medical practices, belief systems etc. The actors involved in such collective action form a diverse group, from political activists to journalists to scientists to social workers to health professionals. "

By drawing from the political process theory, the study combines the analysis of health and social movement theory, giving rise to the proposal for recognition of 'health movements'. While the industrial workers' movement, the women's movement and the nationalist movement took up the issue of health as one among several, the community health movement and People's Health Movement were/are focused centrally on health. These have invariably been/are led by health professionals, which also leads to the conclusion that movements that have health as the central focus are led by health professionals. We can thus term the latter two movements as 'health movements' while the former three can be considered as social movements. 'Health movements' too fall under the umbrella of social and socio-political movements. The substitution of the term 'social' with 'health' is not intended to undermine the 'social' and 'socio-political' character of movements that have health as the focus, but serves to emphasize the focal point of the movement. This also leads us to conclude that the movements that are led by health professionals and have health as the central issue combine social and political activism with medical and health activism. These movements strive to strike a balance between the 'medical' and the 'social'.

The trajectory of collective action in health that has been traced in this study strongly proves the fact that the history of public health has been very strongly influenced by health activism. Health activists have questioned the very idea of development, and have stood up against capitalists, against patriarchal norms, against corporate interests, against transnational organizations and against the State itself. Several key policies, legislations, approaches and steps to improve the health of peoples are the result of the effort of such movements. Collective action in health involves itself with caste and class issues, with politics, economics, medicine, culture. It has in particular represented the voices of the poor and the marginalized and politicized issues of marginalization, inequality, inaccessibility etc. It has questioned the idea of development and attempted to bring about structural changes and continues to do so.

Scope for further research

The area of health activism is a relatively unexplored one although issue-based campaigns and advocacy movements and single-disease focused movements have received attention, such as the AIDS movement, the breast cancer movement, the anti-smoking campaign etc. Such a void can be filled by research. Although the debate continues about the disciplinary domain for research in the field of health activism, ethnographies and research that is multi-disciplinary in nature could provide an answer. Some questions that could be raised, thereby opening up new areas of research in the field of health activism, are: What is the nature of the public debate on health? Is the focus on staking claims or registering protest or offering alternatives or any others? What is the structure of health movements? Do they contain multiple strands with differing goals and ideologies or do they entail a single identity? Are there short-term and long-term objectives in health movements? Are these populist or class-based movements? What are the different health movement organizations and what are the strategies adopted by these? How accountable are they to the people? How representative are they of the people? Initiating research on these questions can lead to the creation of a body of knowledge in the area.

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