ISSN 0976-5484

SOCIAL WORK JOURNAL

(BI-ANNUAL)

Volume 5 Number 1 June 2014

(Subscription: Rs. 500/-)

DEPARTMENT OF SOCIAL WORK
ASSAM UNIVERSITY, SILCHAR – 788011
INDIA. Phone: +91 3842 270821

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Published by
DEPARTMENT OF SOCIAL WORK
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Phone: +91 3842 270821
www.aus.ac.in

Volume 5 o Number 1 o June 2014 o ISSN 0976-5484

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Editors' Note

Health is a concern that envelopes all of our lives, across time and space; and needless to say, across disciplines. In Social Work, it is certainly an area that merits attention as the discipline itself is rooted in social welfare. Definitely, there can be no welfare without well-being and vice versa.

Just as we are late in bringing out this volume due to a variety of reasons, for which we are regretful; ironically enough, the year 2015 has just slipped by whence the international community had set targets, related to health vis-à-vis the Millennium Development Goals that have ruefully not been achieved. Hoping to overcome all that we can and all that we must, we now march our way towards the Sustainable Development Goals. Nonetheless, whether it is with regard to reproductive and child health, or that gnawing pain of cancer; the articles in this issue illustrate that despite the laudable attempts by the Government and/ or non-profit based organisations, much still is left to be done.

We thus reiterate the significance of the need for having taken health as the theme for this issue. Women in particular seem to be at the receiving end when we look at pertinent problems regarding health. This is amply illustrated by the articles on the health status of the women workers in the footwear Industry in Tamil Nadu; and the ethical issues that women confront in hospitals of Kerala.

On a rather macro level, the discussions on HIV/AIDS and public health; socio-demographic changes and its effects on agriculture and health; health inequality and social exclusion, international trade, health and social work, all lend a tremendous diversity to the idea of health and how we seek to interpret it. Yet another novel venture is the paper on armed conflict and mental health in a seriously psychologically ruptured state like Manipur.

We therefore hope that this issue will be a pleasant and enjoyable read, at least for those who are walking on tiptoes in the arena of health; seeking to learn and unlearn the many facets that make up this complex concept which we so casually enquire about whenever we meet someone with a simple "How are you?".

We thank all the authors, reviewers, members of the advisory board, and the editorial board for all their valuable contributions. We are also thankful to Assam University, Silchar, which has served as the springboard for this journal.

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ISSN: 0976-5484 Social Work Journal • Vol. 5 • No. 1 • June 2014 • Page 01-09

Millennium Development Goals (MDGs) and Maternal Health in India: The Long Road Ahead

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Health is a very important and crucial area of human well-being. Considering this fact, the Millennium Declaration laid maximum emphasis on health related aspects and set up three direct goals related to health out of the total eight, which are to be achieved by 2015. Here, an attempt is made to discuss one of the very important health related Millennium Development Goals (MDGs) i.e. MDG 5, Improve Maternal Health. It seeks to examine the progress made so far in India and to draw attention to the slow pace towards achieving MDG 5. India has already lost the race against time to achieve the MDG 5: reducing maternal mortality ratio (MMR) to 109 by 2015. Decreasing the maternal mortality and morbidity in developing countries like India is important because poor maternal health is both an indicator and cause of extreme poverty and it is also associated with other MDGs like child mortality, gender equality and women empowerment etc. Though it has made some progress in reducing the MMR, the country is still far from achieving the MDG target although the timeline has passed by. This paper analyses India's progress towards implementing maternal health initiatives, and various cultural, socio-economic and political factors which are affecting the progress and thus tries to simultaneously emphasize the shortcomings of our efforts and achievements.

Introduction

Health is one of the most crucial aspects of human well-being. It is a common theme in most cultures and is looked upon from various perspectives. Health is not mainly an issue of doctors, social services and hospitals. It is an issue of social justice too. The World Health Organization (WHO) in its constitution declares that the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being. WHO also defines health as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity (Park, 2009). Thus, health is considered as an integral part of development and central to the concept of quality of life.

Recognising the importance of health, the Millennium Declaration adopted by the UN General Assembly in September, 2000, has laid maximum weight on health related goals. 189 nations including India made a promise to work towards the eight MDGs to be achieved by 2015, which were further sub-divided into 18 numerical targets and those are monitored by 60 indicators. Out of the total eight MDGs, three are directly related to health and the others are closely intertwined. The present paper is an attempt to highlight the maternal health scenario in India with respect to MDGs. Maternal mortality data is said to be an important indicator of overall health system because pregnant women need sanitary, safe, well-staffed and stocked facilities. If new mothers are thriving, it indicates that the health care system is doing its job. If not, problems

are likely to exist.

Maternal health is the health of women during pregnancy, childbirth, and the postpartum period. It encompasses the health care dimensions of family planning, preconception, prenatal and postnatal care in order to reduce maternal morbidity and mortality. So, MDG 5 (Improve Maternal Health) aims to reduce the maternal mortality ratio (MMR) by 75% between 1990 and 2015 (Patel, Chang, Srivastava, Patel, & Balkrishnan, 2012). The indicators selected to measure this target were the MMR and the proportion of births attended by skilled health personnel. Though there is significant improvement in the maternal health condition of India, but this has not been sufficient enough to have achieved the MDGs by 2015.

Maternal Health Scenario in India

Maternal health is one of the key areas under the umbrella of health, which connotes the overall health system. Globally, every year nearly 3 lakhs of women lose their lives only because of pregnancy related complications. According to WHO, in its World Health Report 2005, poor maternal conditions account for the fourth leading cause of women's death worldwide, after HIV/ AIDS, malaria, and tuberculosis. Most maternal deaths and injuries are caused by biological processes, not of diseases, which can be prevented and have been largely eradicated in the developed world. The number of maternal mortality is more in the developing countries and India accounts for maximum number of maternal deaths in the world. As per the UN Report of 2013, India accounted for almost 17% of the global maternal death of 2.89 lakhs and ranks first in this regard. Nigeria comes second with nearly 40,000. In contrast, China with the largest population in the world reported 5,900 maternal deaths in 2013 mainly due to its "one-child policy" (The Indian Express, 2014). Again, WHO estimates show that out of 529,000 maternal deaths globally each year 136,000 (which is around 25.7% of the total) are contributed by India (Agarwal, 2005). This is the highest burden for any single country in the world. The WHO reported that India's MMR, which was 560 in 1990, reduced to 178 in 2010-2012. However, as per the MDG mandate, India needs to reduce its MMR further down to 109. Though India's MMR is reducing at an annual average of 4.5%, it is needed to bring it down to 5.5% to meet the Millennium Development Goal (Barnagarwala, 2014).

Though India has been reporting a steady decline in the maternal mortality rate, the latest figure of 178 per 100,000 live births in 2010-12 is an indication that the United Nations' goal may be missed (Ramachandran, 2014). According to the latest study conducted by two organizations: Common Health & *Jan Swasthya Abhiyan*, published in The Hindu (2014), India, which accounts for the largest number of maternal deaths in the world, was already showing signs of its unlikeliness to achieve the fifth MDG of reducing maternal mortality to 109 by 2015.

Besides, as per the estimate done by RGI (2003), it shows that MMR is higher in the eastern and central regions and is lower in the north-western and southern regions of the country.A similar picture is also shown by data collected under

the Sample Registration System by the Registrar General of India. Among all the states of India, only three states, namely, Kerala, Tamil Nadu and Maharashtra are performing very well and had already achieved an MMR of 109 by 2009. Again, within the period of 1997-2009, the maximum decline occurred between 2004-2006 and 2007-2009 (32%), followed by 2001-2003 and 2004-2006 (27%). Uttar Pradesh and Uttarakhand contributed most favourably to the net-decline in MMR of India (Reddy, Pradhan, Ghosh and Khan, 2012). The study of Bhat also shows that MMR is more in scheduled caste (SC) and scheduled tribe (ST) communities and those living in the less developed villages. So, a regional disparity is notable in the rate of maternal mortality. The states where the literacy rate is higher, people are educated and more conscious; enjoy a good maternal health condition. Accordingly, it appears that people from marginalised background with lower socio-economic status suffers the most from maternal health problems. Maternal health condition is closely associated with health and survival of the new born. Thus, disturbance in one aspect of health may affect and entangle all others.

There are various reasons why women succumb to reproductive complications. Experts estimate that 70% of the maternal deaths are preventable. Most maternal deaths are preventable through adequate nutrition, proper health care, including access to family planning, the presence of a skilled birth attendant during delivery and emergency obstetric care. Anaemia and haemorrhage overthrows about 20% and 29.6% of the women respectively (Registrar General of India, 2003). By adopting various measures, these major causes of maternal deaths can be prevented. Anaemic cases can be reduced with proper nutrition and food supplements. In India, there are a large number of women especially those who are from rural, tribal and backward communities suffer from malnutrition. Thus it leads to anaemia and other health complications. Because of it, there may be blood shortage in the mother's body that may cause death during delivery and can also lead to low birth weight and deformity of the new born. The other causes of maternal mortality are puerperal sepsis, hypertensive disease of pregnancy, abortion, obstruction of labour etc. Apart from these medical causes, there are non-medical factors contributing to poor maternal health or deaths. These are associated with cultural, socio-economic, political and other allied aspects like poverty, illiteracy, improper sanitation, pollution, inadequate nutrition etc. So, the health of a woman is closely linked to her educational status and socio-economic status ("State of the World Mothers", 2010). Despite maternal mortality rates showing decline in India, thousands of women are dying every year due to lack of access to basic healthcare facilities. Thus, the primary cause of death in pregnancy and childbirth in a developing country like India is maltreatment of women. This is because people of our nation especially women are conditioned to cope with and not to complain; whereas in developed nations these are not an issue at all. People of the developed nations including women are sensitized and stand boldly for their

rights. Moreover, their medical science is more developed and equipped with modern technologies and facilities. These have helped them to eradicate major health issues, particularly those who are associated with women.

Maternal Health Care Indicators by State

In India, only 15% mothers during childbirth avails all the required components of antenatal care. This indicator ranges from a high of 64% in Kerala and 56% in Goa to a low of only 2% in Nagaland and 4% in Uttar Pradesh (Ram,Mohanty & Ram, 2009). In terms of delivery care, Kerala, followed closely by Goa, outperform all other states, with nearly all deliveries taking place in medical institutions and similarly high percentage of deliveries assisted by health professionals. Tamil Nadu also ranks third in delivery care with 88% of birth delivered in medical institutions & 91% assisted by health professionals. Again, with regard to both of the postnatal care indicators, Tamil Nadu tops the list of the states, where 91% of deliveries have a post-natal check-up within 42 days of birth and 87% have it within two days (Ram *et al*., 2009). Besides these, in the trend of maternal care indicators, rural areas are always lagging behind the urban areas in terms of all the stages of the birth process. In 1990, just 44% of deliveries in rural areas and 75% in urban areas of developing countries were attended by skilled personnel. By 2011, coverage by skilled birth attendants increased to 53% and 84% for rural and urban areas respectively (United Nations, 2013). It is evident that several states are consistently performing below the national average on each of the five maternal care indicators. It has been found that the socio-economically developed states with higher literacy rates are performing well in terms of these indicators. Thus, it is well established that there is an interrelationship among the educational and socio-economic status and the health (particularly maternal health) of the women.

Determinants of Maternal Health

Various factors like socio-economic status, literacy, investments, education and place of residence, awareness etc. are all important determinants of maternal health. At the same time, it cannot be ignored that several other MDGs, like - MDG 1 (extreme poverty and hunger), MDG 3 (gender equality and women empowerment), MDG 4 (reduce child mortality), MDG 6 (combat HIV/AIDS, malaria, TB etc.) are associated and have consequences on maternal health.

MDG 1 has serious consequences on MDG 5. The Planning Commission which has now been rechristened as Neeti Ayog, notes that the incidences of poverty amongst females tend to be marginally higher in both urban and rural areas and there is very less improvement in women's socio-economic status over the years. As per National Family Health Survey (NFHS) 2 & 3, the proportion of anaemic women in between 15-45 years has increased between1998-99 and 2005-06. Thus, various health hazards of females point towards not only lesser nutrition level (anaemic and underweight), but also towards lesser investment in health care of females.

MDG 3 is also intrinsically linked with Maternal Health. NFHS 3 shows that while a significant proportion of currently married women are employed, almost one in three are unable to convert such employment into financial autonomy. Female segments of society are always subjugated and have to face lots of constraints. These coupled together trigger various socio-economic and other non-medical causes that have a bearing on maternal health status.

Improving maternal health is also key to achieving MDG 4 of reducing child mortality. Giving good care to women during pregnancy and at the time of childbirth is crucial not only for saving women's lives but their babies too. MMR has a direct impact on infant mortality. Babies whose mothers die during the first six weeks of their lives are far more likely to die in the first two years of life than babies whose mothers survive.

MDG 6 on TB, malaria, HIV/AIDS is also related to MDG 5. The consequences of malaria in pregnancy can be fatal. TB among pregnant women is not given a special consideration by either of the two programmes of TB Control or Reproductive and Child Health(RCH). Women living with HIV also face discrimination when they go to health centres for delivery or for any other care.

It is quite clear that majority of the health targets are beyond reach and the pace with which we are progressing is not at all satisfactory. Especially, MMR, IMR, malnutrition, institutional deliveries and diseases like TB, HIV/AIDS etc. are areas of concern for India. Moreover, it is important to note that for big a country like ours, the ground reality is even worse. Thus, it is needed to address and integrate all the health related MDGs through a holistic approach. There is a stark need to set up some common minimum programme for all the MDGs. There is also need of more vigorous and sustained efforts on improving maternal and child health along with the other MDGs, especially to meet the new global targets of zero preventable child deaths and a much sharper reduction in maternal deaths by 2030.

Measures Initiated to Achieve MDGs on Maternal Health

Maternal and child health has remained an integral part of the Family Welfare Programme of India since the time of the First and Second Five-Year Plans when the Government of India took steps to strengthen maternal and child health services. As part of the Minimum Needs Programme initiated during the Fifth Five-Year Plan (1974-79), maternal health, child health, and nutrition services were integrated with family planning services. It is said that the Government of India has not drawn any separate programme as the MDGs are quite similar to the objective of its five year plans and other welfare programmes. In the year 1993, the Health Policy Statement by the Government of India was documented with the goal to reduce MMR to 200-300 by 1990 and below 200 by the year 2000. But the goal was not attained within the said time period. In 1992-93, the Child Survival and Safe Motherhood Programme continued the process of integration by bringing together several key child survival interventions with safe motherhood and family planning

activities. In 1996, safe motherhood and child health services were incorporated in the RCH Programme. The National Population Policy adopted by the Government of India in 2000 reiterates the government's commitment to safe motherhood programmes within the wider context of reproductive health. National Population Policy (2000) and National Health Policy (2002) set the goal to reduce MMR to less than 100 by 2010. But the set target remains untouched. Again, the second phase RCH was launched in 2005 with a vision to bring about outcomes as envisioned in the MDGs (Khanna, 2013).

To improve the availability and access to quality health care, especially for those residing in rural areas, the government launched the National Rural Health Mission (NRHM) in 2005, which has been renamed as National Health Mission (NHM). One of the important goals of the mission is to provide access to improved health care at the household level through female Accredited Social Health Activists (ASHAs), who acts as an interface between the community and the public health system. Thus, it was an attempt to work towards universal access to public health services. Besides, the Eleventh Five Year Plan (2007-12) in its 27 National Targets has attempted to reduce anaemia amongst women and girls, which has a direct bearing on maternal health and maternal mortality (Khanna, 2013).

Various strategies of India as outlined in the 2005 MDG Report were wider in scope. These include prevention and treatment of Anaemia (a major cause of maternal mortality in India), through the distribution of iron and folic acid tablets, antenatal care of women to monitor pregnancy progress and any potential complications, provision of emergency and obstetric care, and creation of a workforce of trained birth attendants. Other schemes include safe abortion kits, population control policies, and increased health personnel (Patel, et al., 2012). Also, the Government has introduced the Janani Suraksha Yojana, conditional cash transfer, which is a modification of the National Maternity Benefit Scheme which provides comprehensive medical care during pregnancy, child birth and post-natal care and thereby endeavours to improve the level of institutional deliveries in low performing States to reduce maternal mortality.

Major Challenges

Health work force is a major bottleneck in India in achieving MDG 5 on maternal health. Like the past programs, present initiatives also face various functional and cultural barriers. Although emergency obstetric care remains a priority, inadequate staffing remains a problem and these prevent full utilization. In India, there is estimated to be huge shortfall of 74,000 ASHA workers and ANMs at 21,066. The government norm is one ASHA for 1000 population and one ANM for 5000 population in plain areas and 3000 for rural areas. In this way, skilled birth attendants are not available in sufficient numbers. Again, ANMs who are supposed to be resident at the village sub-centre and facilitate child-births, are often absent from the communities that they are supposed to serve. In addition, a good number of them do not have the

competencies of a skilled birth attendant. Besides, life-saving care is unavailable in rural and disadvantaged areas. There is an acute shortage of obstetricians and anaesthetists in the public sector. About 50% or more Community Health Centres do not have obstetricians and anaesthetists. Many of the Policy Statements of Health and RCH programme look good on paper but aspire little hope of making a difference. NHM also suffers from lots of lacunas and huge gaps between the paper works and execution. Thus, due to improper implementation of government programmes, it become unable to address the basic health issues for which it has been designed. Furthermore, Public Private Partnerships while increasing access and providing some degree of financial protection to the vulnerable populations, are not without problems of quality of care. Accordingly, poor management of health system leads to misallocation of resources, inadequate monitoring of quality of care and slow implementation of programmes. Thus, inadequate infrastructure, medicines, facilities for emergency care and others, all contribute to the high maternal mortality ratio.

Suggestions and Conclusions

The MDGs have helped many countries in galvanizing their developmental efforts. The most important purpose of the MDGs is to focus attention on gaps that remain in achievement and on the changes needed to enable the fulfilment of rights for all especially those who are the poorest and the most vulnerable. Though the MMR in India has declined from 437 in 1990 to 178 in 2010-12, but it is not enough to achieve MDG 5 by 2015. The United Nations Population Fund (UNFPA) estimated that 289,000 women died of pregnancy or childbirth related causes in 2013 and India accounted for almost one fourth of the total. Thus, a huge toll on the lives of women and new-borns persists and there is evidence that women and children are still vulnerable. As long as high levels of mortalities persist, which is a reflection of the poor health of the society, the fruits of development will always remain questionable.

Basically, four elements are essential to maternal death prevention. First is prenatal care. It is recommended that expectant mothers receive at least four antenatal visits to check and monitor the health of both the mother and the foetus. Second, skilled birth attendance with emergency backup such as doctors, nurses and midwives who have the skills to manage normal deliveries and recognize the onset of complications. Third, emergency obstetric care to address the major causes of maternal death which are haemorrage, sepsis, unsafe abortion, hypertensive disorders and obstructed labour. Lastly, postnatal care which is the six weeks following delivery. Besides, interventions outside the defined health sector that address the social determinants of health including improvements in nutrition, women's education and empowerment; as well as better water quality and sanitation will also be needed (United Nations, 2015). The lack of targeted implementation of emergency obstetric care is an important shortfall in India's maternal health strategy. Poor management of the health system leads to misallocation of resources, inadequate monitoring of

quality of care, and slow implementation of programmes. Without proper central planning, there is little coordination between government entities, NGOs, and village health workers; so care is not inclusive and existing efforts are not so effective. Lack of political will has contributed to minimal expenditure on health and little efforts have been made to provide comprehensive maternal health. Given India's current situation, two main areas must be the focus for reform. Firstly, emergency obstetric care has been identified as a crucial part of a successful maternal health package. The government must ascertain which regions have the least access and address issues such as maintenance, staffing, and transportation facility etc. This will certainly assist in reducing the major causes of maternal deaths in India. Secondly, besides, emergency care and skilled birth attendants, a change in political focus to prioritize health is needed. Maternal health in particular must be given focus as a benchmark for a nation's overall health status. Nevertheless, a national mortality study should also be carried out every 10 years to ensure that there are reliable data to indicate progress towards the ultimate goal of safe motherhood.

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ISSN: 0976-5484 Social Work Journal • Vol. 5 • No. 1 • June 2014 • Page 10-23

Reproductive and Child Health Services: Socio-economic Determinants of its Utilization in Northeast India

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Reproductive and Child Health (RCH) Services are an essential service in the promotion of women and child health. Besides this, their services are of utmost significance in promoting a healthy society. This paper is an outcome of a study that was conducted with the objectives of understanding the organisation of RCH care services in Northeast India and to analyse the pattern of utilization of RCH care services in this region. In addition to this, an attempt was also made to examine the socio-economic determinants of RCH services utilization. It is this latter objective that is the main focus of this paper. A descriptive research design was adopted, using non-probability sampling method and non-proportional quota sampling, wherein the four states of Assam, Manipur, Meghalaya and Sikkim were identified for the study. Then one representative institution from each level of healthcare in each state was identified for the purpose of collecting information regarding how the RCH care services are organised and delivered to the people in these states. Besides this, multi-stage sampling was used to collect information from the users' perspective. A total of 800 households were surveyed. This paper tries to establish the fact that woman's education, husband's education, and family income continue to be very significant determinants in promoting an effective utilization of RCH care services. Besides religion and caste, other significant socio-economic indicators such as source of drinking water, type of housing, numbers of rooms, separate kitchen, type of fuel used for cooking, type of toilet were recorded to understand the socio-economic class and how they influence utilisation of RCH services. Significant RCH indicators such as pregnancy registration, ANC utilisation, IFA consumption, type and place of delivery, availing of JSY, PNC services were also studied.

Introduction

The Central Intelligence Agency (CIA) World Factbook, 2014, reports Infant Mortality Rate (IMR) in India at 43.19, while its neighbour China records it at 14.79. Both are developing nations. This contrasting figure should be adequate to serve as a wake-up call to our nation. If we compare the same figure with those of the two most developed nations, namely, the United Kingdom and the United States, which records these figures at 4.44 and 6.17 respectively, it should unnerve us. In addition to this, in 2010, another unnerving fact is that the above source records the Maternal Mortality Rate (MMR) at 200 in India, 37 in China, 12 in the U.K. and 21 in the U.S.

Regarding the All India picture, as per the Sample Registration System (SRS)

Report, 2011, advanced states like Delhi and Tamil Nadu record IMRs at 28 and 22. The same Report notes IMRs for the northeastern states of Assam (AS), Manipur (MN), Meghalaya (ML), and Sikkim (SK) at 55, 11, 52, and 26 respectively. Regarding MMR, SRS 2007-09 notes these figures at 97 for Tamil Nadu and 390 for Assam. It is unavailable for Delhi as well as the other three states as on September 30, 2012. IMR and MMR are indeed strong indicators of RCH and hence we need to get oriented towards their significance if we are to understand RCH in the correct perspective.

Need for a Holistic Approach

It has to be appreciated that reproductive health does not affect women alone; it is a family health and social issue as well. The International Conference on Population and Development, Programme of Action, 1994, had aptly defined Reproductive health as, "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and its functions and processes".

The definition suggests that reproductive health encompasses: a) the ability to reproduce; b) freedom to control reproduction; c) the ability to go through pregnancy and childbirth safely, with successful maternal and infant survival outcomes; d) the ability to obtain information about and access to safe, effective and affordable methods of family planning; e) the ability to have a satisfying safe sex life, free from fear of pregnancy and disease; and f) the ability to minimize gynaecological diseases and risks throughout all stages of life.

In our country several people continue to die due to causes which have their genesis in early childhood illnesses, inefficient and inadequate new-born care, and most importantly maternity and childbirth complications. These factors hamper their early growth and lifelong development.Inadequate management of pregnancy and child birth related complications owing to lack of antenatal care, financial difficulties, and ignorance is a huge challenge today. It is thus pertinent to look at the socio-economic differentials, accessibility, utilization pattern and factors affecting the utilization of RCH services.

Table 1:
Health Infrastructure in Position

Facilities	AS	MN	ML	SK
Sub-centre	4604	420	397	147
Primary Health Centre	975	80	109	24
Community Health Centre	109	16	29	2
Doctor at PHCs	1478	170	104	32
Obstetricians & Gynaecologist at CHCs	69	-	5	-
Health Worker/ ANM PHCs & Subcentres	8723	975	787	291
Nursing Staff at PHCs & CHCs	2795	574	414	24

The Northeast Context

Particular attention is called for in the Northeast as there are additional unique issues related to gender, culture, language, religious faiths, economic capability, and geography while accessing the modern public health services. This paper however looks at the four states of Assam, Manipur, Meghalaya, and Sikkim. The study was conceptualised with the broad aim of understanding the health system

(particularly the provisioning of RCH services) in the Northeast region.

Study Design and Sampling

A descriptive research design was adopted, wherein after understanding the various levels of health facilities that provides RCH services in these four states, household surveys were conducted. This facilitated understanding the health seeking behaviour and also identify the factors that influence the accessibility and utilisation of RCH services.

The mixed sampling method has been used, where in, firstly, using non-probability sampling method and non-proportional quota sampling, the four states were identified for the study. Then one representative institution from each level of healthcare in each state was identified for the purpose of collecting information regarding how the RCH care services are organised and delivered to the people in these states. Besides this, multi-stage sampling was used to collect information from the users' perspective. In this case, firstly, purposive sampling using multi-purpose techniques (theory based, maximum variation, snowball and homogeneous) was used to identify sample districts in the four states. Two districts each were identified in all the states except in Cachar (it is already a relatively large district). From each district, a PHC was identified from which at least two urban communities and at least two rural communities each under it were again identified. A total of 800 households were thus surveyed. The households were identified and selected based on the criteria that the household should have a young mother with at least one living child who is below 5 years of age, and a recall reference period of six months. The tool also had a section on unmarried women and data related to this were collected from 24 respondents in Manipur and 35 in Sikkim.

Socio-Economic Classification

All the respondents were classified into various socio-economic classes using an updated version of Kuppuswamy's socio-economic status scale (Ravikumar, Dudala & Rao, 2013). They are presented below.

Table 2: Socio-Economic Class

Facilities	Frequency	%
Upper	8	1.0
Upper Middle	218	27.3
Middle / lower Middle	339	42.4
Lower / Upper Lower	234	29.3
Lower	1	0.1
Total	**800**	**100**

As we can see from the above table, the least numbers of respondents belong to the lower most and upper most category. Middle and lower middle form the largest majority, followed by lower/ upper lower. India is largely comprised of middle income and lower income groups and data also reflects such a scenario. This is a serious cause for concern in terms of accessibility and affordability, where India's healthcare spending is lagging behind other low and middle income countries thus resulting in huge out-of-pocket (OOP) expenditures. According to the World Bank, in 2000, the total healthcare expenditure for India was 4.4% of the Gross Domestic Product (GDP) as compared to 5.3% in other low and middle income countries (LMIC). In 2010, the figure was 4% for India and

5.7% for the other LMICs. Regarding OOP, it was 67% (India) and 44% (LMIC) in 2000; with marginal declines in both cases at 61% and 37% respectively in 2010.

The above table shows the age group classification of the respondents. We can see that maximum numbers of respondents were covered within the age groups of 20 to 40 years in all the states. In terms of religion, the study covered maximum Hindus in all the three states (Assam - 99.5%, Manipur - 74.5%, Sikkim - 50.5%), except Meghalaya (21%). Christians were highest in Meghalaya -73%, followed by Sikkim - 48%. This is reflective of the religious dominance in these states. However, although the Muslim population covered in Manipur was higher than that in Assam, it is purely related to the selection of communities because Assam has a very large Muslim population in general. It is thus not reflective of religious distribution. As per Census 2011, the Muslim population in Assam forms over 34% of its total population.

Table 3: Age Group of Respondent

Age	AS	MN	ML	S K
	%	%	%	%
15-20	-	9.0	1.5	9.5
20-25	22.5	20.0	22.0	25.5
25-30	43.0	20.5	33.0	33.0
30-35	18.5	26.0	18.0	16.5
35-40	14.5	15.5	18.5	8.0
40-45	15.0	6.5	5.5	5.5
45-50	-	2.5	1.5	2.0
Total	**100**	**100**	**100**	**100**

Regarding caste, it is a known fact that the caste system is not a strong concern in the NER. However, in states like Assam, it has some significance. The other states being based on an aboriginal tribal culture, the caste system has not taken deep roots, unlike what we see in the other parts of India. There were thus 35% SCs in Assam and only 8% in Sikkim. In Sikkim too, the caste system is practiced amongst the Nepalese. It was negligibly covered in the other two states as their presence is also rather low. ST presence was very high in Meghalaya (77%), followed by Sikkim (36%) and Manipur (13%). OBCs were again highest in Assam (48%), followed by Sikkim (41%). The general category population covered was highest in Manipur (85%). It was 17% in Assam, 18% in Meghalaya, and 16% in Sikkim.All the respondents were married except for 12% in Manipur and 18% in Sikkim, who were considered owing to situational and field issues.

Education

DLHS 2007-08 had concluded that non-literate women were less likely to be aware of family life education compared to women with ten or more years of education. Education is effective when it results in changes in one's knowledge, attitudes and practices (KAP). According to NFHS -3 (2005-06), mothers with no education and mothers in the lowest wealth quintile are twice as likely to lose their children in late pregnancy and during the first few days of life as mothers who have twelve or more years of education and mothers in the highest wealth quintile. In the patriarchal Indian society, the low status of women in the household indicates that health seeking behaviour of women in such a traditional society greatly depends on the decision of the partner or other older household members. In such a scenario, her own education will make a lot of difference in terms of awareness and decision making. Recent

studies show that status of women is an important determinant of maternal health (Mahapatro, 2012). Regarding education, the table below presents the details of this study.

Table 4: Level of Education

Education of the Respondents	AS	MN	ML	SK
Illiterate	24.5	8.5	11.5	8.5
Lower Primary	16.0	2.0	18.5	14.0
Upper Primary	9.5	9.5	15.0	27.0
High School	20.5	36	32.5	27.5
Higher Secondary	23.5	23.0	13.5	13.0
Graduation	5.5	16.5	8.5	8.0
Post-Graduation	0.5	4.5	0.5	2.0
Total	**100**	**100**	**100**	**100**

Family Education

Information was collected about the highest education attained by a member of each household that was surveyed. It was found that households with the highest numbers of post graduates are from Manipur, followed by Sikkim. Not surprisingly, RCH indicators are better in Manipur and Sikkim as compared to the other two states. DLHS 2007-08 had reported that any ANC is highest amongst women educated for ten years or more. This observation held constant across all these four states. According to reports, institutional deliveries in Assam increased by less than 7% during NFHS-2 and NFHS-3. In Meghalaya, it increased between 7-14%, while in Manipur and Sikkim, it increased by more than 15%. Thus this corroborates that education and RCH indicators are significantly related.

Husband's Education

Being better educated has been seen to play a strong role in determining the type of healthcare one seeks access to, as awareness of the advantages of types of services is strongly determined by education. Data showed that education of the husband allows women to participate in various decisions within the household. Education also influences place of residence, owing to increased job opportunities and resultant higher socio-economic status. This in turn improves access to outside knowledge and information of both the husband and wife, which influences the women's bargaining strength within the household so that they participate in various household matters.

Occupation of the Respondents

Basu (1992) reports that in India, it has been found that women with greater autonomy are more likely to use antenatal and delivery care than women with lower autonomy. He also highlights that women's participation in gainful and visible employment improvise their bargaining position within the household and is associated with greater gender equality in the distribution of household resources than when women are employed in invisible activities such as domestic work. Thus it can be assumed that a woman with independent financial resources will be able to exercise greater autonomy over her reproductive health. This becomes evident from the manner in which they seek ANC and PNC care. Mahapatro (2012) further adds that a woman with higher socio-economic status in terms of better education and employment has more autonomy than illiterate and unemployed women. 90% of the respondents in Assam were

unemployed/ housewives, 77% in Manipur, 65% in Meghalaya, and 66% in Sikkim. The other engagements were unskilled work, clerical jobs, small shops, farming, etc.

Total Monthly Income of the Family

In addition to education, income is another equally important determinant. We had noted earlier that Out of Pocket (OOP) expenditure on health is very high in the Indian scenario. Under such circumstances, purchasing power will play a vital role in choosing the preferred bundle of goods. Home deliveries thus cannot simply be attributed to lack of education and ignorance; where they feel institutional deliveries are not necessary. The other underlying reasons could range from no time to go to the health facility, distance, unavailability of transportation, and expenses. Besides determining access to healthcare facilities, family income also strongly determines another very important aspect for the woman and particularly, for an expectant mother and the new born baby. Deficiencies of certain nutrients are associated with maternal complications and deaths, foetal and new-born deaths, birth defects, and decreased physical and mental potential of the child. Thus monthly income also plays a great role in decision making related to actual utilisation of the type of RCH services.

The monthly income of all the participants were also quite low with several of them belonging to a family income group range of 1601-4809, with the highest being in Sikkim with 30%. Table 6 below presents the details. Regarding BPL cards, there were 20% in Assam, 22% in Manipur, 4% in Meghalaya, and 38% in Sikkim amongst the respondents.

Table 5: Family Income

Monthly Income	AS	MN	ML	S K
	%	%	%	%
=> 1600	-	-	-	1.0
1601-4809	17.0	18.5	13.0	29.5
4810-8009	37.5	25.5	32.5	23.5
8010-12019	13.0	13.5	29.5	14.5
12020-16019	9.5	11.5	8.5	8.5
16020-32049	19.5	22.5	13.5	18.5
=> 32049	3.5	8.5	3.0	4.5
Total	**100**	**100**	**100**	**100**

Drinking Water

As far as source of drinking water was concerned, piped into dwelling, piped into plot, public tap, hand pump, bore well, protected well, protected spring,Lake/Pond/River/Canal, neighbourhood, purchasedwater, were the major sources. Piped into dwelling was highest in Meghalaya (18.1%) and Sikkim (10.5%). Overall, piped into plot was highest in all the states, with Sikkim leading the list (61.5%), followed by Manipur (35.5%), Assam (34.2%), and Meghalaya (28.6%). Public tap is the other source that is used by a majority of the people where it is 33.7% in Meghalaya, 15.5% in Sikkim, 14.1% in Assam and 10.5% in Manipur. Handpump is used 36.7% in Assam, whereas it almost non-existent in Manipur and Meghalaya. In Sikkim, it is totally non-existent.

With regard to water treatment, 97.5% use boiled water in Sikkim, 70% in Manipur, 64% in Meghalaya, and 27.5% in Assam. Filter method is used by 50% in Manipur, 47.5% in Assam, 23% in Meghalaya and 10.5% in Sikkim. Nobody was consuming untreated water in Sikkim, whereas it was as high as 41.5% in Assam, 21% in Meghalaya and 10% in Manipur.

Type of Housing

Several research have demonstrated that housing conditions are closely related to low income; insecure and low wage employment; and food insecurity suggesting that it is a cluster of disadvantages in living conditions that contribute to poor health (Shaw et al., 1999). Poor quality living circumstances act as social determinants of health, of which income and housing are the most obvious. The presence of stress and anxiety about their housing conditions creates overall distress (Bryant, 2008). Among women, most studies on health outcomes show that women who are economically and socially marginalized have poor health status and higher premature mortality than women with higher income (Auger &Alix, 2008). This understanding is significant in the context of this particular study. The type of house, numbers of bedrooms, separate kitchen, toilet etc. are strong socio-economic indicators and are discussed below.

There were 47% pucca houses in Sikkim, 27% in Assam, 22% in Manipur and 19% in Meghalaya. 66% houses were semi-pucca in Meghlaya, 29% in Assam,42% in Manipur and 33% in Sikkim. Assam had the highest numbers of Kutcha houses (45%), followed by Manipur (37%), Sikkim (21%), and lastly Meghalaya16%. There were also several respondents who had only two to three rooms in their houses, with Assam topping the list.

In this study, it was also found that overall only 28.50% houses were pucca in all the four states. This is quite minimal, despite the fact that the rural houses were not very much in the interiors, thereby giving a sense of semi-urban location. Urban dwellings are assumed to be pucca in most instances. The Report on Housing Condition in India, 2002, No. 488, suggested that out of every 100 households in rural areas, 36 lived in pucca houses, 43 in semi-pucca houses and the rest in kutcha houses. On the other hand, out of every 100 households in urban areas, 77 lived in pucca structures, 20 in semi-pucca structures and only 3 in kutcha structures. In urban slums, 67% of the dwelling units were pucca. It also reported that Tripura, Manipur, Assam and Chhattisgarh were lagging considerably behind the national average in terms of households living in pucca houses. This is probably one of the reasons why there is a far greater proportion of kutcha and semi-pucca houses found in the present study. It is reiterated here that data was collected from 100 rural households and 100 urban households in each state.

Numbers of Rooms Including Kitchen

The respondents from Manipur were found to have greater numbers of rooms whereas a greater proportion of households in Assam and Sikkim were seen to have only one or two rooms. Regarding the overall status of the four states, 27.25% have five rooms or more, 21.13% have four rooms at least, 23.75% have minimum three rooms, 22.13% have two rooms and 5.75% have only one room. This indicates better standards of living. The data on family size showed 25.6% with only 3 family members, 29.1% with 4 members, 18.4% with 5 members and 11.6% with 6 members. The households with larger family members are much smaller and could be reflective of the joint families that have been included in

the study.

Respondents were asked about the numbers of rooms that were used for sleeping. This was included to help understand the socio-economic status of the respondents. Separate bedrooms especially for young couples provide privacy for discussions and decision making related to their reproductive preferences and practices. This will certainly influence maternal and child health and the overall health status of the family

Separate Kitchen

In developing countries, an estimated 4.1 million children under age five die from acute respiratory infections (ARI) every year (WHO 1995). In India, as in many other countries, ARI is the leading cause of childhood death (Murray and Lopez 1996). Mishra and Retherford (1997) point out that smoke from cooking increases the risks of ARIs in children. They further add that in India, women often cook under poorly ventilated conditions using pits or open U-shaped stoves, called chulhas. These stoves burn biomass inefficiently and release high volumes of noxious air pollutants indoors, which can have devastating repercussions, especially in the long run. Moreover, having a separate kitchen facilitates decision making in terms of food and nutrition requirements. In this study, overall across the four states, 92% have separate kitchens in their houses. Households are better off in this regard in Manipur amongst the 4 states while Sikkim is lagging behind.

Fuel Used for Cooking

Behera and Agarwal (2009) state that domestic cooking fuels are one of the important causes of indoor air pollution and consequent health concerns particularly in developing countries. According to the SAARC India Country Report, 2013, more than 60% of Indian households depend on traditional sources of energy like fuel-wood, dung and crop residues for meeting their cooking and heating needs. In rural India, 85% of households use firewood or dung cakes as the primary source of energy for cooking (NSSO, 2007). Laxmiet. al. (2003) also argues that the type of fuel used for cooking is a strong determinant of the family's socio-economic status, which has a huge direct impact on the health of the women who do the cooking and other indoor activities of the household.

Nevertheless, it is a positive indicator that although majority of households (71.7%) fall under lower middle and lower class, a huge majority stated that they use LPG (62.5%) and electricity (24.3%). It was found that electricity is used for cooking by 43.5% in Sikkim, and 36.5 % in Manipur. It is minimal in the other two states. LPG is used for cooking by 81% in Sikkim, 65.5% in Manipur, 55% in Meghalaya, and 48.5% in Assam. Wood is used by 65.5% in Manipur, 58% in Assam, 48% in Meghalaya and 42.5% in Sikkim. Since the northeast region has abundant forestry, it is also seen that 53.5% are using wood. However, unless it is waste and dry twigs etc., using firewood for cooking must be sought to be minimised. Other sources such as bio-gas, charcoal, cow dung cake and agri-crop waste are also used but very minimally.

Type of Toilet Used

There is a direct relationship between water, sanitation and health. It is estimated that 1 in every 10 deaths in

India in villages, is linked to poor sanitation and hygiene. Open air defecation especially around water sources can pose a huge threat to the entire community's health. Human waste is full of dangerous bacteria that can cause diseases like cholera, typhoid, infectious hepatitis, polio, cryptosporidiosis, and ascariasis. When waste is not properly managed, it can come into contact with skin, water, insects and other things that ultimately transfer the bacteria back into the human body where it can make people sick (Pandey and Kumar, 2014). When general health and environment is not healthy, it is bound to affect maternal and child health too. According to Census 2001, 36.4% of the households in India had access to latrine which increased to 46.9% in Census 2011.

Another important thing that is closely related to health is about the types of toilet. There were 6% each with 'No facility/open' in Assam and Meghalaya and 1% each in Manipur and Sikkim. Regarding 'Flush/pour flush' there were 81% in Meghalaya, 77% in Sikkim, 75% in Manipur, and 49% in Assam. Pit latrines were used by 24% in Assam, 14% in Sikkim, 8% in Meghalaya and 7% in Manipur. Other options were exercised by 22% in Assam, 18% in Manipur, 9% in Sikkim and 5% in Meghalaya.

Pregnancy Registration and ANC Utilisation

It was found from data that women in the rural areas are more compliant in terms of ANC registration, availing of any ANC facilities and also in availing full ANC facilities as compared to their urban counterparts. This definitely hints at education not necessarily being always amajor factor of actually utilising ANC care. Availability, accessibility and the role of motivators would definitely also be significant factors. Registration facilities created by the Union Ministry at the sub-centres play an encouraging role. Another positive finding is that all those who registered for ANC availed full ANC services.

Regarding religion and its influence on utilisation of ANC, almost all the Hindus have utilised ANC services (only 1.4% says 'No'). Likewise, for all the other religions too, religion does not seem to have much influence on actual utilisation of ANC in these north-eastern states. A similar conclusion can be drawn in the case of caste too, where a clear majority irrespective of categories have registered as well as utilised full ANC. The concern arises in the case of BPL families, where 78.5% have not registered nor utilised and only 18.2% have done so.

Another aspect we can examine is about family type, where irrespective of family type, a clear majority has availed of ANC services. What is significant is that all the upper class households have utilised ANC fully while a few of the upper middle and lower middle households have not utilised such services. Moreover, the proportion of those who didn't utilise such services are relatively higher among the lower/ upper lower households. This means that economic affordability or purchasing power does play an important role in determining ANC utilisation.

Education is yet again another important variable where there are 1.1% of illiterate respondents who didn't utilise ANC. Contrastingly all post graduate respondents have utilised such services.

Likewise, her own age at marriage is significant as it was found that those who married above 18 years seem to show greater compliance with ANC. One more important observation was that women who have had greater numbers of children show greater compliance with ANC.

ANC Utilisation and IFA Consumption

Data was also collected about households that sought ANC services from Government setting, wherein they were classified as 'No ANC', 'Partial ANC' and 'Full ANC'. A similar representation was done for the private setting too. Data showed that there were respondents who completed full ANC by using a mix of government and private services. It was also found that irrespective of urban or rural dwelling, utilisation of government services are more. IFA consumption compliance was however relatively greater among rural households.

Regarding religion, caste, and type of family, it appeared that irrespective of the category they belong to, preference is for the government services. Moreover, among BPL families, it was seen that they strongly prefer government services as affordability is a major concern. Likewise,when observed against the other variables such as family type, socio-economic class, education of the respondents, husband's education, and wife's age at marriage, it was found that government services are preferred over private sector. The reason as stated earlier is that in northeast India, the private sector is not so evolved unlike in other more developed regions of India. It was also observed that IFA consumption was also higher in the case of nuclear families, the middle/ lower middle and lower/ upper lower socio-economic class. Husband's education influenced IFA consumption to a large extent. It was seen that IFA was consumed for a period of upto three months or more among 59% households where husbands were educated; while where husbands were not educated, only 9.1% households consumed thus. Wife's age at marriage was also a strong determinant where 58.3% of those who were above 18 years consumed IFA tablets for more than 3 months, whereas only 9.9% of those below 18 years consumed it.

Type and Place of Delivery

There were more cases of normal deliveries in the rural areas while there were more institutional deliveries in the urban areas. This is of concern as one of the core agendas under the RCH programme was to encourage institutional deliveries. It needs to be examined as to whether it is mindset, economic constraints, or unavailability of facilities that are paramount in the choice of place of delivery. Religion did not have a significant influence on type of delivery or place of delivery. Caesarean delivery was observed more among the general category households while proportionately the SC households were seen to have opted more for non-institutional delivery. Less numbers of BPL households opted for caesarean delivery. However, majority of them have opted for institutional deliveries. A greater proportion of nuclear families have not opted for institutional deliveries. The upper class are seen to prefer caesarean and institutional delivery. The upper middle class also

showed more inclination towards caesarean delivery. Better educated respondents preferred normal and institutional delivery. Educated husbands as well as older women also seemed to prefer institutional delivery. Greater proportion of women with greater parity did not opt for institutional delivery.

Pregnancy and Delivery Complications

Data showed that there were relatively lesser pregnancy as well as delivery complications in the rural areas. Besides this, it was observed that religion, caste, BPL status or family type did not have much effect on pregnancy complications or delivery complications. Education also did not seem to affect complications much. Similar observations were made for age at marriage and parity.

JSY, PNC and Postnatal Complications

The numbers of JSY beneficiaries were found to be much more from rural areas. However, those utilising PNC services are more from the urban areas. Post natal complications also were marginally higher in the urban areas. Religion was not found to be a significant variable that influenced JSY access or PNC services and related complications. More of SCs and OBCs have accessed JSY. However, irrespective of JSY, STs and general category respondents have utilised PNC services. Post natal complications were quite high across all categories. 11.4% of BPL families have been left out of JSY while 24.3% of non-BPL families have availed of it. Surprisingly a greater proportion of non-BPL families have not availed of PNC. It was also found that family type does not influence access to JSY and PNC, nor PNC complications. Another reassuring finding was that lower the economic class, greater was the utilisation of JSY services. A predictable finding that emerged was that lower and lower middle classes were utilising PNC services lesser than the upper and upper middle classes. Complications were also higher among the lower classes. A greater proportion of lesser educated respondents have got access to JSY facilities, presumably because they either belong to BPL families or to the relatively lower classes. Education also had a strong correlation with PNC where more of the better educated opted for it. A far greater proportion of educated husbands admitted to opting for ANC services. Greater proportion of respondents whose age at marriage is more than 18 have availed of JSY. Age at marriage was found to be an influential variable for PNC too. Although JSY is meant only for deliveries upto two children, it was found that 7.4% respondents with more than 3 children were getting this facility too. It was also found that PNC reduces with increased parity. However parity did not have much effect on post-natal complications.

Place of Delivery and Post Delivery Treatment

Regarding place of delivery, although overall government is preferred over private, there was not much variation across religious categories. Even 'other' options were exercised to quite an extent across religions in case of place of delivery besides government and private. However, in case of post-delivery treatments, majority opted for government followed by private. The

'other' option was almost nullified. Among all the caste categories, SCs and STs were seen to opt the least for private care and depended upon government and 'other' for deliveries. There was not much variation among BPL and non-BPL families about choice of place of delivery as well as post-delivery treatment. However, within the BPL families, almost all of them opted for Government and 'other' as preferred choices. Across family types too, government was the preferred place for both delivery as well as post-delivery treatment. Preference for delivery as well as treatment in private setting is proportionately higher in case of better socio-economic conditions. It was found that education influences choice of place of delivery where the respondents with higher education were seen to opt for private care to quite a large extent. This can be attributed to increased purchasing power. A similar thing was observed where husbands are uneducated and the preference for government setting is higher, which can once again be attributed to lack of purchasing power. When the wife's age at marriage is low, greater preference is shown for government setting.

Compliance and Preference for Antenatal Care

It is an important finding that there were far greater proportions of non-compliance with pre-natal check-up within the first 24 hours in the rural areas. More cases of death were also reported. In the rural areas, it was found that there a greater preference for ante-natal check up in the government setting. But what is disturbing is the prevalence of 'other' as a choice for neonatal check-up in both rural and urban, with a greater prominence in rural areas. As observed earlier, religion does not play a major role in compliance with check-up or with place of check-up. There was an exception in the case of Christians, where it was observed that they were relatively less compliant as well as exhibited greater preference for government. Similarly another observation holds true in this case, where SCs are seen to be relatively less compliant with timely neo-natal check-up. However for choice of place, STs prefer government setting more as compared to the other categories. Surprisingly, there were greater proportion of non-BPL families who have not complied with timely check-up. Higher socio-economic class showed greater compliance and also preference for private care. Likewise higher education meant higher compliance and increased preference for private care. Husband's education also seemed to influence in a similar manner but since the sample was highly disproportionate (educated versus uneducated husbands), it is not easy to draw a definite conclusion. A similar explanation holds for wife's age at marriage where older women show more compliance. Another significant observation is that lower parity showed greater compliance with neonatal care. Lower parity also showed higher preference for private care.

Compliance with Immunization and Place of Immunization

There were more cases of 'partial' and 'no' immunization in the rural areas, which can be attributed to lack of awareness, poor facilities, and economic as well as domestic constraints. Religion, caste and family type were not found to be significant variables regarding

immunization. Proportionately, there was not much difference in compliance with immunization among BPL and non-BPL families for which the government health and family welfare programmes must be lauded. A noteworthy finding here was that despite higher socio-economic class, there were more cases of non-compliance with immunization. Education seemed to have a marginal positive influence on immunization. Similarly for wife's age at marriage and parity, the observation is not strongly conclusive as sample is disproportionate.

Conclusion

The findings of the study underline the significance of several socio-economic pointers in understanding the utilization of RCH services in the Northeast. For instance, education of both husband and wife were seen to be important determinants regarding place of delivery. On the other hand, religion did not have much influence on compliance with ante-natal check-up. In the rural areas, JSY is performing well but compliance with immunization is low in these areas. Thus to further boost the success of the RCH programme, the government must take into consideration the unique elements of the region and its people. The rural-urban differentials must also be noted. A thrust on education, and especially women's education; thus empowering them with awareness to take informed decisions besides of course, the undeniable aspect of economic empowerment is truly the way forward.

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ISSN: 0976-5484 Social Work Journal • Vol. 5 • No. 1 • June 2014 • Page 24-30

Hospital Based Study on Cancer among Women in Barak Valley and Scope for Social Work Intervention

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Barak Valley comprises of the southern part of Assam, with three districts: Cachar, Karimganj and Hailakandi. Cachar Cancer Hospital & Research Centre is located in the Cachar district of Assam. Cancer incidence data were collected from the hospital registry. 1,395 cancer patients were registered from Barak Valley in the year 2014. Among the registered 586 females from Barak Valley, the common primary cancer sites were gall bladder (100), breast (74), cervix (58), oesophagus (41), oral cavity (30) and ovary (28). This study aims to investigate the socio-economic status, tobacco related habits, clinical features and outcomes among the studied patients. A comparative analysis with male counterparts was also performed in oral cavity malignancy group. Data was abstracted from the clinical records of patients with confirmed cancer reported in the year 2014 from the hospital registry. Among the 586 female cases, 55.3% (324) patients were from Cachar district, 30.5% (179) from Karimganj district and 14.2% (83) from Hailakandi district. 79.3% (465) patient's age was found above 40 years. 344 females which constitute 58.7% of patients registered at Cachar Cancer Hospital and Research Centre had monthly income of Rupees up to 6000.00. Majority of women's reported using tobacco (82.4%). Over 90% of patients with cervix, gallbladder and oesophagus cancer used tobacco. 86.7% of females with oral cancer were tobacco users. Out of 71 oral cavity cancer patients, male and female ratio was 4.1:3. Comparative data of treated oral cavity (39) shows that only 46.3% (19) male and 66.7% (20) female received cancer directed treatment. Pre treated average haemoglobin in males were reported 10.9 and in females 11.2. Treated males average weight was 51.7 kg and in females 45.2 kg. 84.2% (16) males were having tobacco habits whereas female's tobacco users were 85.0% (17). Majority of the treated patients were registered in stage IV of cancer. Male stage IV oral cavity cancer was 63.2% (12) and female stage - IV oral cavity cancer was 65.0% (13). After completion of cancer directed treatment, patients were followed up. Female survivals were comparatively better than males and it was additionally observed that among females, stage - III has better survival than stage - IV. Patient follow up is a crucial factor in the management of cancer. Social work intervention can contribute significantly in improving the patient's behavior towards cancer, tobacco cessation, counseling, and can play a key role in the patients' regular follow up for better survival.

Introduction

It is widely known that cancer is a malignant disease which is caused due to the abnormal growth of cells in the body. Jemal, Siegel, Ward, Murray, Xu, & Thun's study (as cited in Ali, Wani, and Saleem, 2011) mentioned that cancer is the second most common disease in the world after cardiovascular disorders. Cells can be abnormal due to several factors and accordingly WHO, in its World Health Report, Geneva, 1997, stated (as cited in Murthy and Mathew, 2004) that, 80 -90% of human cancers may be attributable to environmental and lifestyle factors such as tobacco, alcohol and dietary habits.

Barak valley in the southern part of Assam and comprises of Cachar, Karimganj, and Hailakandi districts. Cachar Cancer Hospital & Research Centre (hereafter CCHRC), located in Cachar is the only specialist cancer hospital in Barak valley, and thereby naturally has to cater to the vast expanse of population across these three districts, not to mention the population of adjoining border states. In 2014, the CCHRC registered 1736 cancer patients, of which 586 were females from the Barak valley. This study analyses the data of women registered with cancer from Barak valley and seeks to understand their psychosocial aspects and the scope of social work interventions. Tamulee (2013) has specified that social workers and doctors are generally reducing the burden of emotions and fear of cancer patients.

Materials and Methods

Data of the year 2014 was collected from the hospital based registry. Only registered females with cancer from Barak valley were considered for this review at CCHRC. Female oral cavity cancers were compared with those in males. Data were analyzed by different analytical tools in Statistical Package for Social Sciences (SPSS) and EPI INFO (Epidemiological software). For survival analysis, life table survival method was used. Chi-square method was also used for some other analyses.

Results and Discussions

Demographic and Socio-economic Status of Registered Female Cancer Patients

586 female patients of Barak valley were registered as opposed to 809 males which constitute 42.1% of female cancer cases. 324 patients were from Cachar district, 179 from Karimganj district and 83 were from Hailakandi district. Cachar district alone represents 55.3% of female cases. In females, the common cancer sites were breast, cervix, gallbladder, oesophagus, oral cavity, and ovary. Gallbladder cancer was found common in all the districts and the total registered gallbladder cancer cases were 100 followed by the 74 breast cancer cases among females. Kapoor and McMichael (2003) conducted a study on gallbladder cancer (GBC) and expressed that "GBC is much more common, especially in women, in north and central India than in the west and south" (p. 209). Misra, Misra and Chaturvedi's study (as cited in Sharma,

Agrawal, Chanchlani, Krishnanand and Rana, 2014) explained that carcinoma of the gallbladder is a highly fatal disease with poor prognosis. It is the most common malignant lesion of the biliary tract and the fifth most common among malignant neoplasm of the digestive tract. Even with the numerous diagnostic tests available, gallbladder cancer is frequently first diagnosed during laparotomy or laparoscopy procedures, which were expected to confirm the presence of benign gallbladder disease. Mahanta, Nath & Rajbongshi (2012) explained that "ca.cervix and ca.breast are the most common life threatening cancers among women worldwide and the same is true for north east region of India also" (p. 27). Total 58 cervical cancers were registered at CCHRC in the year 2014 followed by 41 oesophageal cancers, 30 oral cavity cancers, and 28 ovarian cancer cases. Sharma, Kalit, Nirmolia, Saikia, Sharma & Barman (2014) stated that oesophageal cancer is the most common cancer in women occupying the top three positions in the north east regions as per population data.

Patient's age is another important factor. In 2014, CCHRC registered 11 female cases from the age group 0 - 10 years, 13 cases from 11 - 20 years, 23 cases from 21 - 30 years, 74 cases from 31 - 40 years, 166 cases from 41- 50 years, 158 cases from 51 - 60 years, and 141 cases above the age group of 60 years. Nearly 80% of patients registered with CCHRC in 2014 were above the age group of 40 years. Madani, Jahromi, Dikshit, Bhaduri & Aghamolaie (2010) conducted a hospital based case-control study at Morbai Naraindas Budharani Cancer Institute Pune in 2005-2006 and found that the average age of the patient is 52 years and majority of subjects were above the age of 40 years.

Patient's income is an important factor both for continuation of their treatment and survival as cancer treatment is multidimensional and multimodal. The completion of cancer directed treatment takes several months based on the prognosis of the disease. 166 patients' monthly family incomes were reported to be less than Rs. 3001 and 178 patients' monthly family incomes were documented between Rs. 3001 to 6000. A total of 344 females which constitute 58.7% of patients registered at CCHRC had a monthly income of up to Rs. 6000 and only 242 females reported their monthly family income above Rs. 6000which constitutes 41.3%.

Tobacco Habits of Registered Patients from Barak Valley

Tobacco users were found very common in both males and females. Krishnatreya, Hoque, Sharma, & Kataki (2014) conducted a study in Barpeta district of Assam, which showed that male tobacco related cancer accounted for 65% of all cancers and in females it was 46.8% of all cancers. The results indicate that out of 1395 registered total cases, 1218 patients were tobacco users in any of its form which comprises 87.3% in both sexes. 735 males and 483 females were tobacco users and the percentages were respectively 90.9% and 82.4%. There was association at

5% significance level between sex and tobacco habits (x^2 = 21.80, df = 1, p =.000). Among females 97.6% who suffered from oesophageal cancer, 91.4% from cervical cancer, 91.0% from gallbladder cancer, 86.7% from oral cavity cancer, 73.0% from breast cancer were tobacco users.

Sex and Age Distribution of Oral Cavity Cancer Patients

Oral cavity cancer is one of the common cancers among females at CCHRC. 41 patients were male and 30 were females. Majority of the oral cavity cancer patients registered were above the age of 40 years which constitutes 97.6% males and 96.7% females. 21.9% males and 10.0% females were reported in the age group of 41 - 50 years. The age group 51 - 60 years had a high incidence of cases, i.e., 11 males and 13 females. 19.5% males and 26.7% females were registered above the age group of 60 years. Females were comparatively registered in later ages than males. Older ages have poorer prognosis and survival.

Tobacco Habits of Oral Cavity Cancer Patients in both Males and Females

Female tobacco users were comparatively lesser than males. From total 41 males, 17 tobacco chewers, 1 smoker, and 22 users of both, only 3 patients reported no such habits. Out of 30 females, 24 cases were tobacco chewers, 2 were both chewer and smoker and only 4 patients reported no such habits. 20 females and 19 males from the oral cavity cancers had completed their cancer directed treatment, and from them 17 females and 16 males had tobacco habits which constitutes 85.0% and 84.2% respectively. Here the treatment group from oral cavity cancer showed that female tobacco users are more than male tobacco users. Tobacco chewing was common among the oral cavity cancer patients. Arora's study (as cited in Soni & Raut, 2012) explained that smoking tobacco was a taboo in traditional families but smokeless form of tobacco was widely accepted. Inclusion of tobacco as one of the ingredients of paan highlights the importance of this product and its wide social acceptability of tobacco chewing in ancient India. Women ate paan for cosmetic reasons as chewing it produced a bright red juice that colored their mouth and lips.

Stage Grouping of Treated Oral Cavity Cancer Patients in both Males and Females

26.3% males and 35.0% females were reported in stage III. 63.2% males and 65.0% females came for treatment in stage IV. Over 60.0% cases reported advanced nature of disease in both males and females. Advanced nature of disease has poorer prognosis and survival. The causes of late representations may be their financial crisis as 58.7% patients reported from Barak Valley has monthly income less than Rs. 6000 and basically were daily wage earners. The other causes may be their ignorance, tried other options of treatment, negligence, etc.

Other related Information of Treated Oral Cavity Cancer Patients in both Males and Females

For treating cancer patients it is very important to know their weight and haemoglobin status at the time of their first presentation. From the treated 39 patients, the average body weight of male and female was 51.7 and 45.2. Haemoglobin status of male and female was 10.9 and 11.2. 15.0% female oral cavity cancer patients reported their family history of cancer. 15.8% males and 20.0% females reported the history of co-morbid conditions.

Compliance to Treatment of Oral Cavity Cancer Patients in both Males and Females

Table 1: Compliance to Treatment

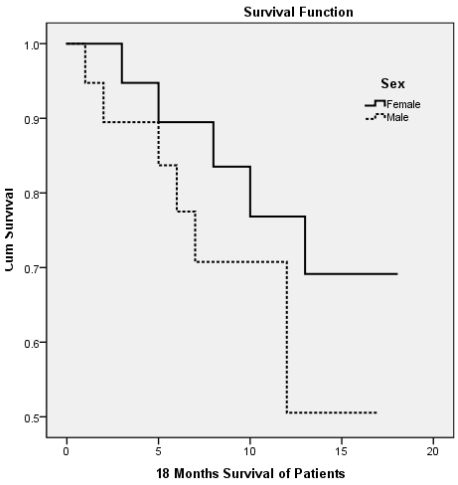
Sex	Treated	%	Non Treated	%
Male	19	46.3	22	53.7
Female	20	66.7	10	33.3
Total	**39**	**54.9**	**32**	**45.1**

Table 1 shows that 54.9% oral cancer patient received treatment. 66.7% females and 46.3% males completed treatment. There was no association at 5% significance level between sex and compliance to treatment (X^2= 2.89, df = 1, p = .089). Compliance to treatment is better among females because family members were keen to have their treatment or they were not the head/ leading members in the family who will earn/run the family. In case of males the compliance to treatment is comparatively less because they were the earning members in the family.

Survival Status of Oral Cavity Cancer Patients

Survivals are assessed at 18 months follow up after completion of treatment in both males and females. Figure 1 shows that the female survival was better comparative to males. Figure 2 indicates that Stage III have better survival than Stage IV among females as advanced stages have poorer prognosis and the disease spreads to the other parts of the body/ organ.

Figure 1:Survival Curve of Treated Oral Cancer-2014

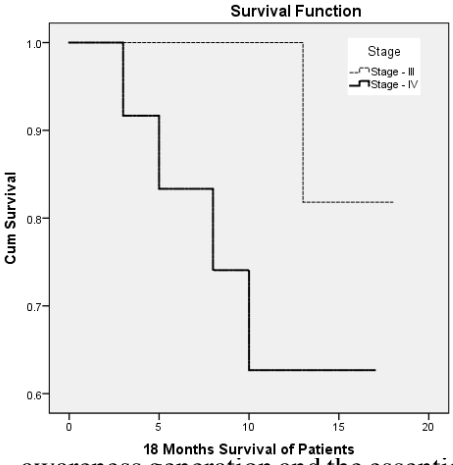


Scope of Social Work Intervention

Social workers in cancer settings are primary providers of psychosocial services in major cancer treatment centers throughout the world; both because of their knowledge about cancer and its psychosocial impact, and because of their practice versatility. Oncology social workers are trained in prevention, education, advocacy, research, and counseling. Their role has evolved to a central role in cancer care.

Berkman (1981) mentioned that Ida Canon became the first hospital social worker at Massachusetts General Hospital in Boston in the year 1919 and

Figure 2 :
Stage wise Survival of Treated Female Oral Cancer Patients



from then medical social work got its root. Since then the hospital patients were viewed not only for medical purposes but also patients were seen in the perspective of bio-psychosocial aspects.

Social workers are professionally trained persons. In medical settings the professional social workers are working as a member of the interdisciplinary team and plays their effective role to deal with the patients and patients' families related psychosocial problems through applying its problem solving approach and counseling.

In CCHRC, the registered patients were having socio-economic issues, history of tobacco use, problems with compliance to treatment and follow up. The fundamental task of social work in cancer setting is to facilitate patient and families coping with cancer diagnosis, treatment, rehabilitation and follow up. Social workers can play an active role of patient's demographic follow up in cancer care. Demographic follow up involves phone calls, posting of letters, using patient's e-mail, sending messages, and conducting home visits. In CCHRC, the team of social workers continuously follow up on all these demographic procedures to improve the long term impact of treatment received by cancer patients and their relatives.

Conclusion

It was found that in 2014, at CCHRC, 42.3% (734) female cases registered, and out of that 586 cases were from Barak valley. Tobacco consumption was common in both males and females. There were more than 55% patients with a monthly income below Rs. 6000 and the majority of patients' age were above 40 years. From oral cancer treatment group it was found awareness generation and the essential patient follow up, to upscale the benefits derived from seeking medical treatment for cancer.

Acknowledgements

We would like to thank Ms. Gayatree Roy (Das), Mr. Sagar Deep Chakraborty, Mr. Premjit Kurmi, and Mr. Sanjib Sutradhar for their data abstraction.

This report could not have been written without their contribution. Usual disclaimers apply.

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ISSN: 0976-5484 Social Work Journal • Vol. 5 • No. 1 • June 2014 • Page 31-37

Health Status of the Women Workers in Footwear Industries: A Case Study of Tamil Nadu Cluster

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This paper seeks to explore the health status of the women workers in footwear industries. It examines the health conditions in terms of health problems, utility of health, safety measures and basic amenities at the workplace. The results indicate that a large proportion of workers have health problems. Thus public health careand filling up of the large gaps in safety measures and basic amenities in these industries are essential. This paper therefore argues that the factors affecting the health of the workers were the long hours of work, absence of leave facilities, unavoidable household duties, lack of basic amenities at the work place, low wages and poor housing conditions. The prolonged working hours in the factory and the dual burden of household duties adversely affected the sleeping hours and promoted restlessness especially among the women workers. The working environment lacked ventilations, lighting, drinking water, bath room and toilet facilities and evidently affected the health status of the workers. This clearly hints that enforcement of labour laws in the factories will solve most the problems and would also improve the employer-employee relations to ensure basic social security of the workers. Although, shoe factories have provided gainful employment to the unskilled workers, the quality of employment remains questionable till today. The onus falls on the government to make efforts so that certain social security measuresare taken to ensure a fair quality of employment.

Introduction

Indian leather industry is the eighth largest source of India's foreign exchange and offers employment to about 2.5 million workers. Leather exports from India have increased from US$ 4634.92 million in 2011-12 to US$5908.82 million in 2013-14.The Indian leather industry comprises five key segments viz., (i) tanning and finished leather, (ii) leather footwear, (iii) leather garments, (iv)leather goods and accessories such as gloves, and (v) saddlery and harness. India is the second largest producer of footwear next to China. In 2012-13, India's share in global footwear production was 11.63 per cent and it produced 17.7 billion pairs and exported115 million pairs. India's share of global trade in footwear was 2.01 per cent in 2012-13. However, 95 per cent of footwear was for domestic consumption.The value of footwear has increased from US$1507.59 million in 2009-10 to US$ 2531.04 million in 2013-14. Major markets for Indian footwear are United Kingdom(US$ 426.05million), Germany (US$ 345million), United States of America (US$312.21million), Italy (US$ 183.7million) France (US$183.09 million), Spain (US$116.84million), United Arab Emirates (US$106.24), Netherlands (US$98.39), Denmark (US$24.46) and other countries such as Australia, Sweden and Canada.

The major production centers of leather and leather products are located in eight states of India -Tamil Nadu(Chennai, Vellore, Dindugal, Erode and Trichy),West-Bengal(Kolkata), Uttar

Pradesh(Kanpur and Agra),Punjab (Jalandhar), Delhi, Telangana (Hyderabad and Warangal), Karnataka (Bangalore and Athani) and Maharashtra(Mumbai).These states (called 'clusters' by leather producers) have different structure of production and labour market structure.Tamil Nadu leather cluster is highly organized and is the leading market for export of footwear from India. This cluster is highly integrated with the global market and is also very capital intensive. Goods are produced using highly mechanized form of production. Kolkata on the other hand, has unorganized segments and its major production arevarieties of leather goods. Leather goods produced for the domestic markets are of low end technology and mostly family owned organizations. Firms in the Agra cluster are also different in that they use both organized and unorganized production forms and produce footwear for both export and domestic markets. Additionally, Agra cluster has a variety of firms ranging from highly sophisticated 100 per cent export oriented firms, small producers who produce for the domestic market to home-based small work units. On the other hand, Tamil Nadu cluster has an exceptional character in which women non-migrant workers account for a large share of the leather industry workforce. The next section discusses the methodology of the study and the later onepresents the analyses of general information about women workers, the health statuses of these women, nature of diseases, sources of health care, their utilization, availability of safety measures at the workplace, and accidents at the workplace, followed by the conclusion.

Methodology

Vellore district in Tamil Nadu was chosen purposively. Vellore district has a dominant presence in the leather and leather based industries in the state and accounts for nearly 40 per cent of the country's export of leather and related products such as finished leathers, shoe uppers, shoes, garments, gloves and so on. The pilot study was carried out during the period November 2012 to February 2013, lasting for four months. The researcher visited footwear industries located in various districts such as Vaniyambadi, Alangayam, Ambur, Vellore, Arcot, Walajapettai, Ranipettai and had in-depth discussions with the managers and supervisors of various shoe factory units. Based on the information, interview schedules were prepared for women workers in the shoe/ footwear factory units. A total of 740 women workers were interviewed in the present study.

General Characteristics of the Sample Workers

The sample data indicated that the majority of workers are Hindus. Out of the 740 sample workers, nearly 82 per cent of workers are Hindus, 11 per cent Muslims, and 7 per cent are Christians. The data indicated that the majority of workers are Hindus. Scheduled Castes (SCs) account for the largest share of leather industry workers from those included in the study. From the sample, data showed 46.2 per cent were scheduled castes, 28.2 per cent backward classes, and 25.5 per cent as most backward classes.

The age of sample workers also clearly

indicated that most workers are in their young age. Nearly 86 per cent workers were aged 40 or below. From the data, 12.3 per cent were illiterates while 87.7 per cent were literates. Most illiterate workers were scheduled castes, (nearly three-fifths) whereas only about one-fifth of illiterates were either BCs or MBCs. The literacy levels of sample workers have been classified into seven categories. Nearly 80 per cent of workers did not study beyond the tenth standard. Almost all the workers did not have any technical qualification such as ITIs/Diplomas. This can also be one of the reasons for lack of upward mobility of workers in the study area. This study also suggests that though there were many government and private institutions established all over the state, none were found to play any role in sending a technical and soundly trained workforce to these leather industries based in the study area.

(a) Health Problems

A question was posed to these sample workers on whether or not their health is affected due to the working conditions. Two-thirds of workers reported having health problems (66.2%).

The details of work related health problems as reported by the workers are shown in Table 1. Nearly 30 different kinds of health problems were reported by workers. They range from simple body pain to major gynecological problems and the proportion of workers suffering from these health problems also varied. Majority of workers reported problems of pain in hand/leg/joint (66.2 per cent), 26.6 per cent reported body pain, 25 per cent reported headache, 22 per cent reported falling hair, 21 per cent had hip pain, and18 per cent of workers suffered from back pain.

Table 1: Health Problems of the Workers

No	Diseases	Persons	%
1	Hand/Leg/Joint Pain	490	66.2
2	Body Pain	197	26.6
3	Headache	183	24.7
4	Falling Hair	163	22.0
5	Hip Pain	157	21.2
6	Back Pain	136	18.4
7	Fingers Pain	126	17.0
8	Stomach Pain	121	16.4
9	Menstruation Problems	94	12.7
10	Chest Pain	74	10.0
11	Eye Pain	67	9.1
12	Skin Irritation	58	7.8
13	Cough	48	6.5
14	Cold	37	5.0
15	Vomiting Sensation	34	4.6
16	Womb Problems	18	2.4
17	Eosinophilia	15	2.0
18	Dermatitis	10	1.4
19	Abortion	8	1.1
20	Typhoid	6	0.8
21	Other Diseases	4	0.5
22	Tuberculosis (TB)	2	0.3
23	Stillbirth	2	0.3
24	Anthrax	1	0.1
25	Diarrhea	1	0.1

(b) Utility of Health

Given the level of income earned by these workers, it is essential to understand the manner in which they seek treatment for their health problems. A question was asked by the researcher on where they seek treatment from; public or private healthcare. Majority of workers get treatment from public hospitals (52.7%). It may be due to two reasons: their income levels are not sufficient to go to private hospitals or the public health care facilities in their areas may be better and they need not have to spend from their pocket for such

work related health problems.

Workers in the study area go to four government hospitals viz., Primary Health Care Centre at the village level (22%), Taluk level hospital located in Vaniyambadi, Ambur, Walajapettai and Arcot towns (39%), Government Medical College Hospital at the district headquarter of Vellore (2.1%), and (4) Employees State Insurance hospital at Vellore (36.2%). Out of 390 workers, majority of workers take treatment from government hospitals, followed by ESI hospitals, primary health care centres and medical college hospitals. Workers reported that working hours of government hospital sparticularly the outpatient department (OPD) working hours were not suitable for them. This forces them to go to private hospitals.

For private care, 92 per cent of workers reported that they take treatment from private clinics and the rest reported about treatment from corporate hospitals. Workers are also compelled to go to private hospitals for ailments which require stay as inpatient for treatment, owing to the need for quality care, and the unavailability of such care in the government hospitals.

The workers were also asked about the extent to which their employers provide healthcare facilities. About 80 per cent of workers reported that their employers do not provide any healthcare facilities in their factory premises; twenty-two per cent reported that their employers referred them to a particular doctor or clinic. About seven per cent of workers reported that the treatment costs were reimbursed by their employers.

(c) Safety Measures

A question was posed to workers on the availability of safety measures available at the workplace and the accidents that happen in the factory premises. Sixty-five per cent of workers reported using hand gloves and 26 per cent of them use mask. 27 (3.6%) workers out of the total 740 workers, reported that accidents do happen at their factory premises. Among them majority reported machine related injuries which happen particularly due to careless stitching and cutting operation activities; while some are fire accidents.

(d) Basic Amenities in the Workplace

In order to assess the basic amenities available to workers at the workplace, a list was prepared which include (1) working space, (2) lighting, (3) drinking water, (4) rest room, (5) toilet, (6) crèche, (7) canteen and (8) other infrastructure. It was found that a majority (63 per cent) reported having good space and 14 per cent even reported it to be very good. However, 21 per cent workers were not satisfied and 1.2 per cent reported bad working conditions. Generally large scale firms had good space. In some units, a separate space is even made available for prayer. Workers from job work units and small scale units reported their workplaces as congested. The space between workers in a particular section of workplace is different from firm to firm. Some factories use conveyors line work system. Regarding lighting facilities available in the workplace,workers' responses weredivided into four categories, viz., (i) bad, (ii) satisfactory, (iii) good and (iv) very good. Among the respondents, 58.6 per cent said that there were good lighting facilities. Most factory units, in

which they are employed, provide them with safe drinking water facilities. Only about two-thirds of workers reported that their factories provide separate rest room facilities for male and female workers.

During the field visit, the researcher also observed that many job work units and small scale units do not have toilet facilities. As far as the sample workers are concerned, only three per cent reported that there is no proper toilet facility in their factory units. Otherwise, most workers responded that their factories not only have proper toilet facilities but they also have separate toilet facilities for males and females.This necessitates one to reflect whether such responses were defensive in lieu of their job security, owing to fear of the management, since it contrasted with the researcher's general observations.When footwear industry employs predominantly women workers, crèche facilities become an essential part of the workplace. Only 28 per cent of the workers reported that the factory units provide crèche facilities. In the field visit, the researcher observed that even in large scale and medium scale export units, the crèche facilities were absent or the rooms were in bad conditions and also poorly managed. The small units and job work units' do not make provisions for crèche facilities at all. 43 per cent of workers reported the availability of canteen facilities in their firms. Most of those workers who reported the availability of canteen also said that the canteen food is good and the price was also reasonable.

Finally, the researcher asked the respondents about the overall working conditions. 64 per cent reported it as good, 9.2 per cent very good, and 25 per cent reported as satisfactory. However, during the field work, the researcher found that the majority of job work units had congested workplaces, insufficient number of toilet facilities, common eating places for male and female workers etc. Moreover, there was the absence of basic facilities such as (a) rest rooms, (b) safe drinking water, (c) clean workplace, and (d) ventilation facilities. These conditions were relatively better in large, medium, and export units. For instance, some factories provided purified drinking water facilities, adequate lighting facilities and ventilation etc.

Conclusion

The health of the female footwear workers are adversely affected and employers continue to fail to provide not only health facilities, but also a decent workplace that would be conducive for the upkeep of health and other safety measures. The major factors affecting the health of the workers were hours of work, absence of leave facilities, household duties, basic amenities in the workplace, low wages and poor housing conditions. The long working hours in the factory and accompanying household duties shortened the sleeping hours and promoted restlessness and fatigue among the women workers. Lack of a conducive working environment such as ventilations, lighting facilities, drinking water facilities bath room and toilet facilities makes it evident that it affects the health status of the workers. This clearly points out that enforcement of appropriate labour laws in the shoe factories will resolve most of the problems and improve the employer-

employee relations as well as ensure basic social security of the workers. Undoubtedly, shoe factories have provided gainful employment to the unskilled workers but the quality of employment is highly questionable. This is so especially in the context of poor health and safety measures, which go on to affect not only the safety of women and children, but also the larger society as reproductive health can become an emerging concern with the reported problems of gynecological issues. Rather than turning a blind eye to this problem which has been ensuing for several decades, it is the need of the hour for the government to ensure that there is fair play in these establishments. A large amount of revenue is garnered by the leather industry in Tamil Nadu and hence it is justified that the workers get their share in terms of decent working conditions to say the least, so that health which is a basic concern for all can be looked after. This will certainly help the poor workers to rise out of their poverty trap.

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ISSN: 0976-5484 Social Work Journal • Vol. 5 • No. 1 • June 2014 • Page 38-43

Ethical Issues in Healthcare Practice: Reflections from Private Hospitals, Kerala, India

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Pregnancy and childbirth are life events that majority of Indian women experience. The State, via its Reproductive and Child Health Programme, offers various medical services to pregnant women in our country. In the endeavour to ensure maternal health, various ethical issues arise, as there are tensions / dynamics that operate between medical care professionals, pharmaceutical industries, and mother's health and well-being. Similarly, medicalisation and commercialisation of childbirth raises a number of medical ethics related issues. In such a scenario, virtue ethics, right based approach and communitarian approaches have immensely contributed to theorizing of medical ethics. Empirical studies from the field can help to complement this conceptual framework. This paper will highlight some of the ethical issues that are very commonly observed during institutional childbirth. Largely relying upon a qualitative paradigm, using the theoretical framework of human dignity, this paper reflects upon ethical issues women confront in hospitals of Kerala.

Introduction

Public Health is concerned with preventing diseases, promoting health, curing diseases, and thus ensuring the well-being of the people. The responsibility of the government and health system to protect the health of its citizens is widely accepted. Amongst the various components of health, maternal health is a very important aspect because it directly affects half of the world's population i.e., women; and indirectly affects new-borns too. In the endeavour to ensure maternal health, various ethical issues arise (Allahan and Jennings, 2002). There are tensions/ dynamics that operate between medical care professionals, pharmaceutical industry, and mother's health and well-being. In an effort to meet targets and bring down the maternal and infant mortality rates, women per se and their human rights are generally neglected. This raises many ethical issues in the medical field. Similarly, medicalisation and commercialisation of childbirth raises number of medical ethics related issues.Virtue ethics, right based approach and communitarian approaches have immensely contributed to the theorizing of medical ethics. Empirical studies from the field can help to complement this conceptual framework. This paper will thus highlight some of the ethical issues that are very commonly observed during institutional childbirth.

Pregnancy and childbirth are life events that majority of Indian women experience. The State, via its Reproductive and Child Health (RCH) Programme, offers various medical services to pregnant women in our country. Such a pre-planned programme actually denies a woman's ability to think and act for herself and is counterproductive and dis-empowering

(Qadeer 1998). She notes that in India, heavily institution-centred, childbirth practices are not necessarily pro-women.

Prior to the 1950s, childbirth in a hospital was unusual for Indian women. The current concept of pregnancy and childbirth is based on the epistemological idea that considers a woman's body as a machine. Today, childbirth is characterised by heavy reliance on technology and medical expertise. Medical procedures that were very sparingly used are now part of routine medical procedure. Pregnancy is considered a risk/medical emergency. But to what extent does such a heavily medicalised and even commercialised childbirth protect the mother's/baby's interests? Does the medicalised process take care of the dignity and interests of the birthing woman? Are there any conflicts amongst the interests of different stakeholders? This paper brings in answers to some of the above-mentioned research questions in the context of Kerala.

Methodology

First, the university's ethics committee gave the approval for the study after resolving the ethical issues involved. The approval was sought from the ethics committees of the three private hospitals where the study was conducted. The methodology for the primary field work is largely based on a qualitative paradigm, which is an attempt to understand the process of medicalisation and commercialisation of childbirth using the framework of human dignity. Sampling had certain limitations, as subjects selected based on probability sampling were not willing to spend time spread over three months and not willing to allow the researcher to observe their deliveries. Purposive sampling was used, which introduces certain limitations as to generalisation and representation of the population. The researcher initially attempted to use probability sampling (to choose hospitals as well as to choose a sample, my plan was to adopt simple random sampling), but this did not succeed because hospital authorities whom I approached via random sampling were not ready to give access for a prolonged period of five to six months, which was necessary as I wanted to observe the childbirth of the respondents. Given the confidentiality, privacy and sensitivity of the issue, it was not possible to choose respondents using probability sampling methods because the study demanded a high level of cooperation and enthusiasm from the respondents too. Still, an attempt was made to ensure that the sample was as representative as possible (in terms of caste, religion, class, education, number of childbirths, caesarean sections, Post-partum surgery (hereafter PPS) failure cases, referred cases etc.).

The sample size was restricted to 15 women per hospital; thus the total size was 45. The tools of data collection were in-depth interviews for the women, observations in the labour room, and interview schedule for the healthcare providers.

Findings

Evidently, the case studies are highly informative and reveal the level, extent and intensity of medical ethics violation. The major findings are presented below. The respondents considered the

humiliating experiences and injustices they faced as exploitation.The feeling that doctors used them as objects for training was also regarded as exploitation. Demands for bribes were termed as economic exploitation. The women identified lack of power and lack of education as being among the factors explaining these experiences.

The women felt abandoned, having the impression that none of the medical staff were really bothered about their/their baby's welfare and health. It was a mechanical act of administering what they thought or felt was suitable at that point in time, whether in terms of medication or a barrage of tests.

Language of Indignity and Humiliation : Kelman (1977) explains how the concept of dignity is linked to the idea of perceiving oneself as valuable and feeling valued by others. According to Schachter (1983), undignified treatment includes: a) statements that demean and humiliate individuals because of their status or beliefs; b) the dissemination of negative stereotypes of a group (religious/social) and implying that group members are inferior; and c) abuse and insults by officials. The life histories and treatment narratives of the respondents reflected all of these points, which they considered to be the language of indignity and humiliation.

Shouting and Brutal Speech : During childbirth, it was common for the nurses and other paramedical staff to shout loudly and rudely at the women. The birthing woman never dared to ask any question nor attempted to clarify her doubts. Shouting happened more often when the birthing woman reached the hospital during the night shift. Nurses were easily irritated, even over very small matters. Their tone of voice was never sweet or polite. Further, the body language shown was that of rejection and contempt.

One respondent explained, "After seven hours of labour pains, the doctor decided that the labour is not progressing and decided to go for a caesarean section. My husband was asked to sign the consent form and the staff did not explain to him the reasons for which I was in the labour room. They were preparing me for the caesarean and a nurse was injecting me. I had my last ultrasound report in my hand. With natural curiosity, I asked her the weight of my baby. Her action scared me. She blasted me and said that I am trying to act too smart by asking questions. She threw the injected needle onto my stomach and walked off.I was shocked and scared. After some moments she came back again uttering abusive words and took the needle and threw it in the waste bin".

Usage of Number, Caste and Body Shape to Identify the Woman : The respondents felt that the use of their bed number, caste and body shape to identify them threatened their existence. They were addressed as *"Primyin third bed", "Pulaya (a low caste group in Kerala)woman in the far left" or "Muslim pig"* (with the suggestion that pigs have more offspring). Numbers are anonymous and non-communicative. Further, it is observed that nurses in their private conversations used caste names to identify the women. Upper caste names were used as a suffix *(e.g. "Bindhu Nair")*, while lower caste names were used with other identifiers. *"Buffalo"* referred to a woman belonging to the lower caste community who

screamed and cried loudly during childbirth. Similarly, *"Muslim pig"* was used for a Muslim woman having her third or fourth child. Meanwhile, Tamil migrant women working in construction were called *"Tamil aanacham pennathi"* (meaning a Tamil woman who is half man).

Women from the Muslim community felt that they were most often made "study cases" for the MBBS trainees (as one amongst the three colleges was part of medical college). The researcher also observed this to be the case. When the researcher tried to clarify the matter with senior doctors, they explained that Muslim women have more children and so they have undergone more labour pain and know the process of childbirth. They were also the most submissive group, so they would obey orders.

Information Sharing : *"The information is all about "me" and "my baby", so why are they so hesitant to share the information?".* By "information sharing", the respondent meant sharing information after each check-up, allowing the woman to ask questions and clarify her doubts. This was of the utmost importance to them, because it would help them to remain *active* throughout the process, boost their confidence and remind them that they are undergoing a natural process. As Sered and Tabory (1999) citingWaitzkin's work of 1991 which mentions that, by restricting the information that reaches the patient, it is not only the disease that takes over the body but also the unknown medical system.

Healthcare providers agreed that *all women have dignity,* but asserted that they have graded dignity. All women are entitled to be considered a "patient" and fellow human being. They should not be seen as objects; this was the level of dignity to which every woman is entitled. According to them, this can be ensured by:

- Considering the "patient" as a human being and listening;
- Nurses dedicating some personal time;
- Obtaining informed consent;
- Preventing other medical staff from violating the patient's dignity.

Medical staff reported that it was not possible to ensure this level of dignity for all women because of sheer numbers, workload and infrastructural limitations. The private hospital staff reported that they themselves are "objects", so how could they protect the dignity of others? They were very stressed because of the targets they were given - for caesarean sections, painless childbirth, number of clinical tests to be prescribed and so on. We can see that this is a reductionist approach, wherein women's lives are not seen from a holistic perspective. Their life situations, societal pressure and structural issues are overlooked or neglected.

Medical Ethics, Medicalisation and Commercialisation of Childbirth : In the private hospitals, women on an average have three to five ultrasound scans and four to six blood tests. They were also informed about the amniocentesis test, which helps in finding out about genetic abnormalities in the foetus. Some respondents (who were well-educated) wanted this test to help them uncover the sex of the baby (in the first/second month). All these tests were done in the hospital laboratory, outside diagnosis was not

accepted. Doctors insisted on keeping the reports in the hospital, so women lacked the opportunity to ask for a second opinion - the reports were only handed over if a woman categorically mentioned that she was going back to her home town for childbirth.

Injections/Medication: The respondents at the private hospital were over-medicated. Folic acid and iron tablets were prescribed as part of normal prenatal care which is recommended by WHO too. In addition, the obstetrician immediately prescribed some medication on hearing any problem such as nausea, headaches, swelling and weakness. All of the respondents had the prescribed number of tetanus injections.

Prescribing medicine was over emphasised, rather than suggesting diet modification or mild exercise. It was common to see medical representatives of leading pharmaceutical companies visiting doctors and making brief reports about their products in the hospital corridors. Doctors were given various decorative items/household goods, and if certain "targets" were met then much costlier, gifts flowed in. They justified this with reference to the low levels of remuneration and other facilities.

Junior doctors were more explicit in their approach - both in meeting targets and demanding cash from the woman once she had been admitted for her labour. They had another justification, saying that medical education in countries like China, Ukraine and elsewhere was costly for them and they had to recover this money while they were undergoing training.

Out of 45 respondents, caesarean sections accounted for 48% of childbirths in the hospital. Doctors pointed to patient activism as the main reason for the increase - if any medical error occurred, the doctor and hospital authorities were sued and police complaints were lodged, resulting in doctors fearing for their reputation and thus pushing for caesarean sections.

Another motivation was the interest of the management in boosting profits. There were targets for the number of caesarean sections and the woman's family members were politely and nicely misinformed to get them to give their consent. The hospital authorities have also purposefully kept the difference in cost between vaginal birth and a caesarean section very low *(approximately Rs. 44,000/- for vaginal birth and Rs. 50,000/- for a caesarean section).*

Most respondents said that their medical reports were not handed over to them after birth. They were told that the information would be safely maintained in the hospital records. Women who were educated and working insisted on being given the reports. If the woman knew the law and insisted, they were provided the report with an additional payment of Rs. 300.

Discussion and Conclusion

No doubt public health professionals operate in an ethically complex and challenging environment. The major ethical issues identified by the participants include paternalism and issues with honesty, conflicting responsibilities, pressures on decision-making, and uncomfortable relations with the pharmaceutical industry. Competing values and obligations are central issues in public health ethics. This study supports that view wherein

multiple and sometimes conflicting responsibilities remain an important issue in healthcare practices. Therefore, relations between the pharmaceutical industry and public health deserve greater attention, insofar as ethics do not hit rock bottom.

The findings about ethics education and training concur with those of Kassel& Young (2002) who found that public health ethics teaching to medical undergraduates and postgraduate courses are minimal and not effective at all. Thus it can be concluded that incorporation of such values while adopting a right based and communitarian approach is the order of the day before humanity gets consumed in the complex world of medical practice.

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ISSN: 0976-5484 Social Work Journal • Vol. 5 • No. 1 • June 2014 • Page 44-49

HIV/AIDS and Public Health: A Social Work Perspective

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Despite recent initiatives and introduction of treatment and care in most developed countries, the HIV/AIDS pandemic continues to spread and aggravate the public health challenges. The growing incidences and prevalence of HIV/AIDS is contributing as one of the major challenges to public health issues. It is not only dragging human lives but it also threatens the overall development of a nation. In the field of public health, Social Work has been playing a very significant role in present days. Likewise to fight against such challenges, there is a need to develop more attention from social work perspective. Thus, the paper intends to highlight social work interventions in dealing with public health issues such as HIV/AIDS.

HIV/AIDS as a Public Health issue

In today's world, public health surveillance has led to identification and prioritization of many public health issues that include HIV/AIDS, diabetes, waterborne diseases, zoonotic diseases, and antibiotic resistance leading to the reemergence of infectious diseases such as tuberculosis. Prevalence of HIV/AIDS is the most serious challenges to public health due to its nature of infectiousness. Thus the problem of HIV/AIDS is a serious public health issue at the global level. Despite recent advances in treatment and care available in most developed countries, the HIV/AIDS pandemic continues to spread through the developing world that aggravate public health challenges. Likewise, India is passing through a demographic and environmental transition which is adding to the burden of diseases. During the past three decades more than 30 new organisms have been identified worldwide including HIV. The challenges of public health rose due to excess burden of diseases such as Tuberculosis (TB), of which India has the highest cases in the world. Out of 9.2 million cases of TB worldwide, every year nearly 1.9 million cases are accounted for by India. Experts have estimated that 2.5 million persons have HIV infections in India which contribute nearly 7.6% of the global burden of 33 million cases (Chauhan, 2011).

As per the latest estimates by United Nations AIDS (UNAIDS, 2013), there were 35 million people living with HIV in 2013, which has increased from 29.8 million in 2001. This has been largely attributed to continuing new infections. Besides this, UNAIDS (2011) had estimated that there were 34 million people worldwide living with HIV/AIDS, of which 50% are adults and children 3.3%. It has also been reported that 1.7 million HIV deaths occurred in

2011. Further, it is estimated that India has the third highest number of people living with HIV in the world. National AIDS Control Organization (NACO) in 2012 had the estimated number of people living with HIV/AIDS in India was 20.89 lakhs, with an estimated adult (15-49 age group) and HIV prevalence of 0.27% in 2011. The above trends of estimations indicate the country's vulnerability towards HIV/AIDS.

To fight against these growing incidences of HIV/AIDS, NACO works towards strengthening and mobilization of community responses through advocacy and outreach. National AIDS Control Policy (NACP) is implemented through NACO at the levels of the National and State AIDS Control Societies (SACS). SACS are the implementing agencies of NACP as is relevant to various states. At the same time Non-Governmental Organizations (NGOs) are also the main implementers of NACP that works in partnership with SACS. They play a vital role in implementing HIV prevention programmes by reaching out to vulnerable groups at the community level. In communities, Community Based Organizations (CBOs) like women's groups, youth organizations and self-help groups are seen as the main agents for change in the community.

Social Work and Public Health

Social work is a practice based profession and an academic discipline that promotes social change and development, social cohesion, and the empowerment and liberation of people. Principles of social justice, human rights, collective responsibilities and respect for diversities are central to social work (IFSW, 2014). The newly adopted definition has given a new route to the social work profession in this current century. On the way to development of professionalism, there have been tremendous landmarks of Social Work in the field of health in addressing and promotion of public health issues. Likewise National Association for Social Workers (NASW, 2005) stated that currently health care social workers provide services across the continuum of care and in various settings. Social workers are strongly involved in implementing of programmes and services of public health both at trauma and chronic healthcare settings. They provide a range of services including health education, crisis intervention, supportive counseling, and case management. In response to critical incidents at both national and global level, health care social workers are increasingly trained to provide interventions in preparing for and responding to traumatic events and disasters. In all healthcare settings, social workers have provided a holistic perspective on problems and situations, highlighting the social antecedents and consequences of illnesses and the need to deal with the larger picture along with the immediate concern (Dhooper, 1997). Thus social workers have been involved in the healthcare field for a long period. The constant growth, demands, and changes in healthcare have had a serious impact on the viability and need for social workers in all areas especially at healthcare settings. The immense expansion of medical technologies provides quality life to many people but the advances in technology have also raised healthcare costs and introduced

social, legal, and ethical dilemmas for individuals, families, and healthcare providers, whose consequences are dynamic and problematic in nature. Human societies are not perfect even if it is not static. Finding solutions to the problems of society is one of the goals of social work practice. In response to this, Bracht (1987), stated that social work in public health focuses on social aspects of health. The emerging participation of social work practice in health issues is globally well recognized. It is therefore reiterated that social workers are employed in different health care settings that include maternal and child health clinics, health planning agencies, national and international agencies and World Health Organization.

Practitioners working in public health provide: (1) outreach services to maternal and child health programmes; (2) direct intervention to individuals and families involved in programmes offered by home health care and other types of community support agencies; (3) health education activities through various types of small group discussions; (4) advocacy and planning activities associated with community health projects; (5)consultation about psychosocial and community factors affecting clients and their utilization of health services; (6)development of policies and procedures for innovative delivery of services; (7) assessment of the community's social and health needs; (8) research and evaluation studies; and (9) training and staff development (Bracht,1978: 243). Despite of historical linkage between public health professionals and social workers, the contributions of social work in this field have been rarely acknowledged.

HIV/AIDS and Social Work Intervention

The problem of HIV/AIDS is well recognized as a very serious and big challenge for the century. Thus, it is pertinent to have multi-level approaches of social work interventions to fight against such public health issues. The discussion of the paper emphasized the perspective of social work interventions in response to the seriousness of public health issue on HIV/AIDS. In identifying the health challenges of the HIV virus which is a serious threat for human life, the social worker plays a pivotal role. It has been observed that people with more vulnerable and High Risk Groups (HRGs) that include female sex workers, truckers, intravenous drug users, man who have sex with man are always and have often been neglected and stigmatized by our society. Social stigmas and homophobias are associated with People living with HIV/AIDS due to lack of awareness and education among the masses and sometimes they were left with no treatment and remain outcasts in their own families and communities. To overcome the challenges of HIV/AIDS, it requires cooperation and comprehensive collaboration between scientific disciplines, governments, social institutions, media, social workers, health care professionals and the general public. In this regard, it has been identified that social work has been on the forefront since beginning for prevention of HIV/AIDS.

In dealing with HIV/AIDS, social workers thus provide support to the

person living with HIV/AIDS through direct counseling, treatment and social justice activities. People who have been infected are facing a number of challenges. Some of these challenges include dealing with the side effects of anti-retroviral medication, coping with grief and loss, and dealing with the continued stigma of HIV/AIDS. Social workers possess efficient knowledge and skills to work effectively with individuals who are living with HIV/AIDS with their unique skills and techniques. Social work may provide education through generating awareness, training programmes and empowering the clients for proper career planning and decision making. In the community context, social workers continue to advocate on behalf of those people living with HIV/AIDS through community organization and policy development. Social workers may promote community education to reduce the vulnerability and prevalence of HIV/AIDS.

The NASW Standards for Social Work Practice in Health Care Settings are designed to enhance social workers' knowledge, skills, values, and methods and to work effectively with individuals, and families (NASW, 2005). If we look at the changing pattern of social work practice, new trends of interventions have been introduced for the society. The approaches of Social Work practice has categorized its services into three different levels. They are: a) micro level for individuals, families and small groups; b) meso level for larger groups and organizations; and c) macro level for community, society or as a whole. The following discussion highlights the social work interventions on HIV/AIDS at these three levels.

Micro Level

This level emphasizes the most basic system referring to an individual and their immediate environment. At an individual level of illness, the main focus of the social worker is on the patient's physical, psychosocial and environmental health needs. Social workers provide counseling to High Risk Group (HRG) of individuals for both Pre-test and Post-test of HIV/AIDS. During the counseling process of individuals, the social worker plays the role of case worker and counselor which provides services not only to patients and the family members but to a holistic and comprehensive approach as the problem of HIV/AIDS usually stigmatize the individual and its family members.

Meso Level

At the meso level, it is very much important to build relationships between and amongst individuals, families and communities. Thus it refers to the interactional processes between multiple micro-systems (for example whole families or community groups). Some of the key areas where mezzo level practices are seen are: a) helping parents for the future care of children; b) linking people to local support services such as drop-in-centres, mobile clinics; c) establish and strengthen group support networks; d) establish self support groups; e) mobilize the PLWHAs and educate them to be an AIDS educator/volunteer.

Macro Level

This level emphasizes on a broad level the issues that affect individuals indirectly (i.e. schools, legal system,

employer, health care provider, state government, etc). While dealing with HIV/AIDS, at the macro level of intervention, social workers may participate in policy formulation and implementation, as well as mobilization and community participation in different programmes of government. Macro level social workers can also bring changes by lobbying for funding from varied sources to assist in the treatment of clients with HIV/AIDS. They may also encourage and build linkages with different stakeholders and vulnerable groups to prevent and control HIV/AIDS. They also promote awareness among the masses about the consequences of HIV/AIDS and ways to looking forward to living with HIV/AIDS. In addition to this, social workers maintain the importance of social work principles while working in the field of HIV/AIDS. The principle of individualization is of immense significance in working with AIDS patients. Social workers are well aware that the patients' adaptive tasks include maintaining a meaningful quality of life, retaining intimacy, coping with the loss of function, confronting existential and spiritual issues and planning for the survival of family and friends *(Dhooper, 1997; Moynihan et. al., 1988; Siegel & Krauss, 1991).*

Conclusion

To fight against such public health issues, besides the government initiatives, social workers can play very important roles. As the problem of HIV/AIDS is a concern for the whole society, social workers can promote its knowledge in addressing these problems. They may provide care and support, counseling, create awareness and educate the people, engage in advocacy and policy planning to protect the rights of the PLWHAs. In prevention and control of HIV/AIDS, social workers encourage advocacy through promoting the understanding of the complex psychosocial factors, societal stigmatization and human injustice while working with the PLWHAs and people with HRGs. Social workers can also promote awareness among the masses and provide counseling among the people of HRGs about the use of condoms and safer sex mechanisms. On the other hand, there are numbers of NGOs working and contributing their efforts to control the vulnerability of HIV/AIDS along with the government. These are working at the local and national level as a partner of NACO and SACS. The National Association of Social Workers of the United States had issued recommendations way back in May 1993 on Social Work practice for people affected by HIV infection. But in India, it is still behind in getting proper recognition in government programmes and policies in such public health issues. There is also a need to adopt a synergetic approach where different statutory bodies work together to fight the challenges of public health. However, what is beyond doubt is that there is a need for more strength and a strategic plan at all levels and effective implementation of HIV prevention programmes to control and prevent such public health issues. Further, more concentration on Government and NGOs partnership approaches to deal with the problem of HIV/AIDS will go a long way in encumbering the increasing threat of the disease as a

public health concern.

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ISSN: 0976-5484 Social Work Journal • Vol. 5 • No. 1 • June 2014 • Page 50-56

Socio-Demographic Changes and its Effects on Agriculture and Health: Issues and Concerns

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This article will give a systematic understanding of the linkages between socio-demographic changes and their impacts on agricultural productivity and health. There are direct and indirect relationships between the socio-demographic changes (i.e. Increase in population, urbanization, increasing nuclear families), agricultural production and increasing health concerns. India is a developing country, in which 70% of the populationlive in the rural areas. Rapid urbanization and growing fast-food culture in urban centres have increased the demand for some food grains other than rice that affects the traditional agricultural practice. The population increase along with increasing numbers of nuclear families affects the per capita landholding, access to basic household amenities and services. In India, food production with an average per capita land holding of 1.4 hectares are unable to satisfy the needs of household demands for food. In such conditions, the rural people are bound to adjust with inappropriate food intake, which results in malnutrition, anaemia, maternal and infant mortality, low birth weight and chronic energy deficiency among adults. This paper tries to argue that moving towards organic farming could be one of the sustainable ways towards promoting health in the face of the fast changing socio-demography of India.

Introduction

India is a populous country which makes up 7% of the world population, spread over 2.4% of the world's geographical area. According to Census 2011, India has more than 1.20 crores of population; among them around 70% population inhabit the rural areas. The country is also experiencing rapid urbanization as Census 2011 has revealed that people living in urban areas are more than 31.1% of the population which increased from 27.8% (2001). It is predicted that India will witness the largest increase in urban population in the next four decades, followed by China. It is also estimated that India will add another 497 million to its urban population between 2010-2050 while China will see 341 million people shifting to cities. There will thus be changes in the demographic character, i.e., age structure, household size, distribution and size of the urban population in different segments as that trend is not uniform across India. States like Bihar, Madhya Pradesh, Chattisgarh, Uttar Pradesh, Odisha and Rajasthan have above average population growth rate and the other states are experiencing a decline. These socio-demographic changes further affect food security because of the increasing population, increasing

numbers of nuclear families and division of parental property, which further increases the numbers of landless and small land holdings. The households having small land holdings are unable to fulfill the food demand for its domestic consumption. This curtails the increase of agricultural Gross Domestic Product (GDP) and food security as well. The household-level food insecurity further raises other issues like malnutrition, hidden hunger that leads to increase in anaemia, maternal and infant mortality, low birth weight among new-borns, and chronic energy deficiencies among adults. This paper, thus, attempts to establish a linkage between the socio-demographic changes and their effects on agriculture and health, and how organic farming could be a healthier substitute.

Socio-demographic Changes in India

The Socio-demographic changes that have been observed are uneven population growth, in which majority of the population is young as per the 2001 census. However, now there is an increasing ageing population slowly. The family structure is also changing from joint and extended to nuclear families with an average of two to three members in urban areas.Likewise in rural areas the nuclear family system is increasing with an average of four members' size. The transition of family from joint/ extended to nuclear family reduced the availability of support system within the family for the child, the sick and elderly persons (Chadda & Deb, 2013).

In India, the percentage of nuclear families increased from 61% in 2001 to 68% in 2011. The total reduction in fertility rate of 0.71% (3.39% in 1991 and 2.68% in 2005) has resulted in an increase of about 8% in the number of nuclear families over 15 years. The reduction in fertility rate is faster in rural areas than in the urban areas. While a reduction in fertility has led to a decline in population growth, it has also led to an increase in nuclear families with fewer members per household. Interestingly, the percentage of households not having basic amenities, also decreased from 34.5% in 2001 to 17.8% in 2011. However, it still remains a major concern in rural areas. It is also noted that the expanding nuclear families limit the per head access of household amenities and consumption of foods. Thus, the increase in numbers of families will affect the environment as well as the food consumption and access to basic amenities. (Lakshmana, 2015).

Urbanization

Urbanisation in India began to accelerate after independence, due to the country's adoption of a mixed economy, which gave rise to the development of the private sector. Urbanisation is taking place in India at a faster rate. The urban centres pull the rural population for employment opportunities. The rural-urban migration has reduced the availability of agricultural labour and increased cost in agricultural labour inputs. Rapid urbanization is often associated with poverty and environmental degradation. Unplanned urbanization places its population at health risks such as poor housing, crowding, air pollution, poor sanitation, insufficient or contaminated drinking water, urban poor, etc.

Food productivity

India had achieved near self-sufficiency in food grains by the mid-seventies. The rate of food grain production, improved from 2.3 percent during the 1960s and 1970s to 2.9 per cent in the eighties (Singh, 2001). It is particularly noteworthy that India could build enough buffer stocks to cope with year-to-year variations in food grain production. Field studies show that during the 1987 drought, stable food grain prices, PDS supplies and the availability of consumer credit enabled drought affected villages to support their consumption at the same level as in normal years (Acharya, 1989; Bidinger, et al., 1990). The annual fluctuations in the per capita availability of food grains declined in the eighties and nineties when compared to the earlier period (Rao & Radhakrishna, 1997) and there was a decline in the seasonal as well as regional variations in the prices of food grains (Bhalla, 1994).

Agricultural production is affected by demographic changes such as population growth and the growth of the nuclear family system. Such an increase in nuclear families have resulted in a decrease in per capita land holding of households, and thus the trend of marginal landholdings are increasing in India. As per NSSO data 63rd Round, average land holding per household is around 1.4 hectares. Agricultural production with marginal land holdings and low soil fertility over a period results in low productivity NSSO (2006).

The growth of food production slowed down to 2.72 percent per annum in the nineties. Ironically, even at the low growth rate of food grain production, the supplies outstripped the effective demand and the nineties saw a rapid increase in the stock of food grains held by the government. Disposal of stocks thus was a cause of concern. Meanwhile, the domestic supplies were not adequate to prevent food gaps, because of reducing soil fertility and usage of traditional farming system in most of the remote rural areas.

Food security thus is a major issue in India as the annual population growth rate is 1.8 percent and relative food production rate is 1.2 percent. India needs an agricultural growth rate of 4.0 to 4.5 percent to reduce poverty and food insecurity significantly (Rao & Radhakrishna,1997). This is within reach. At this growth rate, agricultural development would diversify into dairying, animal husbandry, fisheries, floriculture, horticulture and other areas. These activities are likely to be labour intensive.The best strategy would seem to be targeting a growth rate of about 2.2 percent per annum and achieve it by improving the total factor productivity. This will make available more land and water resources for the cultivation of high value-added crops. The use of HYV seeds, chemical fertilizers and pesticides also causes occupational diseases and resultant health hazards in the long-term among the farmers and the persons who consume those vegetables and food products. To arrest the diseases caused by modern agricultural practices, there is a need for organic farming, which may not be in a position to produce enough food as per the population growth but still it will help to reduce the health hazards and diseases. If flexibility on the supply side is facilitated, production

will adjust to the market forces and generate higher incomes in the rural areas. This would also spur the growth of agro-processing industries in rural areas.

Health

The socio-demographic changes such as population growth, marginal land holding, and slow agricultural growth cannot make pace to fulfill the increasing food demands and thus is bound to have its effect on health. In the 1960s and 1970s, the Green Revolution came in, which made India somewhat self-sufficient in terms of food. However, the usage of chemical fertilizers and pesticides on one hand has increased food production, while on the other hand it has also increased occupational diseases and public health hazards. The run-off water from the rains also contaminate the agricultural land with deadly chemicals in the water cycle and it in turn causes health problems in the long-run. Another aspect of modern agriculture is where the traditional coarse cereals (complex carbohydrates which are high in protein) have been replaced by mill polished rice (simple carbohydrate, low protein). Such usage of machinery in agriculture is also reducing the natural minerals in the food system of human beings (Sarkar et al, 2012).

Hunger, malnutrition and under nutrition are the key dietary factorswhich contribute towards serious effects on health in general and maternal health in particular, in the low income countries. Under nutrition is defined as the deficiencies in energy, protein and micronutrients, which is caused by hunger and malnutrition. Hidden hunger is a form of under nutrition that occurs when intake or absorption of vitamins and minerals are low to sustain good health and development in children and normal physical and mental function in adults. Hidden hunger, also known as micro nutrient deficiencies, afflicts more than 2 billion people, or one in three people, globally (Desai, et al, 2013). Its effects can be devastating, leading to mental impairment, poor health, low productivity, and even death. Its adverse effects on child health and survival are particularly acute, especially within the first 1,000 days of a child's life, from conception to the age of two, resulting in serious physical and cognitive consequences. Even mild to moderate deficiencies can affect a person's well-being and development. In addition to affecting human health, hidden hunger can curtail socioeconomic development, particularly in low and middle-income countries (Desai, N et al, 2004). Africa, Sahara and the South Asian subcontinent are hot spots, where the prevalence of hidden hunger is high. Micronutrients deficiencies cause an estimated 1.1 million of the 3.1 million child deaths that occur each year as a result of under-nutrition. Vitamin A and zinc deficiencies adversely affect child health and survival by weakening the immune system. Lack of zinc impairs growth and can lead to stunting in children. Iodine and iron deficits prevent children from reaching their physical and intellectual potential (Wiesman, 2004).

Malnutrition and hidden hunger are serious concerns in India. The level of hunger in India is ranked very high and at an alarming level by the International Food Policy and Research Institute

(IFPRI) in its Global Hunger Index (GHI). However, GHI for India has reduced from 48.1 scores in 1990 to 29.0 scores in 2015 through various measures taken by the government to combat nutrition deprivation (IFPRI, 2015).

Conclusion

Suitable measures have been taken by the government of India for improving the health and social wellbeing of all; but maximum of the schemes and programmes seemed to be unsuccessful in bringing substantive results. The major initiatives are Family Planning, Reproductive and Child Health (RCH), Integrated Child Development Scheme (ICDS), Mid-Day-Meal Scheme and National Disease control programmes like anemia, diarrhoea, Tuberculosis (TB) and other diseases. Recently the School health programme was started by GOI to reduce anaemia (providing vitamins, iron and folic acid tablets) among adolescents in high schools and higher secondary school going students. Agro-climatic zones' specific studies should be conducted and appropriate policies and programmes of agriculture should be initiated to attain food security in India. The availability of proper diet and additional food supplements provided by the different schemes and programmes in India will surely reduce the serious cases of absolute as well as hidden hunger and thus it will improve the health conditions. Health concerns like anemia, tuberculosis, low birth weight and chronic energy deficiencies are because of long time exposure of malnutrition and under-nutrition in rural areas. There is always a rural urban divide in terms of life style and availability of facilities and infrastructures that makes rural people more vulnerable than urban areas.That is why there is a need of special attention to be given for these populations.

Inspite of several initiatives having been taken by the Government of India, there are far-reaching targets of improving health and social wellbeing. There is a need of improving the availability of food and nutrition (along with food supplements) at the household level through the improvement of organic farming practice and arresting uneven population growth. Sustainable agricultural activities and farming will increase the scope of diversifying the dietary practices and thus will decrease the health complications related to hidden hunger and malnutrition.

In order to resolve and improve the inter-relationships between socio-demographic change, agriculture and health, there is a need for food availability to keep pace with population growth, using sustainable organic farming. That is a paradox. India needs to double its production withregard to its present trend. Thus in order to maximize production and to meet the extra needs(driven by population growth), there will be a need for modern agriculture. If modern agriculture is used, then there will of course be higher production and along with that, more health hazards and occupational diseases. The modern cereals milling system reduces the minerals and protein levels in food, and on the other hand use of chemical fertilizers and pesticides also increases the adverse effects on health through environmental pollution and poisoning of the food. In India, majority of the rural population depends upon certain types of food as the only source

of nutrient to meet the calorific demands for their life. So majority of the rural population have less dietary intakes; and because of the prolonged exposure to undernourishment, it results ina high incidence of anaemia, MMR, IMR, low birth weight of the child and chronic energy deficiency among the aged as well. If traditional agriculture is used for production, then production will be less which will not be able to meet the food demands of changing demographic characters in India. Thus organic farming can be a good solution to reduce the health problems and direct efforts towards making available food keep pace with population growth. If not, it may be too late to regain the ecological balance and human well-being in future.The day should not come when humans may have to live compulsorily on medicines such as food supplements.

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ISSN: 0976-5484 Social Work Journal • Vol. 5 • No. 1 • June 2014 • Page 57-65

Situational Analysis of Health Inequality and Social Exclusion in India

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The contemporary public health system in India and the significance of networking governance in inclusive development are increasingly viewed as appropriate mechanisms for tackling health inequality and social exclusion. Such initiatives are often put into practice in contexts of economic and financial crises, fragmented neighborhoods, hard-pressed public services, and sustained under-investment in voluntary and community sector organizations. Ignoring social inequality and its relations in the present scenario can lead to disregarding many hidden causes of health inequalities. In the 20th century 'social exclusion' has become central to policy and academic discourse in Western Europe, and increasingly in other parts of the world. It is the focus of one of nine global Knowledge Networks established to support the work of the World Health Organization's, commission on social determinants of health. The objectives of this analytical review are to explore the inter-relationship between health, development and meanings attaching to the concept of social exclusion. The paper aims to explore the political economy of health inequality and social exclusion. The paper will also document the composition of global burden of disease among the minorities such as Scheduled Caste and Scheduled Tribes. Further, the paper will examine state response to the rising health inequalities and to control out- of-pocket expenditure.

Introduction

India has witnessed both economic growth and disparity in health sector the past three decades. There are many factors that contribute to this inequality. It can be partly due to factors pertaining to health financing and partly due to distribution of service deliveries. Presence of flaw in the present health system deliveries have been recognized by many studies on the manifold characterization of health inequalities in India. The concept of the root causes of this inequality and social exclusion on some section of society is seen since the days of Aristotle said the Nobel laureate Amartya Sen (2000). Social exclusion though complicated in nature mainly refers to the lack of ability of the community to engage all folks and groups to realize their full potential as expected by the social norms. Marginalization of certain section of the society can be witnessed in most societies including industrialized economies and perhaps it is more prominent in emerging economies like India. In the context of India, poverty and socio-economic status are considered broadly as a proxy to social deprivation. There are some sections of the society that are more marginalized and excluded from the society including

the Scheduled Castes (SC) and Scheduled Tribes (ST). To reiterate the point, Nayar (2007) pointed out, ill health should include apart from the health financing and distribution of services, the governance and public policy framework should also include variables like poverty and socio-economic status of the marginalized.

Review Protocols

The exploration was restricted to peer-reviewed articles published during the period of 1995 to 2012. It was undertaken by the authors during the month of July-August 2012. Since the health of SCs and STs are both a public health and a development issue, we searched databases in both the health and social sciences: PubMed, EconLit, JStor, EPW and Social Sciences Index. Four inclusion criteria were to be met for articles to be included in our review. These were: (a) evaluations or intervention studies of a population health intervention, including surveillance systems, health promotion or prevention programs, and treatment programs, (b) studies undertaken with an SC, ST population or in an area where the majority of the population have SC/ST affiliations in India, (c) studies with a population health outcome(s), which included morbidity or mortality, and risks of ill-health and (d) involving primary data collection (NFHS data). Studies that addressed genetic disorders or evaluated a drug or plant for therapeutic properties were excluded. The review of articles proceeded in three steps. First, we conducted our searches using the following key words: (a) SC and ST (b) Political Economy, Networking Governance (c) Social Determinants of Health. Since population health interventions can be defined using a variety of terms, we did not include a term for intervention. And we also did not include the global experience and general population in our review. We searched the literature for articles and studies that included SC/ST as the beneficiaries and their health outcome in India. Secondly, titles and abstracts were screened to meet inclusion criteria, including whether the study assessed a public health intervention. Thirdly, the references of the selected articles were reviewed to identify other articles not found in our search.

Results

Since the launch of the Commission on Social Determinants of Health (CSDH) in March 2005, it has been endowed with a task to collect, collate, to synthesize and recommend addressing health inequality around the globe. The major contributions of the Commission are the importance it gives to the topic on social determinants of health and the recommendations it follows related to women and gender equity, social exclusion, health system. The social determinants of health are the state of affairs where people are born, grow, live, work, and age indicating their health. In social science literature, the concept of social determinants reflects upon where community attributes and factors influencing individual health status are considered the role of social determinants (Alston, 2005).

Dimensions of Inequality in Health

Gender, place (status, rural-urban disparity), religion and caste, socio-

economic status, provision of health services are the dimensions for measurements of health status. The 1998-99 National Family Health Survey (NFHS)-2 reveals a sharp regional and socio-economic divide in health outcomes with the lower caste, the marginalized, and emerging economies bearing a disproportionate burden of mortality. The SC and ST are clearly at a disadvantage and our systematic review shows that development has been slow in case of these groups as compared to others. It is well known that Infant Mortality Rate (IMR) is a sensitive indicator for socio-economic and health services development. This can be discerned when the IMR is disaggregated across socio-economic groups and the association between the two is obvious. Deogankar's (2009) analysis shows 'The IMR in the poorest 20 per cent of the population is 2.5 times higher than that in the richest 20 per cent of the population. In other words, an infant born in a poor family is two and half times more likely to die in infancy, than an infant in a better off family. A child in the 'Low standard of living' economic group is almost four times more likely to die in childhood than a child in the 'High standard of living' group. A child born in the tribal belt is one and half times more likely to die before the fifth birthday than children of other groups. A female child is 1.5 times more likely to die before reaching her fifth birthday as compared to a male child.

Health Inequalities in India

Health inequalities differ in health experience and health status between countries, region and socio-economic groups. It refers to a broad range of differences in circumstances and behavior that are in most cases socially determined. Health inequalities in India are related to socio-economic status, geography, gender and are compounded by high out-of-pocket expenditure. 39 million additional fall into poverty every year as a result of such expenditures. A very wide range of sources including academic literature, government reports, multinational agency report etc and the fact relevant in India is as: Life expectancy at birth is 63 years for boys and 66 years for girls, The mortality rate of children younger than 5 years is 65 per 1000 live births, 18 per cent of deaths and 20 per cent of disability adjusted life years, burden of chronic disease account for 53 per cent of deaths due to communicable disease, maternal and prenatal disorders and nutritional deficiencies. This clearly indicates the services non-affordability and services non-accessibility in health care among the SC/ST populations. Bio-medical technology treats health as a purely individual or personal biological phenomenon. Health of individuals and groups are largely determined by the

Table 1: Anemia among Women and Children by Caste/Social Groups in India (in percentage)

Social Groups	Anemia among women				Anemia among children			
	Women	Mild	Moderate	Severe	Children	Mild	Moderate	Severe
SC	56.0	37.2	16.5	2.37	78.3	22.0	49.7	6.6
ST	64.9	41.2	21.4	2.3	79.8	22.8	50.1	6.9
OBC	50.7	34.3	14.5	2.0	72.0	22.8	44.4	4.8
Other	47.6	33.3	12.9	1.5	72.7	23.6	44.1	5.0
Total	**51.8**	**35.0**	**14.8**	**1.9**	**74.3**	**22.9**	**45.9**	**5.4**

***Source** : Adapted from Nayar:2007*

socio-political, environment and technological forces.

There are considerable differences between different caste groups regarding prevalence of anemia among women and children. The differences in the proportion of women and children with anemia seem to be more prominent among women belonging to SC and ST population. Proportion of women and children with severe anemia also brings out these caste differentials (Table 1).

As we can see, SCs and STs anaemia are more than the total population which clearly indicates the reasons, namely, lack of accessibility, lack of service availability, affordability, and health expenditure pattern (loss of wages, fee for drugs and consultation, travel expenditure etc.) (Sigamani, 2010) Similarly, Infant mortality and child mortality is high among the SCs and STs. The differentials are more prominent while considering post-neonatal mortality, child mortality and under 5 mortality. The difference between SCs (consisting of upper castes) and STs with the general population stand out in the table in most of the above variables (Table 2).

Inequalities within the System

The general decline in infectious diseases does not necessarily indicate that all classes benefitted equally from medical advancement. There is inequality of resource distribution in the health care system. 70 per cent of the Indian public living in rural areas is served by 20 per cent of the doctors, major institution of medical care are urban based, people of rural areas have to depend upon the Primary Health Centres (PHCs) network and its non-functional referral system. Most of the curative and diagnostic equipment too are extremely costly and located in central hospitals, which account for the overall misdistribution of resources leading to the present stage of health inequalities in India.

Table 2: Infant and Child Mortility (In Percentage) by Caste/ Social Groups

Social Groups	Neonatal Mortality	Post Neonatal Mortality	Infant Mortality	Child Mortality	Under 5 Mortality
SC	40.1	20.2	60.4	25.2	84.0
ST	35.6	22.1	57.6	23.4	79.6
OBC	35.3	15.8	51.2	16.3	66.6
Other	29.8	13.7	43.5	14.1	57.0
Total	**43.4**	**24.2**	**67.6**	**29.3**	**94.9**

***Source** : Adapted from Nayar:2007*

Inequality of Access

The inequality of access to services is transparent in our rural-urban dichotomy. Resources are concentrated in the urban areas. Also, it is ironical that 70 per cent hospitals are in urban areas, 90 per cent beds are in urban hospitals and majority of the doctors are settled in urban areas. Lack of availability of paramedical staff and essential medicine adds to the severe situation of services delivery system in rural areas and even though the resources are concentrated in the urban areas, the entire urban population does not get the benefit of the urban hospital network. Equally, even the PHC is not accessible to all the rural population in terms of information, drugs, doctors, hospital care, and transport and life support system. And SCs/STs have neither education nor access to health institution and health professionals.

Inequality of Participation

The people were not involved at the planning and evaluating process relating to health issues which revolves around them. Apart from the medical personnel, no one else has any power of making independent decision. This in turn leads to misrepresentation and misguided interpretation by influential people for their own selfish benefits. The neglected remains neglected despite the fact that government has allocated budget for the excluded in the societal hierarchy. Felt needs and real needs of the people has to be considered and should be looked into during the process of planning and evaluation. Mostly the international donor organizations plays major role in formulation of condition based programmes, which has limited relevance in fulfilling the felt need of the population.

Inequalities in Health Status

In a stratified and hierarchical society where resources are limited, those at the bottom of the hierarchy will have the least access to all resources. Considering India in its entirety, two of its most socially depressed groups - SC and ST - have some of the worst health outcomes: for example, 28.9 percent of STs and 15.6 percent of SCs have no access to doctors or clinics and only 42.2 percent of ST children and 57.6 percent of SC children have been immunised. Of course, it is possible that the relatively poor health outcomes of India's socially backward groups has less to do with their low social status and much more to do with their weak economic position and with their poor living conditions

Public Policy: A Step in the Right Direction

Over the past two decades, Indian government welfare priorities in general and health policies and programs in particular have attempted to redress social disparities. Social inclusion has been a critical focus of constitutional, political, economic, and social agenda since India's independence in 1947. Welfare policies, including health policies, demonstrated a preoccupation with both material and social inequality. Despite a promising performance on macroeconomic variables, the slow rate of reduction in poverty, the low quality of employment generation, growing rural urban disparities, and low health indicators such as slow progress on the MDG with regard to infant and maternal mortality rate have been a source of concern.

Policy Implications and Recommendations

The National Common Minimum Programme (NCMP) of the government of India has put emphasis on inclusive growth with emphasis, among others, on ambitious programs for public health services provision. India's apex planning body has dedicated two recent five-year plans to strengthen redistribution policies to address inequalities in the society. The recent twelfth five year plan framed by the Indian government, for instance, aimed to provide essential primary health care to reach underserved and underprivileged populations and also to devolve funds and implement decentralized planning. But progress has clearly been slow and recent policy documents have restated the need to strengthen further these measures towards a "new vision of growth." Part

of the problem lies in the understanding of the issues and challenges at hand.

As India's economy continues to grow and the health of the population improves, there is a need for greater attention and resources to be allotted to those populations who have not benefitted from the country's economic growth and who continue to face high levels of health needs. Despite pursuing affirmative action for more than fifty years, there are persistent gaps in health and well-being between SCs and STs. This suggests the need to devise and implement new policies. Given the large gaps in knowledge on how to improve the health of SCs and STs, resources should be targeted to developing a critical mass of researchers in this domain, including training of researchers with SCs and STs Affiliations.

Social policy and programs in India, including in public health, have traditionally been driven by development priorities set by the poverty debate, with a focus on the poorest and most marginalized. Welfare policies in India have tended to focus on instruments of affirmative action and have aimed overwhelmingly at initiating social programs to redistribute jobs and housing or intermediate inputs such as education and health among the SC and ST.

Many of the health inequalities in India are not inevitable or immutable and can be amenable to public policy via improving living standards and boarding educational opportunities in a fair and equitable manner. Yet, the pathways to redress these challenges need serious consideration. There is a need to target programs and interventions that are simultaneously oriented both to the poorest and most marginalized, i.e., SCs and STs also across populations to address a range of socioeconomic measures across the society. The full implications of the social gradient and its role in mediating relationships between economic development and health in India needs therefore still to be fully reflected in the changes and choices made in health policies. Reversing accumulation of generations of health disadvantages requires a massive surge of resources and it might be best to begin with what is measurable and achievable, even if smaller, steps in that direction.

Conclusions

Caste plays out in India just as race plays out in the United States and the social class in Britain. Birth seems to determine health, education, employment, social and economic outcomes. Systemic injustice requires much more than a change of heart; it requires changes in social structures. Social injustice is killing people and mandates the ethical imperative of improving the social determinants of health. SCs and STs populations continue to carry high burdens of 'diseases of the poor', namely undernutrition and infectious diseases. While there is a growing body of knowledge on the health needs of SCs and STs, there is a paucity of data on how we can address these needs. This suggests that future research priority be given to quality public health intervention studies that assess a broad range of interventions and outcomes. Key programs to evaluate include: (1) interventions specific for SCs and STs

populations, both disease-specific interventions and comprehensive health programs (2) SCs and STs development programs that fall outside of the health sector, but address key determinants of health, and (3) population level interventions to identify how these interventions may better address the needs of SCs and STs.

The findings of this review identified three effective strategies for improving health outcomes among SC and ST populations in India. They are lowering of out-of-pocket expenditure expenses; easy access to medical facilities showing rapid results; and easily administered programs, multi-pronged approaches at the micro-mezzo and macro level; and including SCs and STs participation in the intervention. The participation of indigenous populations in public health interventions has been found to be an effective strategy in other contexts. The evidence base, however, is insufficient. There is a need for a better understanding of how to improve health by pursuing public health management and public health intervention research appropriate for SCs and STs Populations.

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ISSN: 0976-5484 Social Work Journal • Vol. 5 • No. 1 • June 2014 • Page 66-78

International Trade and Health: Uncharted Terrain for Social Workers?

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In the changing global political economy, international trade plays an important role in shaping the lives of the people. If we look at the recent debates, the intersection between international trade and health is an area that caught the attention of many researchers and policy analysts. However, Indian social workers have not given adequate importance in understanding this global reality. This article is an attempt to bring forth the discussions among social worker on international trade and health. It also argues that there is an urgent need to introduce international trade and related components in the curriculum.

Introduction

With the introduction of new instruments in the form of trade and investment agreements to further liberalisation and globalisation, researchers have shown a renewed interest in the discussions on trade and development linkages. Infact, the impact of trade on development is an area of concern for many development theorists as well as policy makers. The reasons for this concern are multifaceted. The impact of trade on labour, health, agriculture, education, employment and women are well documented (Khor and Ocampo, 2008; Sexton, 2001; Choudhury, 2012; Shaffer and Brenner, 2004). According to Shaffer and Brenner J. E., "Under new agreements through the World Trade Organization (WTO) that cover vital human services such as health care, water, education, and energy, unaccountable, secret trade tribunals could overrule decisions by democratically elected officials on public financing for national health care systems, licensing and training standards for health professionals, patient safety and quality regulations, occupational safety and health, control of hazardous substances such as tobacco and alcohol, the environment, and affordable access to safe water and sanitation"(Shaffer and Brenner, 2004).This article is an attempt to draw the attention of social workers to the issues arising out of trade and health linkages. More specifically, this paper makes an attempt to elucidate on the linkages between trade and access to medicines.

Trade Related Macro Social Work: Still a Long Way Off

For a long period, macro issues especially those relating to structural issues were conveniently left unaddressed by the professional social workers at the global and national level. Micro level issues and individualisation of structural problems received paramount importance in theories as well as practice in the early stages of social work profession. In fact, Bertha Reynolds in her critique of casework has pointed out this problem of "individualisation". If we delve into the

history of professional social work, the very emergence of radical social work can be located in the vacuum created by the micro and meso level social work. Since then, there have been many efforts in the west to address the macro/ structural issues in social work (Mullaly, 1993; Moreau, 1979). In India, this is of a recent origin (George and Marlowe, 2005; Bodhi and Tripura, 2013).

For social workers, international trade has been like an elephant in the room phenomenon. There is a space for justifiable doubt on whether professional social workers make any arduous efforts to understand the dynamics of international trade and investment and their impact on the lives of the common people. The question to be asked is how do social workers help the common people to insulate themselves from the shocks and stresses of international trade and other macro level factors. It remains to be seen whether they are audacious enough to venture into understanding the dynamics of the issuesand problems with a structural approach.

At the international level some efforts are made to understand and document the trade and development linkages from the lens of the social work profession. For instance, Yixuan Wang's work on trade and access to HIV medicines in developing countries is one of them. Similarly, Lynne M. Healy, and Rosemary J. Link present a wide range of discussions on human rights, development and international trade in their work(Healy and Link, 2012). According to Colleen Lundy, "in order to effectively respond to social concerns we need to understand the financial underpinnings of our world… trade agreements are no longer just trade in goods such as automobiles, steel or lumber, they are increasingly about trade in services". While discussing about Canada, Lundy also informs us that "the social and health services under attack by these policies employ the majority of social workers" (Lundy, 2011).

In India, the literature on trade and health from social worker's perspective is almost non-existent. In fact, we have very few literature on the developmental linkages of trade from a social worker's point of view. Though there have been many discussions on 'anti-oppressive social work', 'indigenisation' and 'decolonialisation' of social work, trade and trade policies have not figured significantly in any discussions. It is also a fact that there have been references to macro issues other than trade. For instance, referring to liberalisation, Vidya Rao writes, "These policy packages played havoc not only on agriculture after the 1990s but also on the nutrition and health of our people. The rate of farmer suicides is only a symptom and there is a need to address these issues much more comprehensively. Primary concerns about agrarian crises rests on policy. Clearly policy shifts have escalated risks in agriculture. Because social protection is framed primarily to minimize the risks faced by the government and the economy, the idea of social protection has amounted to very little contribution. Social workers have not been engaged with agrarian crises as the social work curriculum does not include the political economy of land administration, agrarian relations and agriculture technology. Only now some small scale efforts are being made to prepare social workers to work on this matter" (Rao,

2011). Therefore, it would not be incorrect to argue that discussions on both the local and global political economy; especially of trade, received little attention from Indian social workers.

International Trade and the Institutions Affecting Public Health

If we look into the history, international trade was not of the same dimensions as what we have today. Both the volume and value of international trade have gone up significantly in the past few decades (Khor and Ocampo, 2008). There is a remarkable difference in the way trade was organised in the Pre-WTO period,i.e., during GATT(General Agreement on Trade and Tariffs) regime. When GATT was formed in 1948 India was one of the founding members. The effort to establish an international trade organisation finally culminated into the formation of GATT in 1948. GATT remained as the framework for international trade for more than four decades. The journey of GATT had not been very smooth, as GATT was essentially envisaged as a stop gap arrangement for an international trade organisation. The lack of consensus on the content and the form of the proposed international trade organisation compelled the countries to follow GATT till the formation of WTO in 1995.

With the introduction of the WTO-led trade regime, a new set of players and instruments have been introduced into the global economy. These new players and instruments are able to bring in a new political economy of development at the global level(Khor and Ocampo, 2008). Various issues of trade were taken up at the numerous rounds of GATT. Many agreements on several aspects of trade have been negotiated and concluded under the aegis of WTO since the inception of the WTO. The major agreements are: 1) Trade-Related Aspects of Intellectual Property Rights (TRIPS), 2) General Agreement on Trade in Services (GATS), 3) Agreement on the Application of Sanitary and Phytosanitary Measures(SPS), 4) Agreement on Technical Barriers to Trade (TBT), and 5) Agreement on Agriculture (AoA). Apart from these WTO agreements, the free trade agreements (FTAs) and investment treaties also have their own impact on the health of the people.

WTO-TRIPS and Access to Medicines

The WTO's Agreement on Trade-Related Aspects of Intellectual Property Rights is known as TRIPS. It is supposed to "strike a balance between the long term social objective of providing incentives for future inventions and creation, and the short term objective of allowing people to use existing inventions and creations. The agreement covers a wide range of subjects, from copyright and trademarks, to integrated circuit designs and trade secrets. Patents for pharmaceuticals and other products are only part of the agreement" (WTO, 2001).

The Uruguay Round of GATT discussions served as a framework for the negotiation of intellectual property rights and thus provided for world-wide patent protection. Most of the International conventions before TRIPS (Trade Related Aspects of Intellectual Property Rights) did not specify

minimum standards for patents. Intellectual property laws, especially patent law, were national laws. In fact, in the pre-Uruguay Round negotiations of GATT, there had been a strong opposition from developing countries to the inclusion of intellectual property rights (IPRs) in the new GATT treaty.

The TRIPS agreement covers a wide range of subjects, from copyright and trademarks, to integrated circuit designs, geographical indicators and trade secrets. Patents for pharmaceuticals and other products are only one part of the agreement.

There are two types of patents-process patents and product patents. In process patenting the method of producing the chemical ingredients for a product or medicine is patented. In product patent, the product itself is patented. In the process patent regime, one is allowed to produce the same product through several other processes. However, in the latter case no one is allowed to produce the product even through other production processes.

It is interesting to note that prior to the launching of the negotiation on the TRIPs Agreement there was no product patent protection for pharmaceuticals in 40 countries. Indeed even after the conclusion of the TRIPs negotiations some twenty WTO members did not provide for product patent protection. Among these member countries a few did not even provide process protection in the pharmaceuticals sector (WTO & WHO, 2002). When the WTO came into effect on January 1, 1995, minimum standards of protection for all forms of intellectual property: patents, copyrights, trademarks, and industrial designs and licences has been set through the TRIPS. According to this agreement, governments are not supposed to disclose information of commercial value provided for marketing licences, for instance, for pharmaceuticals and agricultural products. TRIPS also introduced patent protection period of 20 years on seeds, pharmaceutical drugs, genes and diagnostic tests, and also on minor innovations which are more "discoveries" than "inventions". The 'minimum standards' prescribed by the TRIPS Agreement can haveimmense implications for the developing countries (WTO & WHO, 2002). From the beginning of the introduction of the TRIPS, policy analysts especially from the developing world were a bit apprehensive about various TRIPS articles such as Article 27(relating to patentable subject matter), Article 28-30 (relating to exclusive rights), Article 32 (relating to revocation and forfeiture), Article 33 (relating to Terms of Protection), Article 34 (relating to reversal of burden of proof) (Chaudhuri, 2002; Abrol, 2004).

In the last 20 years, provisions of TRIPs have been under critical scrutiny. The TRIPS compliant patent regime has already increased the burden of health spending. Various studies comparing drug prices across countries find that those with the most stringent patent protection laws have higher pharmaceutical prices on average than those with less stringent patent laws (Chaudhuri, 2002). The combination of unfair WTO patent rules and ruthless corporate strategies to maximise profits are contributing to the global health crisis where hundreds of millions of poor people suffer the misery of chronic ill-

health and early death (Watkins and Fowler, 2002; Malpani and Kamal-Yanni, 2006; MSF-USA 2010).

Introduction of TRIPS- compliant Patent Regime in India

Once India became one of the signatories of the WTO and resultant TRIPs Agreement, she was compelled to amend the Patent Law that was once acclaimed by UNCTAD as a model for developing countries. After a series of threats from the US, the government amended the Patent Act, 1970, in consonance with the TRIPs regime to accept the product patent regime for pharmaceuticals. Section 5 of the Indian Patent Act, 1970, had excluded pharmaceuticals, food, and chemicals from product patenting. This exclusion was part of the strategy devised by the government to control the monopolistic practices of MNCs operating in India. However, the 2005 amendment completely deleted this section and paved way for product patent regime for pharmaceuticals. Similarly, the amendment also extended the term of patent protection. The term of patent protection is now extended to 20 years from the date of filing of patents. According to the 1970 patent Act, it was only seven years.

Prior to the 2005 amendment, the Patents Act, 1970 had a provision for a Pre-grant (Post-Acceptance) Opposition under Sec. 25. According to the Section 25 (1) of the Patent Act, once the application is filed, within four months of publication "any person interested" could make a representation before the opposition board created under the Act on the grounds of a wrongfully obtained invention as regards novelty, patentability, industrial application, prior knowledge in prior art etc. In this case, opposition is filed after the examination, amendment and publication. As against this, in the 2005 amendment, pre-grant opposition is filed to the application as applied for. This is done with a view that if any applicant files a frivolous patent, the rigorous exercise to be undertaken is saved and public time in examining that application is saved. Similarly, under Section25 (2), 2005, the amendment provided post grant opposition. It should be noted that various patient groups and local industry players have used the pre-grant oppositions to block the frivolous patents as well as the ever-greening of patents. In fact, some of these casescourted controversy even at the international level.

Another very important change is in section 3, which specifies what inventions cannot be patented. In clause(d), earlier new use for a known substance or process or machine was not eligible for patents. But after amendment if there is new use of the existing substance, process, or machine resulting in a new product or having at best one new reactant, it can be patented now. However, based on the section 3(d), the patent office has rejected many patent applications. A review of the latest developments show that Section 3(d) is under attack from both developed countries as well as multinational pharmaceutical corporations such as Novartis (Chaudhuri, 2010; MSF-USA, 2010). Even after the 20 years of TRIPS regime, the Indian Patent Act is a target of corporate fury.

Another amendment is related to the issue of compulsory licensing (CL). CL is when a government allows someone

else to produce the patented product or process without the consent of the patent owner. Compulsory Licensing (CL) is enabled under four sections of the Patents Act. Under Section 84, general CLs can be issued by the Controller on application. This section enables the generic companies, after three years of grant of patent, to apply for CL when: (1) the reasonable requirements of the public with respect to the patented invention have not been satisfied, or (2) the patented invention is not available to the public at a reasonably affordable price, or (3) the patent is not worked in India. Generic companies can make use of this provision to manufacture and sell patented drugs at affordable prices. The problem with this provision is that there is a three-year waiting period to apply for CL. Under Section 91, CL can be issued for a related patent/dependent patent on receiving an application. Section 91 enables the innovators of dependent patent or related patent to manufacture technologically upgraded products so that it would substantially contribute to the establishment or development of commercial or industrial activities. Under Section 92, CL can be issued on the basis of a notification by the Central Government of circumstances of national emergency or in circumstances of extreme urgency or in case of public non-commercial use. After the notification, CL can be granted to a generic company so that the drug is made available to the public at an affordable price. Section 92 (A) enables the controller to issue CL on application for manufacture and export of patented pharmaceutical products to any country having insufficient or no manufacturing capacity in the pharmaceutical sector for the concerned product to address public health problems. In other words this section can be used to issue CL to a generic company when another country wants to import drugs. It should be noted that this is only applicable to those developing countries which have insufficient or no manufacturing capacity. Apart from these, there is a provision for 'Crown use' in Chapter XVII (section 100). This provides for the use of inventions for the purpose of government and acquisition of inventions by the Central Government. Under Government use license, it can intervene at any stage of the patent term to acquire patents. Under this provision, manufacture, procure, distribute and sale of the patented drugs should be purely on 'non-commercial basis'. This means governments can make use of this provision to utilize it for national disease control programs.

Though there are many sections in the Patent Act to safeguard the public interest, the government has not yet shown the required political will to make optimum use, if not maximum use. For instance, though we have serious problems with regard to access to medicines In India, even after 10 years of the product patent regime, only one CL has been issued in India.

According to Chaudhuri, "While amending the Patents Act, 1970, India has not taken full advantage of the flexibilities, which the TRIPS agreement provides" (Chaudhuri, 2002). The provision related to patentable subject matter has invited severe criticism from different corners. Unlike the Patent Act, 1970, the amended Act is clearly biased towards the patentees at the cost of ignoring the drug needs of the bulk of

the population. Chaudhuri also argued that the new Indian Patent Act provided more extensive protection to patentees than what is required by the TRIPs agreement (Chaudhuri, 2002). Earlier, in 1993 itself the Gujral Committee in its unanimous report shared its apprehension that extending of product patents to pharmaceuticals would result in steep increases in prices. Another important point of concern was that treating importation as working of a patent provided for in the TRIPs text would prevent establishment of manufacturing facilities in India. The Committee also cautioned that extending the period of patent protection to twenty years would limit access to new technology and introduction of new products in India. It was further of the view that specific instruments must be provided to ensure that the "indigenous drug industry is not gobbled up by the foreign multinationals. The primacy of the public interest over the patent holders should be ensured" (Zaveri, 1998).

Post-TRIPS Indian Pharmaceuticals and Access to Medicines

The introduction of TRIPS-compliant patent regime and the autonomous liberalization policies espoused by the government of India in the 1990s in a way changed the very political economy of the Indian pharmaceutical sector. In fact, it would not be incorrect to argue that these policy induced changes altered the structure of the pharmaceutical industry. It introduced new players and actors in pharmaceutical politics in India. In the post-TRIPS phase one could witness seven important changes. They are: 1) Weakening of the domestic sector, 2) entry of expensive block buster patented drugs to the Indian market, 3) shrinking of domestic policy space, 4) increasing number of patent related court cases, 5) MNC takeover of Indian generic companies, 6) increasing presence of foreign investors in pharmaceutical sector, and 7) increased import dependence for bulk drugs (Abrol, 2004; Chaudhuri, 2010;Dhar and Gopakumar, 2006; Selvaraj, 2014). In fact all these changes have its implications for peoples' access to low priced quality medicines in India. Households spend a sizeable amount of money on medicines. Studies have shown that their out-of-pocket (OOP) expenditure constitutes 69 per cent of overall health expenditure. Further evidence shows that, while 70 per cent of the households' out-of-pocket health expenditure in urban India goes into buying drugs, in rural India the share is as high as 77 per cent. The WHO estimated that 50 to 65 per cent (499-649 million people) of the population in India lacks access to affordable and quality medicines. Both the patented and generic drugs are out of the reach of the common people as the drug prices have gone exorbitantly high. In fact, patented medicines are prohibitively priced. For instance, take the case of the drug, *Trastuzumab. Trastuzumab* is used in combination with *Paclitaxel* in the treatment of metastatic breast cancer and in whom *Anthracycline* treatment is inappropriate. It is administered intravenously. Usually, following an initial loading dose of 4 mg per kg body weight, patients receive a weekly dose of 2 mg per kg body weight until disease progression. Here, Roche's single vial of *Trastuzumab* costs Rs. 1,35,200. Therefore, an average Indian would not

even dare to imagine the cost of treatment, which is required for 52 weeks. Similarly, *Erlotinib* which is used as a second-line treatment option for patients with non-small-cell lung cancer is another controversial case. *Erlotinib* is given orally at a recommended dose of 150 mg/day and the typical treatment duration of 125 days. A pack of ten tablets of *Tarceva*, Roche's brand of *Erlotinib* costs Rs.40300. Therefore, treatment with *Erlotinib/Tarceva* for 125 days would cost Rs.503750. In another case, *Bevacizumab* is used in the treatment of patients with metastatic carcinoma of the colon or rectum. In normal cases, *Bevacizumab* is administered as an intravenous infusion at a dose of 5 mg/ kg body weight once in every 14 days and treatment is recommended until there is underlying disease progression. That means an average Indian with body weight of 65kg would need 300mg, i.e., three vials in every two weeks. This makes treatment cost Rs. 92950/per month. Cancer Patient Aid Association (CPAA) notes, "(For) about 50% of the population in India, who are in a hand to mouth situation, and earn less than Rs.100 a day or are unemployed, treatment for cancer is inaccessible and unaffordable, as the price of cancer medicines and treatment is way above the reach of the common man" (CPAA, 2010:7). They also argue that even the lowest priced generic medicine produced by Indian companies is not affordable to the low income category of people. The point to be noted is that affordability of medicines continues to be a serious problem.

Perverse profiteering and accessibility problems have a colonial history in India. During the time of colonialism and immediately after Independence, MNCs with their monopolistic market power virtually looted Indian patients. There are many documented evidence on these issues. For instance, in 1959, the United States Senate's Anti-Trust and Monopoly Subcommittee, headed by Estes Keafauver found that American Cyanamid sold 16 capsules of Tetracycline to chemists in India, at $6.52, and to chemists in Argentina, at $1.19; that is, at 128 per cent and 23 per cent respectively of the United States price. Further, the subcommittee came to the conclusion that monopoly created under the colonial patent laws helped these American companies to charge exorbitant prices (Sokhey, 1962). After studying the pharmaceuticals market the Keafauver Committeewrote, "The conclusion would appear to be warranted that in this industry the mere existence of patent protection is not a guarantee of invention, nor is its absence much of a barrier" (as quoted by Sokhey, 1962). The Committee also made three important points that: 1) patents led to predatory prices and excessive margins; 2) extravagant sales promotion increased costs and prices of drugs, and 3) most of the new products were in fact mere minor molecular modifications, and no more effective than established drugs on the market (Gagnon and Lexchin 2008; Sokhey, 1962). Even after 50 years of the Keaufauver Committee, the same problems persist in India and the government is too incapacitated to deal with problems as it is constrained by the obligations made in the international treaties and also due to the international trade pressure. It has to be remembered that the Eighth Report

of Standing Committee on Chemicals & Fertilizers (2005-06), noted that after the introduction of TRIPS compliant product patent regime there would alteration in the prices of drugs in the country. It also stated that there is a pronounced need for the Government to keep the prices of drugs within the reach of the common man at this crucial time. The Committee, therefore, recommended that the Ministry of Chemicals and Fertilizers in co-ordination with other concerned Ministries should set up a mechanism which would closely monitor the price behaviour in the wake of the amendments in the Patents Law and take appropriate corrective measures for enforcing proper moderations (Government of India, 2005). Though, the government has initiated the process for introducing price negotiation for patented medicines, not much progress has been made so far. Presently, there is not even a single mechanism to monitor or control the prices of patented medicines in India. Considering the escalation of drug prices and disease burden, India may be heading towards a "treatment time-bomb."

The Post-TRIPS phase also witnessed an increased activism of civil society for better access to medicines situation in India. It should be remembered that these struggles were taking place in India at a time when the entire world was looking at India as the "pharmacy of the developing world". Thus a TRIPS-compliant patent regime also has further added to the challenges to access to affordable medicines in India. It should be also noted that various provisions of the Indian Patent Act such as Section 3(d) are being attacked both in the domestic courts as well as international fora. Another matter of serious concern is that the MNCs are regaining their lost ground in the Indian pharmaceutical sector in the post-TRIPS phase. The increasing number of mergers and acquisitions and contract manufacturing and research deals are symptoms of this problem. It is true that some of the domestic players have grown and evolved themselves to the stature of MNCs. However the Indian industry has become increasingly import dependent and export oriented; neglecting the domestic needs and epidemiological realities.

Free Trade Agreements and Access to Medicines

Once the developed countries realised that the multilateral forum such as WTO is not really working in their favour because of its democratic functioning, they started engaging in forum shopping. Thus, free trade agreements and regional trade agreements have become new platforms for trade negotiations and trade-offs. These FTAs and RTAs were generally "WTO-plus" in its content and spirit. These FTAs have provisions for extensive protection of intellectual property rights in the form of extended patent terms, drug-patent linkages (system or process by which a country links drug marketing approval to the status of the patent(s) corresponding to the originator's product)and data exclusivity (a set period of time after the marketing approval, during which no one else may rely on or use the innovator's data to obtain a marketing authorization for a particular product). For instance, most of the FTAs concluded by EU and US have "TRIPS

plus" provisions that have very high standards of IPR protection. Hence implications for access to medicines also are more detrimental (Khor and Ocampo, 2008; Malpani, 2007). The transpacific partnership agreement (TPP) recently concluded by twelve countries is expected to have severe implications for access to medicines across the world.To quote MSF on TPP "Doctors Without Borders/Médecins Sans Frontières (MSF) expresses its dismay that TPP countries have agreed to United States government and multinational drug company demands that will raise the price of medicines for millions by unnecessarily extending monopolies and further delaying price-lowering generic competition. The big losers in the TPP are patients and treatment providers in developing countries. Although the text has improved over the initial demands, the TPP will still go down in history as the worst trade agreement for access to medicines in developing countries, which will be forced to change their laws to incorporate abusive intellectual property protections for pharmaceutical companies." (MSF-USA, 2015). It should be remembered that many policy analysts have cautioned India on the India-European Union FTA which is under negotiation. They argue that India-EU FTA can further worsen the access to medicines situation in India. They also argue that, if India, "the pharmacy of the world', is affected it can affect the access to medicines situation in various parts of the world.

Conclusion

The schism between profit maximisation and unmet health needs of population has been well documented in different points of history. However, in the past two decades with the introduction of the new global trade regime through WTO and various FTAs, the problems and issues in accessing quality and affordable medicines are aggravating. The current situation calls for an urgent need for concerted efforts to address these issues and problems arising out of the international trade with utmost importance. Social workers with adequate knowledge, passion and skill can play an important role here. But the question is -are Indian social workers informed enough or prepared enough to contribute in the realm of theory and practice?

A cursory look at the curriculum of social work courses offered by various institutions would reveal the fact that, presently social work training does not include enough inputs and discussions on international trade and its impact on human lives. It should be noted that the model curriculum drafted by the Gokarn Committee incorporated a section on 'world trade' in the paper titled "Political Economy of Development" at the post graduate level (UGC, 2000). However in actual practice, only passing references are made about international trade while discussing about liberalisation and globalisation. Therefore, there is an urgent need to introduce more trade components in social work education. There is also a dearth of literature on state specific issues and its dynamics relating to international trade. Hence, there is also plenty of scope for research based documentation on trade and health issues. Another important area is that of advocacy. Media advocacy and policy

advocacy are indeed indispensable to place the issues in both the public and policy realm. Mobilisation of patient groups and general public against the violation of health rights by trade instruments is another area that social workers can contribute immensely.

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ISSN: 0976-5484 Social Work Journal • Vol. 5 • No. 1 • June 2014 • Page 79-86

Armed Conflict and Mental Health in Manipur: Exploring the Major Factors of Deterioration

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Researchstudies around the world have documented the negative impact of armed conflict on mental health. However, the Indian state which is experiencing it as well as involved in for almost three to four decades, in nearly half of its constituent states have not taken the issue seriously. Conversely, the silence or avoidance of the issue by the state does not negate the suffering of the people in these areas. With this background, the paper tries to examine the major factors that contribute to the deteriorating mental health in the armed conflict ridden state of Manipur in Northeast India. It concludes that the people of the state have been continuously exposed to violence and also to the various facets of the conflict situation with limited intervention. The issue of mental health and armed conflict therefore needs to be collectively addressed since the complications of mental health as repercussions of armed conflict will continue to prevailunless the conflict is not resolved or transformed in a non-violent way.

Mental Health: Fallout of Armed Conflict

It has now been firmly established that the situation of armed conflict has a detrimental effect on the mental health of those living in active conflict zones, particularly on women and children. However, it remains a least priority area as to how different characteristics of conflict lead to specific forms of psychopathology and psychological impairment in civilians. This is likely due to the fact that majority of the research on the psychological effects of armed conflict has been conducted on war veterans despite the fact that war leads to a greater burden on the civilian population than on soldiers. Although early studies on civilians tended to focus on the impact of war on the risk of developing Post Traumatic Stress Disorder (PTSD), it has now become clear that the effects of conflict extend beyond the direct effects of violence to include a host of social and economic hardships that can be as equally important in determining the likelihood of developing a mental illness (Belland others 2012). Murray and others (2002) similarly observed that the impact of war arises both from the direct effects of combat namely, battle deaths and from the indirect consequences of war, which may occur for several years after a conflict ends. However, military conflict has not received the same attention from public health researchers and policy makers as many other causes of illness and death have. The issues related to the

physical, emotional and social consequences of violence still needs to be pushed to the very top of international, national, and local public health agenda.

Uppsala University's Conflict Data Program (UCDP) reported there were 33 active conflicts in the world in 2013. If there are at least 25 battle-related deaths, it is classified as active conflict while more than 1,000 lives lost are classified as war. UCDP has been recording violent conflicts since the 1970s. As per the report, the number of active conflicts in the world has remained relatively stable over the past ten years that fluctuates between 31 and 37 as compared to the period right after the end of the Cold War, where more than 50 conflicts were active. The war like conflict has also declined by more than 50 percent since the early 1990s from 15 to 7 in 2013. Murthy and Lakshminarayana (2006) give a clear picture of the consequences of war on mental health in various parts of the world. However, the consequences of armed conflict on mental health particularly in the developing and underdeveloped countries are yet to be addressed significantly. Razzouk Denise and others (2010) observe that low and middle income countries (LMIC) face the challenges of (i) severe scarcity of mental health resources, (ii) inequitable distribution, and (iii) inefficient utilization. Further they stated that African and Asian countries have the greatest shortage of mental health research capacity. Luiteland others (2013) observed thatvery few epidemiological studies have been conducted among the general population in Nepal and no such study has been conducted in the context of armed con?ict. This is despite the fact that a number of qualitative and quantitative studies are already being carried on to document the impacts of political violence. It remains a least priority area as to how different characteristics of conflict lead to specific forms of psychopathology and psychological impairment in civilians. This is likely due to the fact that majority of the research on the psychological effects of armed conflict has been conducted on war veterans despite the fact that war leads to a greater burden on the civilian population than on soldiers.

The Indian state is also encountering armed conflict for the last three to four decades in the state of Jammu and Kashmir; Central India covering the seven Maoist-hit states - Chhattisgarh, Jharkhand, Odisha, Bihar, Andhra Pradesh, Maharashtra and West Bengal; and the Northeast India particularly the state of Assam, Nagaland, Meghalaya and Manipur. There are few studies on the consequences of armed conflict on mental health on Jammu and Kashmir (Ali &Jaswal, 2000 & Hassan &Shafi, 2013) but unfortunately, apart from some newspaper reportages, publications on Central India and Northeast India are very rare. The issue is yet to be a priority of the government and health professionals (ICMR, 2005). For instance, Pathare (2014) observed that mental health disorders account for nearly a sixth of all health-related disorders in India. Yet India has just 0.4 psychiatrists and 0.02 psychologists per 100,000 people, and 0.25 mental health beds per 10,000 populations. This is a fact as less than 0.1% of our health budget is spent on mental health.

According to a survey conducted in the north-eastern states by the Directorate General of Health Services under the Ministry of Health and Family Welfare, number of cases of chronic mental disorder in Manipur was 23,886 and minor sufferers numbered 1,19,430.While the neighbouring state of Assam has 500 beds in government sector, Manipur has only 10. Meghalaya has 70, Nagaland 25, Tripura 16, Mizoram 14 and Arunachal Pradesh 10. The report further added that in the northeast, no provisions are there till date for treatment of such patients in the private sector too (The Peoples' Chronicle July 18, 2013).

Armed Conflict and Mental Health in Manipur: Exploring the Major Factors of Deterioration

Akshay Kumar (The Sangai Express May 03, 2010) of the Regional Institute of Medical Sciences (RIMS) observed that the normal lives of the people have been greatly affected by the prevailing conflict situation. Some of the reported psychiatric disorders are (i) PTSD, (ii) Depression, (iii) Anxiety Disorders, (iv) Adjustment Disorders, (v) Psycho-somatic Disorders, (vi) Substance Use Disorders, and (vii) Psychosis (Lenin, 2010). The Department of Psychiatry at RIMS and the Jawaharlal Nehru Institute of Medical Sciences (JNIMS) are in fact the only available facilities to deliver mental health services in Manipur. However, there are only 6 Psychiatrists out of 24 required and there is only one clinical Psychologist out of 36 required and only two psychiatric social workers although 48 are required (The Peoples' Chronicle, July 18, 2013). The people of the state have been continuously exposed to violence and also to the various facets of the conflict situation with limited intervention. In this scenario, the question of addressing the situation is limited. This section thus discusses some of the major factors that contribute to the deteriorating mental health in Manipur.

Figure1: Decades of Exposure to Violence: No. of Bomb Blasts from 2004-2013

(i) Conflict Situation

Manipur, an erstwhile sovereign kingdom in Asia (Hanjabam 2013), can aptly be called 'Miniature India' considering the substantive similarities with the kind of equation mainland India has with the rest of the country in terms of multiplicity in ethnic composition and demographic variations. It comprises of the Meiteis, Meitei-Pangal, 36 Scheduled Tribes, and 07 Scheduled Castes. The tribes are broadly categorised as (i) the Manipuri Nagas and (2) the Manipuri Chin-Kuki-Mizo or also otherwise called Zomis. Besides, there are many communities from outside the state who have settled for business purpose. After the "taking over" of Manipur and administering of direct rule from New Delhi, the first armed movement was for the restoration of sovereignty of Manipur led by HijamIrabot. Subsequently, the political vacuum created by the New Delhi administration resulted into different conflicting demands based on ethnicity. A British Broadcasting Corporation

(BBC) commentator once described Manipur as "India's Bosnia" (Singh, Hanjabam&Sanasam 2011). The intensity of ethnic conflicts increased in such a scenario which was manifested in some of the infamous ethnic conflicts such as (a) Hmar-Kuki (1959-1960); (b) Kuki-Naga 1992; (c) Meiteis-MeiteiPangals 1993, (d) Kukis-Tamils 1995; (e) Kuki-Paite 1997-1998 etc. Fig. 1 indicates the multiplicity of the conflict and militarization. This has militarized the state and also created a situation of constant fear among the general population for the last many decades.

(ii) Militarization

The concentration of central security forces in the capital and adjoining areas of Manipur is such that Robinson (2005) remarks it as an occupational force rather than the defence of the country. The level of state sponsored militarization deserves attention as it has been militarizing the state since 1980 after imposing the draconian Armed Forces Special Powers Act (AFSPA) to the whole of Manipur. This Act legitimised full scale military operations, permitting even a non-commissioned officer to kill anyone on mere suspicion. Besides AFSPA, other security legislations are (i) Unlawful Activities (Prevention) Act, 1967 (UAPA), (ii) Prevention of Seditious Meetings Act 1911, (iii) Official Secrets Act 1923, (iv) Maintenance of Public Order Act 1947, (v) Punjab Security of the State Act 1953, (vi) National Security Act, 1980, (vii) Code of Criminal Procedures (Manipur Amendment) Act 1983, and (viii) National Investigation Agency Act 2008 (Civil Society Coalition on Human Rights in Manipur and the UN, (2011),hereafter (CSCHR).

Assam Rifles has the highest number of troops' presence in Manipur. They are deployed for counter-insurgency operations. In addition to these, there are the state police personnel. The improving relationship between India and Myanmar was exploited with numerous joint operations to flush out armed opposition camps in the Indo-Myanmar border areas. Moreover, combing operations, either to nab a suspect or as a deterrent measure, are undertaken from time to time at any specific area, and comprises of cordoning off a specific location, use of a ZORO-masked informer (usually surrendered armed groups) to identify an armed rebel, house searches, etc.

(iii) Torture

The act of torture is widespread. Michael Otterman (2007) reveals the long history of U.S. torture. He shows how these procedures became standard practice in today's war on terror. He further observed that, after 9/11, they were revived again for use on enemy combatants detained in America's vast gulag of prisoners across the globe, from secret CIA black sites in Thailand to the detention centre at Guantanamo Bay, Cuba. Similarly Ian Cobain (2013), reveals how the British have repeatedly and systematically resorted to torture, turning a blind eye where necessary, bending the law where they can, and issuing categorical denials all from WWII to the War on Terror, via Kenya and Northern Ireland. It also shows about the barbaric assault on the mind, or "Menticide", which was part of the torture process and its impact on the

prisoners.

The UK perspective will be more relevant in the Indian context as the Indian government (being a colony) largely relied on the UK pattern of governance even to the extent of adopting the Police Act 1861 which is still in force. For instance, the government of India adopted the British model of counter-insurgency in Mizoram by carpet bombing the areas by Indian Air Force and also by adopting the same model of village regrouping. Barman (2013) stated that these ideas were picked up by our officers from the colonial British playbook. The British had regrouped villages during the Boer war in the early 20th century, in Malaya, where they interned Chinese in special camps and in Kenya where villages were uprooted to crush the Mau Mau revolt. The adoption of the AFSPA was also a British model. It was an ordinance adopted by the British to suppress the Quit India movement during the height of India's freedom struggle in the early 1940s. Under this Act, the people of the region suffered the most as it was intentionally imposed to suppress the peoples' voices.

Cobain (2013) stated that there are secret interrogation centres in Delhi during the Second World War and during the cold war. So the controversial "five techniques", (sleepdeprivation, hooding, subjecting to noise, food and drink deprivation, and "wall standing" or stress positions might be used in India and Manipur in particular as India has been adopting most of the British model of counter-insurgency operations. Besides, the presence of secret detention centres has strengthened the claim. In Manipur, almost every person who is arrested or detained is tortured; and the common methods include verbal abuse, psychological torture, blind-folding, hooding, beating, electric shocks to the genitalia, water-boarding, etc. The practice of torture (CSCHR 2011) continues with impunity. Human Rights Watch (HRW) reported a series of torture in Manipur in the year 2008 which substantiate the practice of torture. The report is used selectively in this paper as an indication of torture in Manipur. The documentation of testimonies of torture have shown that they are mostly cases of arrest owing to false information, and were released later on. This is also indicated in the HRW report. However, none of the extreme torture cases are reported as many of them become victims of extrajudicial execution. The report documented by the HRW(2008a &b) could be because of the trust to HRW for justice and its protective mechanism. It can also be seen as a process of countering torture but many of them remain silent, mainly because of the fear of reprisal from the state and also lack confidence in the state for delivering justice. For instance, a media house outside the state of Manipur was chosen for exposing the sequential photograph of a fake encounter (July 23, 2009) of Th. Sanjit (Rehman, 2009) even though the photograph was taken by the local journalist. Similarly, none of the judicial enquiries report relating to these issues have been revealed so far.

(iv) Extrajudicial, Summary or Arbitrary Executions

The situation of extrajudicial, summary or arbitrary executions in Northeast India particularly Manipur has caught

the attention of the UN Special Rapporteur of extrajudicial, summary or arbitrary executions, Christof Heyns. As part of his country visit to India, he also interacted with the victim's family, as well as the human rights and civil society groups in Northeast India at Guwahati, Assam. During the interaction, CSCHR (2012) submitted a report entitled "Manipur: A Memorandum on Extrajudicial, Summary or Arbitrary Executions to the Special Rapporteur". They observed that fake encounters are not a recent phenomenon in Manipur. It has been going on for the last three decades. Similarly, in a report of the Independent Citizens' Fact Finding (2009) constituted after the fake encounter at Imphal city (July 23, 2009), concluded that, Manipur Government at the highest level confirmed that more than 260 people were killed in encounters in 2009 in the State. The same report also indicates the large number of gallantry awards (reportedly 74 out of 220 in the country) was won by the Manipur Police personnel in the same year. This really indicates the knowledge and support of the state to these fake encounters. This was the situation since the imposition of AFSPA Asian Legal Resource Center (2006).

In response to a Public Interest Litigation (PIL) filed by the Extra-judicial Execution Victims' Families Association of Manipur (EEVFAM) and Human Rights Alert (HRA) (2012) alleging that there had been apathy on the Centre and Manipur government's part to bring to book the guilty among armed forces and state police, for the 1,528 extra-judicial killings in the last 30 years, the Supreme Court of India appointed a three member committee to randomly probe six cases. The committee comprising of the former Supreme Court judge, Justice N. Santosh Hegde; the former Chief Election Commissioner, J.M. Lyngdoh; and the former Karnataka DGP, Ajay Kumar Singh, concluded that the six cases are all fake encounters. The committee stated that the killings were undertaken "with impunity" and there was a "certain pattern" indicating that they were all stage-managed. Despite specific guidelines from the Supreme Court issued from time to time to the States and the Centre, to prevent fake encounters, the extra-judicial killings continued in Manipur (The Hindu, April 4, 2014). In a recent development to the PIL, the Supreme Court ordered to submit the reports of 27 cases of alleged fake encounter killings in Manipur and to be made available to the petitioners and the Union government (The TelegraphAugust 9, 2014,).

Conclusion

The protracted armed conflict in the state is the major deteriorating factor for mental health. In addition, the continuous existence of conflict situation for decades and the inadequate response mechanism to the situation has multiplied and complicated the problem. With the limitation of infrastructure and manpower, the role to be played by the health professionals has not materialised so far. Besides, the armed conflict in Manipur is likely to prolong and continue as no immediate solution seems to be in sight. The government and proscribed armed opposition group remained contentious and had still not been able to come to any consensus

about the roots of the armed movement. Besides,the economic dimension of the conflict is likely to complicate the problem as both the parties in conflict remain adamantly rigid and doesn't seem to show any willingness to compromise on the situation. In addition, the present situation of Manipur did not get any attention so far from the concerned government. The issue of mental health and armed conflict needs to be collectively addressed as the complications of mental health and repercussions of armed conflict will continue to persevere as long as the conflict is not resolved or transformed in a non-violent way. Only then will it automatically diffuse the existing conflict situation that sustains the factors for the deteriorating mental health in Manipur.

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