

Understanding and listening to the voices of the poor

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In the last three days, we have been discussing issues like who are the poor? Are we listening or are we not listening to them? We are not discussing whether the poor are saying some thing, because they are. We have to ask if these voices reach those who are in the position of power to act and change the situations?

The three monkeys of Mahatma Gandhi: Mahatma Gandhi used to keep small statues of three little monkeys on his table - one closing its eyes, one closing its mouth and one closing its ears. He used to say that these statues meant, see no evil, hear no evil and speak no evil. As children in India, we were all taught this story of three monkeys and in India you can easily buy similar statues. This story is taught to us as a moral parable as part of our moral values and education. However, there is another syndrome of “three monkeys” afflicting our decision makers.

The Syndrome of Three Monkeys – (In Persons with Power)

- Selective blindness
- Selective deafness
- Selective silence with selective Amnesia

For the persons in power, the message of Mahatma Gandhi means selective deafness, it does not mean “hear no evil”. They have selective deafness because they can hear the voice of World Bank and International Monetary Fund, but they can not or do not want to hear the voices of the poor.

Then there is selective blindness. Anyone, who has worked for an extended period for any community health programme in any region, can see that the public health systems are collapsing. We can see resurgence of communicable diseases. We can see certain health problems, which we had never seen before. But the decision-makers, they do not see these problems. They have a selective blindness. Poverty lines go up and down, depending on the different formulas they use to calculate poverty. Every thing is relative and statistics are only lies, to be used for convenience. Even while starvation deaths take place, to cover up the impact of human devaluing policies economists can show how the poverty line has gone down.

With that you can also see `selective silence'. When it is convenient, they remain silent, they do not take a clear position.

Let me give an example. After all the discussions about rational drug use in the World Health Assembly, there have been big discussions about compulsory licensing and parallel import of life-saving drugs. At a SEARO (South-East Regional Office of WHO) meeting, where all the delegates of South Eastern Asian countries were present, the agenda item of “access to medicines” came up for discussion and there was a complete silence. Everyone involved in the health, knows that prices of drugs have spiralled up. This is one of the reasons why public health systems are collapsing,

because small institutions can not afford to buy the drugs and poor people cannot afford to buy the drugs. The states are backing out from their financial commitments for health, so they are not buying enough medicines, even for the national health programmes. I had thought that our representatives, the delegates representing us, would speak about these issues. I had thought that if we put pressure on our democratically elected governments, they will raise their voice in the WHO health assembly because the Intellectual Property Rights (IPR) regime is not in the interest of the poor, but they did not say any thing.

There is another syndrome, that of the **selective amnesia**. You do not hear anyone talk about Alma Ata Charter any more. First, they had forgotten Alma Ata and had started to talk about selective primary health care. They said that only growth monitoring, oral rehydration, breast feeding, immunisation and family planning are important health issues. Then this phase passed and now they are all talking about fees for services, stakeholders dialogue, etc. When they say “the stakeholders”, they are not talking about people and the communities. The national health policies and even the international aspirations about “health for all” have been forgotten.

Changing Scenarios

Global scenarios – free market, international trade regimes, unipolar world

National scenarios – countries debt burden

Health scenarios – more disease burden, vertical programs funded by World Bank

Increasing poverty, increase in number of poor, decreasing access to health, education, & food
Decreasing services

Let's us now look at the changing scenarios. As far as the poor are concerned, the forces against them are much bigger than before. **The global scenario** is dominated by the free market, international trade regime and a mind-set that markets will save the world. This kind of mind-set afflicts every one, especially the decision-makers.

Where the **national scenarios** are concerned, majority of the poor countries are crushed under the debt burden. For paying back the huge amounts of interests for the old loans, new loans are being taken from World Bank. The World Bank decides about the health priorities of countries and national governments have increasingly less voice about their own health needs. Thus the responsiveness from our national governments, which we could have expected at the national level, is not there, because the power lies some where else. During the 70s and 80s, we could talk to our policy makers, influence the policies, advocate and push for a comprehensive health care. Now we find that because of the new loans that they have taken, including a large number of new loans from the World Bank for the vertical health programmes, our governments have less power. The new loans come with certain conditions, which influence our national policy negatively.

As far as the **health scenario** is concerned, the disease burden is on the increase. According to the new WHO disease classification system, the diseases under ICD Z 59.5 (extreme poverty) are on the increase. The poverty-related diseases are on the increase, because extreme poverty is on the increase. Official responses to this situation is not through the optimisation of the resources, it is not through the comprehensive primary health care but it is through the vertical programmes! So we have to consider the question of poor and excluded groups in this context.

Changing Scenarios – Voluntary Organisations

- Availability of funds is less
- Support is available for selective issues and not for comprehensive approach – why?
- Aid fatigue?
- Demand for performance indicators
- Change in paradigms towards economic growth, market driven, bio-medical approach based health

Changes are also taking place in the world of the **voluntary organisations**. For some of them, I feel very hesitant to use the word Non-governmental Organisations (NGOs) because in many places, corporate bodies and multinationals have also set-up their “NGOs”. Thus, private interests, for-profit interests, service providers and non-profit volunteer organisations are all lumped together. How do you separate the non-profit organisations from these multinational “NGOs”?

The amount of funding available to NGOs has decreased. International funding now must go to Eastern Europe or it must go to different disasters and conflict areas while funds for development activities are less. Availability of funds for comprehensive primary health care, is much less. Support is available only for selective issues and vertical programmes.

Is it because of the **aid fatigue**? They say that poor people are not doing anything, they are only getting poorer. They say that the poor persons are not helping themselves. It is part of what I call, the victim blaming. Or is it that there is a change of paradigm and perspective that is taking place, even in the international NGOs?

At the same time, for any funding, the issue of **performance indicators** is becoming rigid and increasingly unrealistic. Funds can come if you are willing to say that maternal mortality will be reduced by this much and infant mortality will reduce that much. At the same time, people are not able to afford food, when 20% of the maternal mortality is due to anaemia and 85% of pregnant women are anaemic, how do you propose to reach these beautiful and unrealistic performance indicators only through selective and vertical approaches? These performance indicators focus only on the biomedical view of sickness.

Changing International Health Priorities

- HIV/AIDS, Reproductive Child Health (RCH), Adolescent Health, TB-DOTs, certain kinds of Research – are international priorities
- Organisations operating on ideals of faith, compassion and mission with genuine people's participation, are no longer fashionable and are changing

At the same time, there is also a change in the **international health priorities**. HIV/AIDS along with Reproductive Child Health (RCH) are both seen as international health priorities but in a very narrow sense not in a holistic sense. For example, both **Reproductive Child Health** and HIV/AIDS have something to do only with women? The men also have something to do with these two priorities? The behaviour of both men and women has a lot to do with decisions about pregnancies, abortions, etc. When these become unsafe, many women lose their lives. So the response to these problems cannot be building more abortion clinics, but it is also important to look at the reasons, which lead to the too many abortions and its effect on women's reproductive health. Should there be abortions for gender selection, as happens so often in our country? Should abortion be used as a substitute for the family planning? So often, they are being used as a substitute of family planning, so the trivialization of abortion is a big issue for us.

In some other countries, criminalization of abortion is a problem, because women do not have the choice. Women may have even 3 or 4 abortions of female foetuses, till they are sure that they are going to have a boy. This is demographic fundamentalism and is closely linked to sexual violence and oppression of women. Are these issues not linked to HIV/AIDS and Reproductive Child Health (RCH)? In the official RCH programmes, they do not talk about sexual violence, women issues, etc. For them, it is only family planning, safe motherhood, HIV/AIDS and safe abortion.

There is a lack of sensitivity in dealing with girls and women, who are victims of **sexual violence**. Even though they may have physical injury, unwanted pregnancy, infection with sexually transmissible diseases or HIV, be forced to undergo unsafe abortion or bear the effect of the violence psychologically for life, sexual violence is not part of the reproductive health programs.

The question of **infertility** is a big social issue. Women are deserted by their husbands because of infertility but it is not an issue for official Reproductive Child Health Programmes. We, persons involved in women's health, feel that the definitions given to official RCH programmes are inadequate because they do not keep account many important issues and have a very narrow focus.

Adolescent health is also becoming an international health priority. Suddenly they are worried about adolescent health, because increasingly adolescents are getting pregnant. In developing countries, young children and adolescents are a higher percentage of population compared to adults. But adolescent health is not just sexual health, just about safe sex and avoiding pregnancy.

Adolescent health has to be seen with our own social-cultural context. It has also to deal with mechanisms of peer group pressures, issues like substance abuse and the changing social scenario.

Example of Tuberculosis (TB): TB is another international health priority. Where TB is concerned, there is a move towards internationalising of the health policies. This means promoting standard, inflexible regimes for the whole world. TB has to be treated with what is called Directly Observed Treatment (DOTs). But if the prices of the DOTs drugs are going to be so high and if these programmes are running with international loans from World Bank, how long are poor countries going to continue taking new loans, in spite of our already huge debt burdens? The loans come for 3-4 years of vertical programmes. In India only one-fifth of our districts are so far covered with the DOTs (it means access to be drugs is ensured). So our question is, what about the remaining districts? What about medium or long term plans, when the loans will be finished? It all seems to go with a very myopic vision of intensive, short-term vertical programmes, without looking at the basic constraints like unaffordable drugs and collapsing public health.

The production of anti-TB drugs and accessibility of prices of anti-TB drugs are important for defining health strategies. Drugs like INH and Thiacetazone are now being produced less, because they are not part of the DOTs. When no new anti-TB drugs are on the horizon, is it wise to discard old well known drugs? I am aware of the problems with skin reaction caused by Thiacetazone in some countries, where TB infection is linked to AIDS, but in situations where you don't have DOTs, should the patients be left without any drugs? Is it now DOTS or nothing?

On one hand, we say that we stand for rational TB care. On the other hand, if unhygienic conditions, which produce vulnerability to TB, are on the increase, if poverty is on the increase, if malnutrition is on the increase, then should the "rational TB care" still mean only DOTs? Why does no one speak about comprehensive TB care?

For certain kind of research, lot of funds are available. For example, there are lot of funds available for research related to sexual behaviours of different groups, often without sensitivity to the local context.

"Professionalisation" of NGOs: NGOs have taken over the mask of "professionalisation" from international donors and big multilateral agencies, so they also work for very specific areas with vertical approaches because they get money for that kind of work. They are very different from the organisations operating on ideals of faith and compassion, like those organisations, which have worked on leprosy. Mahatma Gandhi inspired many of them, many of them were and are mission institutions, who have given their lives for their work. For long years, they worked in a community, where they have seen certain gradual changes. They were completely different from these new "professional" organisations, which come for 2-3 years projects, if they find funds from a donor. As the fashions and whims of the donors change, they stop what ever they are doing and they start with something new. They work for girl child projects for a few years because that is in vogue with the donors, then donors decide that they want to fund adolescent health, so they forget about girl-child and start adolescent health projects. If they work for AIDS then they are concerned only about those

dying from AIDS and persons in the same community can die from starvation, diarrhoea, malaria, TB, dowry deaths, but they are not concerned, because it is not their “project”.

Understanding the Silence – Reasons for Silence

No trust

No hope

Previous bad experiences – example, people interested in research but not in doing something, so people feel used/exploited, they never hear the results of the studies.

False promises in the past

The communities do speak, but who listens to their voices? They may also be articulating their concerns through the silence. It is up to us to understand this silence. Especially the women, when they are in a group, they may not speak. Silence may mean that there is no trust, or it may mean that there is no hope. They may feel that so many people have tried to change the world and to deal with different issues without any success, so that there is a deep rooted sense of hopelessness. There are all kinds of persons coming and promising to the communities, making big speeches about the suffering humanity, and in spite of all the promises, the people continue to suffer. This is especially true of political parties coming to the communities.

Changing Nature of Listeners

- Private consultancy firms collecting data
- Industries and corporations are entering the development programs
- Move towards Local self-Governance
- Conflict between:
 - We will give you free medical care & education
 - We will help you to organise to meet your own needs and access to what is your right

Nature of Listeners: However, there are so many kinds of groups coming to “listen” to the communities. Like the private consultancy firms all over the rural areas. Like the drug companies wanting to know from the community how they are treating different diseases. Like the persons interested in learning about local traditional healing systems. We have started to discover all these different groups with their different motives, suddenly interested in the “voices” of the communities. We are one billion persons in India and we have more than 200 million strong middle-class, who represent a “market”. So the different private consultancy firms come and ask all kinds of questions and communities become hunting grounds. They are hunting for institutions like hospitals and their questions may be linked to ideas of promoting private insurance. Investment for private health sector is encouraged. So industries and multinationals are entering the “development

programmes”. Many different companies have now funds for some “community health and development programmes”.

In India, according to our constitution we have local self-governance of the communities through “Panchayats” (village councils). This means that elected persons from the village will form part of the village council and 33% of the seats of the council are reserved for women. This seems a good step and every one hopes that there will be decentralisation of decision making at the village council level. But the powers of these councils are very limited. Often, they do not know about their own powers, as there is not sufficient support and capacity building of the village council members. So they do not know the decision making process and the importance of their decisions. So who is the real representative of the community here – the village council members, who have been elected by the villagers or the NGOs, which say that they are working for the people and represent people’s voices? To whom do communities speak? Poor persons in the community will go to those that they feel will listen to them.

How can you promote development in this situation where on one hand, a group may be promoting self-reliance and development through their own efforts and on the other, you have a group, coming with money to provide free medical care and free education? Naturally, the communities get confused in such a situation.

Expressed Priority Needs of the Poor

- Food, water, work, livelihood, fair wages, safety for women, transport, ...
- Health and education are much lower in hierarchy of priorities – ask for hospital doctor, lady doctor for women, English medium or good schools
- NGOs becoming willing partners of top-down vertical health programs – different from community priorities

Expressed Priority Needs of the Poor: In most of the places, the expressed priority needs of the communities include food, water, work, livelihood, fair wages, safety for women, transport, etc. Education and health issues usually come much later in these priorities. Most of the health groups are not in a position to help the communities with those other priorities and they focus only on the health related needs. To answer such specific questions, communities usually answer that they need a new doctor or a lady doctor for the women or a new hospital. If you talk to them about community health services, preventive medicine and self-reliance, they are not very interested because other ‘corporate NGOs’ are willing to provide such medical solutions. So wherever communities health programs were initiated in 70s and 80s, like in Latin America, Central America, Philippines, etc., it was much easier, because they did not have all these private sector entities coming in the villages in this way.

Even when you talk of basic education, even in villages where, there is no primary school, the communities ask for English teaching good school, because they think that going to such schools will help their children to get jobs later on.

NGOs today are becoming willing partners of top down vertical health programs, which are very different from community priorities. When there was a severe malaria Falciparum outbreak in Rajasthan in India, family planning camps were being organised. When there was a big malaria outbreak in Assam in India, such seminars on HIV/AIDS were being organised. I do not say that you should not organise family planning or AIDS/HIV related activities, but if community needs an urgent intervention, you can not close your eyes and go on doing your own vertical programmes.

Dilemmas of NGOs – Unable to Answer Priority Needs of the Poor

What to do?

- **Listen with empathy**
- **Listening & acting by providing critical information**, documents, contacts, links...
- **Joining the poor** for moral support and solidarity example, anti-globalisation protests, Food Rights Campaign
- **Public interest litigation** – going to the Courts/Tribunals to fight for rights
- **Advocacy** – A. Sensitising those who can help poor; B. Those who need to change attitudes like on gender issues
- **Training with critical awareness** – people's education for health action
- **Providing services** for Malaria and vector-born diseases, Tuberculosis, mother & Child health, Reproductive child health, primary health care, etc.

Role of NGOs as Listeners: As NGOs, we are not always free to do what we wish, even if we know the urgent needs and priorities of the communities where we work. Some times, we find ourselves in a dilemma because of this. However even in such situations we can be respectful to the communities.

At least, we can listen with empathy instead of saying that no, we only deal with health care. Even giving time to listen to and to understand the issues can be a contribution. Listening and supporting by providing critical information and providing documents, contacts, links etc. to the communities so that they are able to take action, can be invaluable. We can join the poor for moral support, for example in initiatives like Narmada dam protest, anti-globalisation protests, Food Rights Campaign etc. We can help them through Public interest litigation – which means, going to the Courts/Tribunals to fight for rights of the marginalised groups. We can help through advocacy by sensitising those who can help the poor and by helping in change of attitude of decision makers. We

can also providing services for malaria and vector-borne diseases, tuberculosis, mother & child health, reproductive child health, primary health care, etc.

Other efforts have been made for advocacy that means, sensitising those who can help the poor, including some judges and parliamentarians. It is important to be able to identify potential allies in decision-making roles, to inform them about the issues, and to help them to interact with the communities and with poor groups.

Another important target group for sensitisation is that of health personnel. Some efforts have been made to bring a change in the medical education. In our medical colleges, we are not taught women's health, we are not taught mental health, we are not taught social roots of mental health problems etc. We are taught about theories of Freud, Jung, etc. and then we realise that social cultural context of our mental health problems is so different from some of these theories. For example, a study of the NIMHANS (national institute of mental health) has shown that for neurosis, the traditional health systems in India can be much more effective than western-medicine based hospitals and the patients are much more responsive.

NGOs can also support through training with critical awareness – for example, people's education for health action. Like the five booklets that are part of the People Health Assembly - these deal with different issues linked to primary health care and the Alma Ata declaration including commercialisation of health care, and what globalisation does to people's health, the issues related women, elderly and disabled persons, etc. These booklets have been translated to several regional languages. People working in the field understand some of these issues now, because of the discussions and debates within the people and health movements but if you talk to medical doctors, or even post graduate specialists, often they have never heard about it. They do not know what is WTO, and how does it influence health. So there are gaps in mainstream medical institutions. This is critical information and building the capacity of communities and these specific groups so that they are able to analyse the issues and are able to make choices is very important.