Unequal Communication

Health and Disasters As Issues of Public Sphere

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Contents

Unequal Communication works three times over the problematic of asymmetry in communication. Communication is a two-way traffic; we have the right to communicate, we have also the right to be communicated. On this two-way right is built the public sphere and the public domain. Yet, how exactly a matter becomes one of public domain and how exactly public sphere engages with an issue or makes it a matter of public concern requires study of the relevant institutional processes, which brings out the asymmetries in communication. The inequalities are evident the moment communication is studied not in terms of vague philosophical theories, but in terms of concrete institutional practices, which decide how a matter is going to be "public". On the first occasion *Unequal Communication* shows how a public disaster such as flood is communicated to the public, the dynamics of communication, its one-way nature, the erasure of certain themes and actors, and the valorisation of others. On the second occasion, it again picks up a "public issue", public health, and shows in terms of media analysis how certain issues of health become public – public but unequally public, because again some of the broader concerns vanish in the process of communication, and those that remain appear as communicable because they were plastic enough to be transformed and changed from what they were. The third time the volume works around the question of public communication is when it takes it up for scrutiny the recently conducted pulse polio campaign in West Bengal – again a matter of public health – and shows how certain matters of public health are regarded as more important as public matters than others, and those whose welfare and health are involved in this vital decision have no voice at all in these great communicative acts. In all the three analyses of the issue of asymmetry in communication, it is not surprising that women figure as unequal agents. In birth and death, heath and disaster, we can find the public sphere communicating with women not as the equal other; similarly women's lives and voices are communicated in the and to public domain again as marginal voices only. *Unequal Communication* is about media study, study of disasters and scandals, gender study, and a study of the asymmetries in communication. In an unequal society, it shows, communication does not flow horizontally, it flows vertically – from top to bottom, and from powerful to the powerless.

Reporting Disasters: Flood, Displacement and Media Sensitivity

Nilanjan Dutta

The Research Problem

"Nobody ever goes to Bhutni. Except when a calamity strikes," wrote a journalist in a Kolkata weekly a few years ago. The short sentence summed up, though it was not intended perhaps, the media response to natural disasters in West Bengal.

Floods occur almost every year in the state, and river-bank erosion takes place almost every day. Nature takes its toll, instigated by human blunders. Hundreds die and thousands are displaced by these disasters. In large parts of North Bengal, particularly Malda and Murshidabad districts, the problem has become endemic. Disaster-induced displacement has become as "natural" in these places as the calamities themselves are considered to be. In other districts such as North 24-Parganas and Nadia, too, the problem is growing. The otherwise docile rivers in these districts had given enough warning signals in 2000. The majority of the displaced people are poor, and at least half of them are women. As the poor are dispossessed of their right to shelter, the women, being the most vulnerable among them, are the worst sufferers. Losing their homes to the river, they have to struggle much harder given the compulsions of family and society.

The problem is an age-old one and leading scientists have pointed out in various periods that although floods may seem inevitable in the riverine region, non-sustainable development projects were responsible for enhancing the danger.[1] In early 20th century, Prafulla Chandra Roy observed that expansion of the railroads by the British colonial government without assessing its impact on the course of rivers on their path hindered drainage and triggered floods in northern and eastern Bengal. Another factor, according to him, was the rampant construction of barrages by the landlords for the safety of their estates and agricultural land. Meghnad Saha, too, had opposed "hasty" implementation of projects in the years immediately following Independence. In 1959, irrigation expert Kapil Bhattacharya had pointed out that the Damodar Valley Project and and Farakka Barrage provided recipe for floods. The authorities did not listen then and there is little hope that they would, now. As this paper deals with media response, it may be recalled here the largest Bengali daily, *Ananda Bazar Patrika* had, at that time, called Bhattacharya a "Pakistani agent". Now that his warnings have largely come true, one finds the scientist's name referred with reverence in the columns of the same newspaper.

Government policy has fallen miserably short of addressing the problem in a proper and systematic manner. Or, as the critics say, "vested interests" have prevented the policies from becoming really helpful for the people. Social tensions have risen as a result. People demanding erosion control measures were fired upon in Akherigunj, Murshidabad and agitators for the completion of a drainage canal lying incomplete for three decades at Jangipara, Hooghly, were booked for rioting in 2000. These were indications of the measures that might be taken, until the next great disaster.

The media are supposed to put up a herald for the leaders and commoners to see the truth, so that the former can adopt measures that mitigate the people's misery, and in case they don't, the latter can pressure them to do it. Have the media played this role in this case? This study seeks to address this question by analysing print media content relating to floods and river-bank erosion in West Bengal in the past five years, taking into account both 'mainstream', meaning Kolkata-based big newspapers and local small newspapers vis-à-vis literature produced by activist groups. The objective of the study is to find out whether and how far the media have been sensitive towards people's rights and gender issues in sourcing and presenting news of those affected by the disasters.

Disaster Management In West Bengal

Calamities are best forgotten - until they strike again. This seems to be the motto of our disaster managers. The recent floods in West Bengal pointed this out clearly. The victims, however, know it would be coming every year.

Two regions are almost always affected badly, the lower Damodar Valley in south Bengal and the Ganga-Padma basin in the north. People of these areas have been living with annual floods for decades. During the last few years, a number of residents' organisations have come up in these localities, cutting across party lines. They have a common agenda: to convince the authorities of the need for proper flood control and disaster management planning. Some of these local groups came together with other activist organisations to form the Banyatran O Pratirodh Samanway Mancha in 1998. The demands have elicited little response. People have become accustomed to living with the floods.

Of course, if they knew exactly when the waters would rise and how much, those who could find safer places would try to move out. But they do not have the means of knowing it; the authorities do. The knowledge does not reach those who need it the most. Talk about information technology!

Even as the state and central departments blame one another, they both hold two factors responsible for the floods: abnormally high rainfall and release of dam waters. Normal rainfall, however, is just an average. Preparedness presupposes that

one should take into account the upper and lower levels it had reached in the past, as well as climatic changes. In September 1978, 770 mm rainfall in 48 hours led to what was called the 'worst flood of the century'. No lesson was learned. In 2000, as a new century began, we realised that there could be something worse than the worst.

Dam management has cut a sorry figure. There was a long debate in Parliament on 5 March 2003 (during the NDA regime) on a motion brought by Left MP Sunil Khan calling attention "Regarding continuous erosion of banks of Ganga causing threat to hundreds of villages in Bengal".[2] The then minister of water resources, Arjun Charan Sethi, in his reply, tried hard to impress that there had been no dearth of Union government initiatives to tackle the problem.

The Ganga Flood Control Commission constituted by the Central Government in 1972 had prepared comprehensive plans for flood management for all the 23 river systems of Ganga basin of which West Bengal is also a part. These reports/plans have been forwarded to the State Government for implementation of the recommendations made therein.

In 1996, the Planning Commission had constituted as Expert Committee (namely Keskar Committee) which had suggested various short term as well as long term measures to be taken up by the State Government as well as Farakka Barrage Project Authority (FBPA). At the request of the Government of West Bengal, the Planning Commission had sanctioned, as a special case, additional funds of Rs 30 crore to he State under the State Plan funds to enable the State to take up top priority schemes during the financial year 1998-99. The Farakka Barrage Project authorities have also incurred an expenditure of Rs 10.4 crore on anti-erosion works both in upstream and downstream of Farakka Barrage.

He was also "glad to inform the House that the above scheme for providing Central assistance to the Ganga basin States for taking up critical anti-erosion works is also being continued during the Tenth Five-Year Plan for which an outlay of Rs 133 crore has been kept". Khan though, complained:

The Government of West Bengal is demanding Central assistance for the last 25 years to combat the situation. The Chief Minister of West Bengal wrote a number of letters to the Union Government. An All-Party delegation met the Government at New Delhi and the present Chief Minister personally apprised the hon. Prime Minister of India about the gravity of the situation. But everything went unheard.

Congress member Adhir Chowdhury, on his part, commented, that "the entire responsibility is to be borne out by the Central Government is simply a fallacy being churned out by the State Government out to hoodwink the erosion-affected people…".

There is indeed politics involved, but one should look beyond party politics. Irrigation engineers admit privately that after the monsoon, when the storage should be kept at the 'dead level', it is deliberately kept at the 'tide level'. This is done to satisfy the needs of the powerful rich farmer lobby for water-intensive *bodo* cultivation.

The September rains are uncertain. If they do not come, the stored water will save the irrigation engineers. If they come, the dam waters will exceed the flood level and have to be released. Otherwise the dam will burst. In this case, the dams and their managers are saved, the people in the flood zones are killed.

As it is, the dam beds are silted and so are the drainage canals. The Centre would rather release funds for relief after the floods than release adequate funds for dredging regularly. The state government is a willing player, as routine release of funds and dredging will not give it the publicity it gains bargaining for relief.

Erosion

In north Bengal, the problem is compounded by the release of waters to save the Farakka Barrage and alarming erosion along the Padma's banks. The Padma-Ganga Bhangan Pratirodh Samanway Mancha, a citizens' forum of Murshidabad, has been campaigning for a long time for a thorough review of the project. A similar demand came up from a public hearing conducted by the National Alliance for People's Movements in the Damodar Valley in south Bengal in April 2000.

The rivers eroding their banks, on the other hand, have been devastating people's homes, life and livelihood in a rapid pace. And it is creating a new category of internally displaced persons – the disaster refugees. While the number of such people is yet to be accurately estimated, a researcher writes in a volume on homelessness in India:

The erosion of the Ganges has continued unabated for the last three decades. Such areas as Shantipur, Ranaghat and Chakda have been the worst affected. Many large villages like Beharia, Boyra-Malipota, Pujalia, Brittir Char, Jaal Nagar under the Shantipur police station simply do not exist today. The entire 174 km stretch along the Ganges, from Bhutni in Malda to Jalangi in Murshidabad, has been facing erosion. In 2001 alone, about 2,500 families were rendered homeless in Malda. Two school buildings, with a student population of 500, are now under water. About 191.41 sq.km and 356 sq.km of land in the districts of Malda and Murshidabad respectively have been eroded between 1931 and 1999. The thickly populated downtown of Dhuliyan in Murshidabad is now under threat. The District Planning Board estimated the loss in April 2000, as six high schools, one police station, three banks, one panchayat (local government) office and at least 42 primary schools, all of which are now completely under water. The problem is that erosion does not always inundate the homes and residential places. But remaining at homes without the basic

conditions of life is as good as losing homes. In 1994, three-fourths of Jalangi town in Murshidabad district was submerged in the Ganges as a result of erosion. About 3,00,000 people of three blocks of Malda and eight blocks of Murshidabad faced the threat of being displaced. About 6,00,000 persons have been displaced in these two districts. Many have lost their cultivable lands. Moreover the number of times the same family has been displaced ranges from an average of four to 16 times. It means that the displayed families have nowhere to go but to move within the unsafe and threatened areas.[3]

The non-descript rural area of Panchanandapur of Malda district hit the headlines in 2003. The Union water resources minister, during the parliamentary debate mentioned earlier, said:

In connection with the erosion problem on the left bank of the Ganga on the upstream of [Farakka] barrage near Panchanandpur, the Central Water and Power Research Station, Pune had submitted a report based on the Satellite Imageries indicating development of a new channel on the right bank downstream of Rajmahal [hills in Bihar] which could develop in the coming years, thereby reducing the attack of the left bank. The above behaviour of the river is to be further studied by carrying out model studies through the CWPRS in association with the State Government.

Between 2.30 AM and 4 AM on 5 September that year, two villages and the plush bungalow of the state irrigation department, Ganga Bhavan, at Panchanandapur were swept away by the surging waters of the Ganga. Four other villages had seen the same fate earlier the same year because of erosion.

The submergence of the villages did not make big news. But destruction of the bungalow did. The media reacted the same manner as the administration. All senior officials from the irrigation department, police and district offices rushed to the spot. And so did reporters and photographers of all media houses. While the reports did mention that 125 families of the two villages along with 1,200 families of the four submerged earlier had no place to go,[4] there was hardly any follow-up on how they were living afterwards. A block development officer was quoted claiming, “Relief materials had been reached to all families of Gangabhavantola and Mandirtola as these villages had the risk of being eroded.”[5]

The claim came at the end of the long report. However, in the first paragraph, irrigation officials were quoted saying that the erosion was due to the sudden subsidence of the water level of the Ganga. The media did not question the discrepancies between the two official comments: If the erosion was “sudden”, why were relief materials sent to the villages beforehand and if it was forecast, why were the villagers not evacuated and rehabilitated, instead of being left to be submerged along with some “relief materials”?

The English newspapers seemed to be more concerned over the destruction of the Ganga Bhavan than devastation of the villages. A four-column report in a major English daily, for example, presented the news with a strap: 'Water moves 250 m in five hours, 450 families homeless'. The headline said: 'Ganga gobbles up Bhavan'.[6] There are two pictures, showing 'before' and 'after' views of the Bhavan. In the body of the report, however, there is no interview of a member of even one of the homeless families. A number of people associated with the bungalow – its 'errand boy', night guard and the irrigation department executive engineer – were quoted at length though. It does not fail to add this vivid description: "The Bhavan was a luxurious two-storeyed bungalow with elegant bedrooms, a specious dining hall, and a living room." The hundreds of people's homes (the figures vary widely – as much as 125 to 450!) that were lost did not have such features to mention.

If the media behaviour in reporting the destruction of the Ganga Bhavan vis-à-vis the two villages seems odd, a later reporting on the submergence of the entire Panchanandapur is outrageous. Activist-columnist Jaya Mitra comments:

There was a small news item in an inside page of 7 September's newspaper, 'Erosion is unabated. If its intensity does not decrease, Panchanandapur will cease to exist before the 15th.' The day when the news was printed, there was no existence of Panchanandapur on the banks of the Ganga in Malda. It is a strange magic reality – long after a person is dead, his medical report comes, 'The patient is critical.'[7]

Leafing through newspapers of earlier years, it becomes amply clear that the phenomenon of erosion could not have been sudden. It has been going on for a long time. The problem becomes acute in monsoon, as water pressure on the natural banks and human-made embankments increases. So, before each monsoon, the government takes a stance that it was dead serious to repulse the monster this time. The media seem to play along.

In April 2002, for example, state finance minister Asim Dasgupta was reported declaring that work on a Rs 24 crore project for checking erosion must take off within four days "without any excuses".[8] If one read that news item without much knowledge of the ground realities, one might expect that the problem would be solved soon.

As news items on erosion seldom inform the reader that it is an ongoing process, they also seldom enable the reader to comprehend how widespread the phenomenon is. It is seen as a local disaster. But, if one reads multiple newspapers, one can see that it is a common problem of the people living in almost all river banks of West Bengal. So degraded have these river banks become, that we find reports scattered in the media about erosions and human displacement in places that are far apart. For example, even as we were reading about the erosion in Malda and

Murshidabad, similar disasters were happening in Cooch Behar, North Dinajpur, North 24-Parganas and several other districts.

In Cooch Behar, the otherwise docile river Torsha had engulfed the homes of about 200 families in the Madhupur gram panchayat area. A newspaper report records the lament of Lutfar Rahman, a peasant in his sixties, in a song composed by him: "O River, you have taken all, except me."[9]

Two rivers, Nagar and Kulik, have played havoc in the Raiganj block of North Dinajpur. Here, 22 villages were reported to be facing submergence owing to erosion in May 2002. Already, more than 1,00,000 people had lost their homes. The famous Kulik Bird Sanctuary was also damaged. Every year 500-600 houses were going under water, said Raiganj panchayat samiti president Liakat Ali.[10]

In North 24-Parganas, a report from the Baduria block said in May 2002 that erosion of the banks of Ichhamati was leading to the submergence of hundreds of acres of land, turning once-solvent farmers into landless labourers. Ashamed to seek work in their vicinity, many were forced to migrate with their families.[11]

The previous year, it was reported from Howrah district that the century-old bazaar, Bakshir Hat, had lost much of its western portion because of erosion of the banks of Rupnarayan.[12] In Nadia district, three rivers were reported to be breaching their embankments over a stretch of about 300 km.[13] Mahboob Zahedi, former state minister and MP from Katwa, Burdwan district, expressed the fear in 2004 that erosion of the Ajay and Ganga banks might lead to the destruction of 600-year-old human habitations.[14] The ruling CPI(M)'s daily organ *Ganashakti* reported the erosion of the Hooghly banks at Burul, South 24-Parganas.[15] Even within the Kolkata municipal area, the Hooghly has gobbled up houses eroding its banks at Badartala in Ward No.141.[16]

Putting the media reports together, we find an unabated process of erosion-induced disaster, homelessness, landlessness, economic impoverishment and human displacement.

Floods

All the confusions in reports on erosion are found in the news items on floods, too. Let us see a couple of examples. A front-page report in a leading Bengali newspaper on 18 September 2004 is headlined: 'Chhara hochchhe jal, panch jelay banyar bhrukuti' (Water being released, floods frowns on five districts).[17] So, the reader supposes, flood is imminent. But this is being said when large areas are already under water! The picture above the item shows a woman and her children on a makeshift raft floating through a flooded village in search of a safe place. In the body of the

news, there are ample information to suggest that the floods are already there. West Bengal relief minister Hafiz Alam Sairani is qouted as saying that as many as 60,000 people in South Bengal had been affected. Yet, in the headline, the obvious difference between an impending and an ongoing disaster is overlooked. Headlines are extremely important in newspapers. Many readers, because of the paucity of time, cursory reading habits and various other factors, just glance through the pages and gather their impression of the happenings in the world around them mainly from the headlines. For this, words have to be chosen carefully by the desk persons or the editors to make the headlines as accurate and appropriate as possible. This caution seems to have been thrown to the winds while phrasing this front-page four-column headline on a calamity. Reading more than one newspaper, one expects to get more information or different angles on a particular news. But in the case of floods, it only increases the confusion. Let us see a report on the floods in an English daily published on the same day. The item[18] , in this case, appears not on the front page, but at the most important piece – left-hand top – of page 8, the 'Bengal' page. Most English newspapers nowadays push news that they believe would not interest their main target, the city reader, to the 'Bengal' or 'districts' pages much inside. Some, like *The Times of India*'s Kolkata edition, have even abolished this page, perhaps thinking it would be a waste of newsprint or spoil the 'urban' look of the paper. However, the news item in question seems to be headlined more appropriately as 'Fresh areas inundated'. This, at least, is an admission that flood is spreading, instead of giving an impression that it is yet to come. But, one is confused if one reads beyond the headlines of the two items. While the former gives the 'affected' figure as 60,000 for entire South Bengal', the latter puts it at five times higher, 3,00,000, for the North 24-Parganas district alone! Reading the one-column 'turn' on page 7 after the four-column page-one news in the Bengali daily, one would come to know that more people are indeed affected – at least 2,00,000 in Bagda block of the North 24-Parganas alone and 2,56,000 in Nadia district. These information are given by district officials, and hence come much behind the minister's comment, even though the figures are significantly higher. Neither of the reports carry quotes from the affected people. Official comments are supposed to be sufficient for presenting the picture. We do not know the feelings of those bearing the brunt of the calamity. We do not know about the struggle of the women like the mother on the raft with her children in the picture. Like erosion, the extent of the floods is also not clear. Reading the newspapers in mid-September, it would seem that it is happening in South Bengal. One would not have a clue that floods had started in North Bengal much earlier and large parts of the region were still marooned. As early as 9 July, 2004 a Press Trust of India despatch said, "A child was washed away at Khaprail in Siliguri sub-division as most of the rivers in North Bengal were in spate on Friday following torrential rains in past three days." Every time there is a flood anywhere, the media repeat the same story. The answer to "Why did the disaster happen?" is constant. "torrential" or "incessant" rains, followed by the discharge of water from the dams. In the examples we were discussing above, both the Bengali and the English newspaper mentioned the same cause, quoting officials. Reading this year after, it would seem as if the release of water is also a "natural" phenomenon like the rain. Why should such an

action be taken every year if it is known to invite disaster and if it cannot be avoided, why can't there be at least a sane alert and evacuation system? These questions are seldom raised.

Compare this with the intro of the report on the 2004 floods in a small newspaper published from Murshidabad:

Flood comes like destiny in Kandi sub-division every year. When monsoon comes or a deep depression forms, the waters engulf wide areas of Kandi. Every year, we have to write the same report. There is no respite from this.[19]

People's Voice

Any mindful reader may recollect that in the event of an inundation, how less frequent are quotes of the affected people than those from the officials. The poor, who are always the worst hit, are heard less. And women, who constitute at least half of the suffering people and suffer the most, are the least quoted. If they are, it is because they lament more loudly. This trend of reporting is visible even in the Leftist daily, *Ganashakti*.

Seeing the photographs of erosion every day, local resident Renu Dasi only cries beating her chest. She cannot think of a place where she can take shelter. She implores anyone who goes to see erosion: 'Save me, Babu.'[20]

In September 2004, a 64-year-old woman died in the same block. The newspapers reported that she and her family had been living in a relief camp after her home was submerged by the Ichhamati. With an ailing husband, two daughters and a son, she had been the bread-earner of the family. But, she could not earn anything for the last two weeks. The camp dwellers staged a demonstration, alleging that she had died because of starvation.[21]

Such instances of the media focusing on a disaster-affected woman who, after all the calamity, was still struggling to feed her family, are rare. Unless something extreme happens like the death of this woman and the resulting demonstration. Though in occasional columns such as the one by Chakraborty cited above do we hear the voices of women and children, in the news reports one hardly finds them. Economic concerns of the marooned people, whenever reflected in the media, are mostly expressed through male voices, in spite of the fact that women are no less worried about making the ends meet in the difficult situation. Thus, in an area under waist-deep water for more than a fortnight, if a reporter sees "many people living on makeshift platforms erected on tree-tops. Women are rolling *bidis* sitting on the platforms,"[22] the striking image of the women carrying out their usual economic activity in the midst of deluge remains no more than a passing mention in the report.

The attitude of the media towards the people who are at the receiving end is, at best, 'sympathy' for the 'victims'. The 'victims', when they do find their voice in the reports, can only lament or look passively. An illustration:

Resigned residents of Bazarpara and Misirpara stared helplessly on Sunday morning as the Ganga gouged out chunks of earth as it crept closer to the Pagla, each strike bringing a cluster of about 20 villages closer to doom."[23]

The people, in reality, are not so passive though. As river expert and activist Kalyan Rudra writes:

The formation of deltas and changing course of the river are all facts, but these hundreds of thousands of people are not ready to accept the convoluted logic of science-technology-development and contractor-bureaucrat-leaders as an unavoidable truth of disaster…. [In Malda] they have formed the 'Ganga Bhangan Pratirodh Action Committee', a citizens' forum free from party-dependent politics…. Apart from this, a 'Sara Bangla Khara-Banya-Bhangan Pratirodh Committee has been formed. This organisation, too, wants prevention of erosion and rehabilitation of the affected people."[24]

Such actions by the people at the grass-roots level are often not noticed by the media. More visible are the occasional murmuring by the parliamentary political parties, especially if elections are round the corner. Thus, when 2,000 school students from the erosion-hit Chechania and Hogolberia areas of Nadia district send post-cards to the then Prime Minister Atal Behari Vajpayee appealing, "Respected Prime Minister, please save our villages and our schools," it finds a mention in the newspapers only through the columns of human rights activist Tapas Chakraborty.[25] But, before the panchayat elections, we hear chief minister Buddhadeb Bhattacharjee giving a call to "build up massive protests at every level from the state" to force the Centre to solve the erosion problem.[26] Soon, the ruling Left Front officially recognises that 40,000 people have become "refugees" because of erosion of the Ganga banks and organises a march by them to Kolkata from Malda.[27] Left Front MPs themselves march to Parliament with the demand of checking erosion.[28] These reports also remind us that the Opposition Congress has already been vocal over the issue.

The voice of the people is heard only if it becomes loud enough. Their action is noticed only if they do something 'drastic'. Like they did during the visit of state finance minister Asim Dasgupta and defence minister Pranab Mukherjee to the flood-ravaged Murshidabad, Malda and Burdwan districts. On the eve of the visit, Jagatpati Saha, a farmer, committed suicide in Murshidabad seeing his crop go under water before harvest. This angered the people, who gheraoed Dasgupta. The residents demanded maintenance of embankments. "The contract for embankment

maintenance goes to the local mafia, which neglects the work," they told Dasgupta.[29]

Mukherjee took no chance and made an aerial survey of the affected areas. Commenting that relief materials were not being distributed properly, he offered more Central assistance. Interestingly, while the Left Front in numerous other occasions has alleged that the Centre was not generous in its disaster-relief aid to West Bengal, this time Dasgupta refused. That, he perhaps he feared, would be an admission of the state government's drawbacks.

Another flood-affected youth committed suicide in Bangaon block of North 24-Parganas district the same month. He reportedly took the step after being humiliated by some panchayat officials when the homeless man approached them for a tent.[30]

Bizarre events always make big news. It is true in the case of flood and erosion, too. If desperate people take a desperate step, the media do not hesitate to play it up. In July 2004, a youth in Malda had a "dream" that the river Phulahar was demanding a human sacrifice to stop ravaging its banks. He hacked an 80-year-old neighbour and offered his blood to the river. The news was made a seven-column flier in Kolkata's largest Bengali daily.[31] The report informed that Phulahar had engulfed five villages in the area the previous year and 80 per cent of four more in the current year, displacing about 1,500 families. Once well-to-do peasants had become beggars now. However, it forgot to mention that the state's leftist housing minister, during his visit to the area exactly two years back, had advised the residents to sacrifice a goat to please Phulahar. The item had appeared in the same newspaper.[32]

When the people get too much agitated, it becomes a 'law-and-order problem'. In a recent paper[33] analysing the role of English newspapers during the floods in Bihar, a researcher writes: "A region is submerged in an annual ritual of flooding and that becomes an occasion for the media to celebrate the absence of the state." He argues that there is a market interest of the media in doing so. The majority of the English newspapers in Patna have land or family in the waterlogged countryside. These members of the educated middle class "elite" resent their present lack of "hegemony" over the state in Bihar and feel good when the media "taunts the state for its inaction". However, such a motivation to "expose" the state, even if it is true for Bihar, is too narrow to be generalised. On the contrary, it is usual for the big media to reflect the interests of the state in case of a conflict with the poor marooned people.

A Reuters despatch catch-lined 'Mobs attack police, troops in flood-hit India from Calcutta on 25 September 2005 said:

Hungry mobs in marooned villages attacked relief teams and troops on boats in flood-hit eastern India on Monday, where monsoon flooding has left at least 208 people dead and 165 missing.

"People were fighting with each other and attacking our men to make sure they got a place in the rescue boats," a senior army official told Reuters. The boats can carry 25 people at a time, while hundreds are stranded on rooftops and in trees. A railway spokesman said several trains carrying relief material for flood victims had been looted.

Police fired shots in the air to disperse an angry mob in Nadia, 150 km (95 miles) north of Calcutta, which had clashed with other police carrying food for flood victims. In the worst-hit district of Murshidabad, 100 km (60 miles) further north, air force helicopters dropped food packets for marooned villagers, officials said. Relief officials are scheduled to meet later on Monday to discuss the situation. In West Bengal, as many as 800,000 houses have been washed over by flood waters causing about three billion rupees ($65 million) of damage, a government official said on Sunday. The flooding, triggered by heavy annual monsoon rains, took a dramatic turn for the worse last week when the sluice gates of three major rivers were opened to prevent dams from bursting.

Nowhere in this report, filed by a reputed international news agency, do the members of the faceless 'mob' – who in this case are the hapless disaster-struck villagers – have anything to say. It is sufficient for the readers to know the 'official' version. And going by that, one may conclude that the people had an intrinsic tendency to turn violent, which they could not suppress even at the moment of crisis, while the administration was making its best efforts to help them.

The most brutal assault of the state forces on the disaster-hit people in recent times took place at Akheriganj, Murshidabad, in July 2000. Thousands of people staged a sit-in on the boulders at the banks of the Padma, responding to the call of Banya O Bhangan Pratirodh Committee. They demanded work in the dry season and stopping of boulder-laying in the monsoon, which resulted in millions of rupees going into the water every year. After a round of talks with the district officials failed, police and rapid action force beat them, threw their meagre belongings into the river, and fired on them killing one person and injuring scores of others including pregnant women and aged persons.

This incident was reported by the mainstream media.[34] However, it was left up to the local small newspapers of the district to follow up what happened afterwards. And their reports, which were obviously not available to the readers in other parts of the state, exposed a more gruesome scenario. The police brutalities did not stop at the firing. So angry had the administration become at the protests by the disaster affected people, that they were to be taught a real good lesson. Many among the 65 people arrested were tortured at the police station later to extract revenge.[35]

Expectations From Media

The above discussion enables us to critique media role in disaster reporting in West Bengal in the following respects:

- Items on floods and erosion fail to answer the five classical questions that a news report is supposed to answer. These are: Who, What, When, Where, Why and How, or as they say in journalism schools – the Five Ws and an H. Who is suffering (man, woman, or minister)? Who is responsible for their suffering (nature, planner or dam contractor)? What is happening (flood, erosion, both)? When is it happening (this year or every year)? Where is it happening (in one district, or everywhere)? Why is it happening (excess rains or myopic preparedness)? How to tackle this problem (temporarily relief or long-term solution)?

- Having failed to answer these questions or providing faulty and confusing answers, the media have failed to perform its three most important functions — inform, educate and influence – as far as disaster-reporting is concerned. Neither do people in the affected areas get authentic information or forewarning from the media, nor do readers in other areas get effective education about the matter, not to speak of the policy makers being influenced by media reports in this regards (it is rather the media repeating the official briefings in most of the cases).

What are the possible ways to change the scenario? Studies on disaster reporting in India are difficult to come across. Even if one finds such a study, one encounters the problem of lack of understanding of the internal media processes as well as of the media-reader interface by the scholars.

In a scholarly volume on disaster mitigation, D.R. Sikka makes some observations and suggestions regarding mutual co-operation between the weather and climate experts and media.[36] Though most of his suggestions concern the radio and TV, there are important points regarding the print medium also.

The regional and national newspapers could solicit special articles before the impending advent of the adverse weather season with advice on steps needed to minimize the impact of adverse weather in the event of its striking the area. There is a rich talent in the country who could be encouraged to contribute such articles. National newspapers could place consultants on their staff on weather and climate-related issues who could then be contacted when found appropriate.

In the hours and days before a big storm is expected to hit an area, the weather report can become a front-page story for the newspapers….

Apart from this, there are suggestions for the Met office to "make increasing efforts do develop good media relations", providing immediate responses and authentic information to media inquiries on weather, preparing special information kits for the media before the beginning of each season, etc.

While all these steps are necessary, these cannot change the attitude of the media towards natural disasters. The issue has to be looked at from the point of view of the human beings who suffer – women, men and children. Their voices are to be transmitted by the media to their fellow human beings – the readers elsewhere who may not be suffering at the moment – as well as the powers that be who have the resources at their disposal to prevent or at least mitigate such sufferings. Otherwise, any extent of "expert" or "specialist" contribution would make media reports authentic weather bulletins, but not people's friends in need. Moreover, it is the regular news items which most of the readers notice and draw their conclusions from, special articles are less read, less understood and less relied upon. So, it is the reporters who gather news at the grass-roots and the sub-editors who process the news, give headlines and lay them out on the pages need to be sensitised much more on the gender and human rights aspects of the disaster reports.

This is not an easy task. More so, when the internal composition of the media staff is changing rapidly in terms of social background and orientation. Uttam Sengupta, a senior working journalist, observes:

A devastating flood manages to draw media attention only when the flood waters inundate parts of the urban landscape and is usually described as "worst-ever" when stocks of grain stored by the rich and middle peasantry get washed away.[37]

If that is so, it is not only because the urban middle class or the rural rich are closer to the power elite and their sobs are more audible than the wails of the poor. While their social position has always been so, the have-nots have never been so invisible to the media. There are more complex factors at play. Advertising and market have almost completely displaced all other motive forces for the media. And the journalists of today are recruited and re-oriented to suit this situation. This phenomenon itself merits a full-fledged study and cannot be discussed in detail within the scope of this paper. But one point needs to be emphasised: Intensive interaction with social activists and social movements, rather than exercises with scholars and experts, can break this barrier.

Notes

1. *Banyar Chalchitra: Samasya O Pratirodh*, Banyatran O Pratirodh Samanway Mancha, Calcutta, 1999

2. http://www.palrupchand.com/debates3.htm

3. India: Homelessness at Home by Samir Kumar Das, in Paula Banerjee and others, ed., Internal Displacement in South Asia, New Delhi, Sage Publications, 2005

4. *Ananda Bazar Patrika* (ABP), Kolkata, 6.9.03
5. *Ibid*
6. *The Telegraph* (TT), Kolkata, 6.9.03
7. *ABP*, 28.9.04
8. *ABP*, 10.4.02
9. *ABP*, 14.6.04
10. *Sambad Pratidin*, 23.7.02
11. *Bartaman*, 12.5.02
12. *ABP*, 2.7.01
13. *Gram Gramantar*, Krishnagar, 11.11.03
14. *Kalam*, Kolkata, 26.6.04
15. *Ganashakt*i, Kolkata, 19.12.02
16. *The Statesman*, Kolkata, 25.10.03
17. *ABP*, 18.9.04
18. *The Statesman*, 18.9.04
19. *Murshidabad Beekshan*, Berhampore, 20.10.04
20. *Ganashakti*, cited above
21. *Bartaman*, 26.9.04 & *ABP*, 26.9.04
22. *ABP*, 26.9.04
23. *TT*, 31.8.04
24. *Jana Muktikami*, December 2003
25. *Aajkal*, Kolkata, 17.11.99
26. *ABP*, 20.1.03
27. *ABP*, 14.2.03
28. *ABP*, 3.3.03
29. *TT*, 11.10.04
30. *ABP*, 9.10.04
31. *ABP*, 25.7.04
32. *ABP*, 19.7.02
33. The 'State' revealed in newspaper headlines by Rahul Ramagundam, *Economic and Political Weekly*, Mumbai, January 8, 2005
34. *ABP*, 19.7.2000
35. *Rangdhanu*, Berhampore, 30.8.2000
36. 'Role of Media in Disaster Preparedness' by D.R. Sikka in Pardeep Sahni and others, ed., *Disaster Mitigation: Experiences and Reflections*, New Delhi, Prentice Hall of India, 2001
37. *TT*, 10.8.04

How Newspapers Report on Gender and Public Health

Dulali Nag

The fundamental human rights as declared by the United Nations sit uneasily with the historical and cultural multiplicity that actually exists in today's world. The sphere of human rights is always a sphere of contention where historically specific cultural norms and social institutions come into conflict with the universalistic norms of a presumed society that guarantees equal access to the fundamental human rights for all its members.

One such area of conflict is the differential access of the genders to the rights declared by the UN. The very idea of universal humanity irrespective of sex defies the ground reality of gender differences. Yet, any historical world is structured upon gender difference in some form. Therefore, attempts to ensure the functionality of these rights – such as the right to work, right to health, right to education, right to freedom of speech and so forth – equally for all members of a society most often run into the obstacles of social and cultural norms and institutions. The very notion of human rights thus becomes an issue of contention among different social groups.

Within the very limited space of this paper, I would examine how a section of the print media in India covers the issue of health, which is one of the fundamental human rights. Gender differential as it manifests in the social distribution of health care and facilities will be the primary focus of the inquiry. I would be looking at how and to what extent this section of the print media covers women's condition in the public health care system in this country.

The Media and Civil Society

An active civil society is the first precondition for a healthy democracy. The media plays, or should play, an indispensable role in making a vibrant civil society possible by disseminating information that brings to light the lack of access to fundamental human rights among particular groups in the society. The question is, to what extent does the media perform this function? That is where auditing the performance of the media becomes important in keeping a democratic culture of politics alive.

I have chosen one English, *The Telegraph*, and one Bengali newspaper, *Ananda Bazar Patrika*, for the purpose of this essay. Both the papers are published from Calcutta, though recently *The Telegraph* has started bringing out editions from other major cities of India keeping in mind the local political situation and interests. For my study, however, I shall be focusing only on the edition that comes out of Calcutta.

A comparative study of an English and a vernacular newspaper should shed some light upon the difference between the construction of "news" for a comparatively regionally focused vernacular readership and a pan-Indian and globally affiliated English language readership. The attentive reader though should take the qualification "comparatively" above into serious consideration: the difference in linguistic affiliation between the two groups is not absolute. There is a sizeable percentage of bilingual readership familiar with and interested in both the pan-Indian/global and the regional/local. Such readers, however, mostly divide their interest between the English language and the vernacular newspapers according to topic. For the bilingual reader, normally the two linguistic domains constitute different spheres of their social life. While they turn to the English language papers mostly for national, political and international news and commentaries, to be well informed in matters cultural and social they turn to some vernacular newspaper of their choice.

We have to keep in mind therefore that since linguistic functionality plays a major role in determining the sphere of interest for a reader, the newspaper editors keep this in mind while deciding the style and content of their news. The point is important because this directs our attention to the dialectical relation between civil society and the media: each influences and is influenced by the other. We must keep in mind that a newspaper, apart from being a supposed disseminator of accurate information to the civil society, is also a commodity that has to pitch itself to its targeted social group of customers.

But this need not be taken as a chicken-and-egg situation where one does not know where to begin. While the media and the civil society cannot be methodologically delineated as cause and effect respectively, the issue of media-responsibility *can* be formulated in the space between "events" and their "representation", what in common language we identify variously as "bias" or "untruth" or "slant". The formulation, though not simple, can still provide us with a legitimate ground for critique.

Media, Responsibility and Truth

This idea of a "legitimate ground for critique" needs a little elaboration for that is what will provide us with a yardstick for measuring the degree to which a newspaper fulfills its responsibility toward the civil society.

One area of contention in defining legitimacy of critique is the confusion about the difference between "truth" and "facts". Commonly we oppose *truth* to *lies*; but it is possible to veer away from truth by riding on *facts*. The courtroom declaration demanded of witnesses that they provide "the truth, the whole truth and nothing but the truth" is one of the most illuminating examples of how facts are allowed to masquerade as truth. Most often in the court of law what passes for the

verity of a statement is actually the facticity of it constructed around the idea of "evidence", and a case gets built around what is understood as the "facts of the case". Consider a rape case: whether the accusation is true may often goes beyond the mere fact of a physical penetration to the understanding of and the expectations from the situation on the part of the involved parties. Most often it is the woman's understanding and expectation that get ruled out of court as "unverifiable" as their facticity cannot be determined in a way that the legal tradition of "evidence" demands. Similarly, reports carried in newspapers often provide us with the "bare facts" of an event claiming that they should "speak for themselves". Yet, it is in the *choice* and the textual and pictorial *arrangement* of these "bare facts" that we are often told a story that – unless the reader happens to be unusually alert with a critical bent of mind – can make the facts speak for someone other than themselves.

The first point leads us to the second, and even more complicated, question of the idea of truth upon which we are trying to find our critique. Clearly this is not a concept that can be nailed down very precisely. It is not on my agenda to do that either. So far I have been using the idea of "truth" to create an entry into the problematic area of *representation* and the *organisation of facts*. The problem can be defined thus: is it possible to rank different representations according to their degree of truthfulness? It is a problem because we do not have any universally accepted definition of the truth of a situation. It will vary depending on the perspective of the person making the representation. If we grant that, what can be our ground for ranking representations according to their truthfulness?

But once we give in to such absolute relativism, we will have no space left for any critical engagement with *any* representation. If everyone's, or at least every social group's, truth is accepted as *different* in an absolute sense, then any critical engagement with that "truth" is ruled out, thus erasing the difference between truth and orthodoxy to usher in the reign of absolute power. As long as one has any commitment to contest absolute power, one has to continually make efforts to see beyond the immediately accessible "truth".

To avoid the impasse of absolute relativism, we have to shift our base from *truth* to an *objectivity grounded in a perspective*. This way we do not stay mired in the age-old objective/subjective dichotomy and are enabled to construct a critical space where we can continually strive to go beyond the limitations of a perspectival subjectivity to reach for a degree of objectivity.

A view-from-nowhere as a representational ideal is ruled out in this position. We take it for granted that a perspective – a view-from-somewhere – is an integral part of any representation.

An idea called "peace journalism"[1] found ground among some journalists during the Iraq war as a means of ethically and professionally engaging with an event they politically opposed. For journalists who subscribed to this position, the political-

ethical problem they faced was that by providing coverage – and very major coverage at that – to war violence and violence-promoting activities of politicians and others, they were being a party to inciting more hatred and violence in society at large. In order to be true to their political-ethical position of anti-violence they argued that they would take initiative in seeking out efforts at peace being made in society at any and all levels, regardless of their actual success at promoting peace. At least equal coverage being given to these efforts should make more readers reflect on the possible means towards peace and may even inspire them to take an active role in the process. Journalistic objectivity in the traditional sense for these professionals betrays their political-ethical responsibility as members of the civil society.

This is where we encounter the conflict of interest between one's responsibilities to the civil society and to one's profession in an organised sector. No doubt the media is accountable to the civil society, but its members are also internally accountable to a professional code of order that holds together the foundation of the entire sector.

I want to argue that this perceived conflict is the result of a theoretical blindness of not perceiving the *totality of the social universe* in which these different perspectives reside. Once this fact is acknowledged, the possibility of seeing beyond the immediate truth born of one's socially circumscribed perspective becomes conceivable. Julian Baggini provides us with a very apt example to illustrate this point: "[T]he physics of light wavelengths and reflection is much more objective than our perception of colour, because it is a mode of understanding that transcends our particular viewpoint. A blind person can, for example, understand the physics of light as well as a sighted person".[2] In this example, Baggini brings into the focus of our imagination the entire physical universe that goes into creating all the different perceptions/truths of colour which makes possible an objective understanding of the unique physical process that produces all the differently experienced "truths" about colours.

Since I cannot argue this point any better than Baggini, I shall quote him again. "Objectivity, then, is a *matter of degree* and is about minimizing the extent to which our beliefs and accounts depend upon our particular localized and subjective viewpoints. So while it is true that there is no *pure objectivity*, one can always try to get a *more objective* viewpoint".[3] [Emphases mine]

The relativist's claim thus rests upon a privileging of *experience* or the *meaning* of experience as circumscribed by the immediate social and cultural structures and values at the expense of the *process* through which it is made. An attention to the process opens the way to see beyond the circumscribed truth to glimpse many other truths, equally processed, and be in a position to make a comparative study of these processes. Objectivity grounded in perspective can therefore be defined as being able to detach oneself from the immediacy of a perspectival truth, understand the process of its construction and be empowered to

make an ethical judgment about the social value of a perspective that one began from. Defined thus, the idea of objectivity allows us a critical space beyond the constraint of socio-cultural immediacy.

To come back now to my starting point – that of the question of the responsibility of the media to strive to be objective and truthful in the sense of "minimising the extent to which our beliefs and accounts depend upon our particular localised and subjective viewpoints" – conflating the media and the civil society to the point where the media only represents localised and subjective viewpoints of specific civil societies would be fallacious. The responsibility of the media is to open up a critical space for debate over an issue regardless of whichever civil society they identify with or target as their readership. This is the minimum requirement for a democratic political culture to flourish. A committed peace journalist would be short-changing her responsibility to her chosen civil society should she confine herself to reporting peace-activism in its narrow sense without exploring its context and its various dimensions. Should she not do so, she might be surprised to discover that some of the peace activists are potentially as oppressive in support of their position as the people engaged in the war. With such a discovery, she can open up a space of critical debate on the best means towards peace rather than unreflectively reporting peace activism as one truth among many equal truths during the time of a war.

Media, Public Health, Gender

We are now in a position to focus our attention on our purpose at hand, that of a critical study of media reporting on public health with special attention to gender.

To recount the parameters of the study: I have taken two Calcutta-based newspapers, one English – *The Telegraph* – and the other Bengali – *Ananda Bazar* – to critically review their reporting on gender and public health spanning two years starting from July 2002 up to the August of 2004. I have scanned these two papers over the specified period for their reporting on public health and women. Given that the right to health is one of the fundamental human rights, my review will critically examine the newspapers' performance in informing the public of women's access to this fundamental right in the public health care system. Given that both the newspapers are considered national papers, the study will examine the papers' performance from that angle.

Our above discussion about the media's responsibility to provide objective report is particularly relevant in this case. As I have argued, objectivity of an account should be evaluated in terms of the degree to which it is able to illuminate the social-political processes that go into producing an event. While there might be many versions of the same event each claiming its own truthfulness, we would judge a newspaper report on how far it has been able to adjudicate among those various truths to provide us with a comparatively objective account.

Scanning Result

'Public health' is defined by the Institute for International Medical Education as:

Organized efforts of society to protect, promote, and restore people's health. It is the combination of science, skills, and beliefs that is directed to the maintenance and improvement of the health of all the people through collective or social actions. The programs, services and institutions involved emphasize the prevention of disease and the health needs of the population as a whole. Public health activities change with variations in technology and social values but the goals remain the same: to reduce the amount of disease, premature death, and disease-produced discomfort and disability in the population. Public health is thus a social institution, a discipline, and a practice.

Following the above definition, I was immediately struck by the complete absence of the coverage of women in the public health sphere in the newspaper reports. This is true for the English as well as the Bengali language newspaper. Given this observation, the question I want to ask and then try to answer is: what is it in the structural and narrative logic of the production of news reports that permits such exclusion?

Let me try here to summarise the major public health stories carried by *The Telegraph* in the chosen period. This should then lead us to look at the construction of particular stories to critically explore the narrative and structural strategies of the papers.

The Telegraph

Two or three major news that were covered quite extensively in the paper over this period are: the ramshackle condition of the public hospitals in the state of West Bengal and the abnormally high number of death due to negligence in them; the national debate on the pesticide content of cold drinks; the SARS (Severe Acute Respiratory Syndrome) epidemic and its impact on India; events of doctors being taken to court on the ground of criminal negligence. Apart from these major stories, there are more or less regular reports on outbreak of mysterious killer diseases in various remote rural parts of the country, the supposed progress of e-technology in the public health care system, various policies enacted or implemented in the public health care system, and some occasional articles on public health issues.

None of these stories focuses on the gender-difference question in the organisation and distribution of the health care system, let alone provide affected women a voice through the reporting. It is a fact that none of these events lends itself easily to a gender-conscious treatment, and therefore can be used as exculpatory evidence by the people involved in producing these reports at various levels of the news organisations. Our question, however, goes deeper than that: *Why* and *how* is it

that the media gives priority/prominence to those national and local events that are gender-neutral on the surface? Are all these events *truly* gender-neutral? *What* are some of the important gender-specific public health issues that *should* have been, but are not covered by the media?

I will break up my analysis into three sections to answer the above questions. Special attention needs to be paid to the foundational assumptions of the narratives of the news reports. The three sections will be:

- The *categories* under which a newspaper organises its reports
- The *sources* from which the information are collected
- How the information are organised in the form of a *narrative*

This break-up is informed by the understanding that newspaper reporting is a discourse structured by a number of factors. My representation, no different from any other, has to grapple with choosing some facts from a multitude of facts while at the same time staying committed to objectivity grounded in perspective. The perspective I have adopted is a gendered one. Yet I do not want that to so completely colour my choice of facts that I am blinded to the entirety of the production of news reports. A theoretical understanding of the structuring of news helps by guiding the choice of facts from a position that is autonomous of the chosen perspective.

The categories normally used to slot the reports tend to break the connectivity between the news. For example, the category "International" may feature under it the news of an international conference on the global status of HIV/AIDS along with some statistics on India. But this is not linked with the local news which gets published under "Region" as state health policy that seeks to combat a rising trend of tuberculosis among women especially in the red-light districts. What gets left out is that HIV/AIDS increases the vulnerability of the infected people to opportunistic infections among which tuberculosis is the most prevalent. The sources of news reports too have to be understood as discursive systems of storing data. Thus hospital records may be organised according to the name of the diseases and according to sex, but may not offer any cross-referencing that may reveal which diseases are more prevalent among women and which among men. Lastly, the narrative structuring a report is extremely important in understanding why certain connections are highlighted in a piece of news and certain others disregarded. The narrative provides the *angle* for the story, without which a report cannot attract attention of its reader.

Categories

News reports in *The Telegraph* are categorised in political-spatial terms. After the front page which houses all news across categories that are regarded the most

important of the day, the rest of the newspaper is divided into foreign/international, national, edit page, Bengal, regional, leisure reading which once a week carries a "fitness" article and a column by a professional fitness expert answering readers' questions. Along with this core part of the paper, it carries a daily supplement, The Telegraph Metro, that focuses primarily on news and articles on the metropolis Calcutta, and a weekly supplement called KnowHow, which carries articles on new scientific – of which medical is one – discoveries and debates in India and elsewhere.

Any event, therefore, is classified according to the part of the country/world where it is taking place. It follows therefore that the definition of an "event" is spatially circumscribed. Thus, an outbreak of an epidemic in rural Tripura is classified under "regional", even though the virus may have traveled there with migrant labourers from Bangladesh and thus could equally be classified under "international". This circumscription of a public happening is what then goes into the formation of the narrative too.

Let me illustrate my point with a few examples from my scanning.

On September 3, 2003, a news of death due to hunger appeared on the "nation" page. The place where the actual deaths took place was the district of Bhagalpur in the state of Bihar. The news therefore was slotted under "nation" in this edition of *The Telegraph* which comes out of Calcutta. Patna, the capital of Bihar, does not fall within the scope of my scan, so I do not know if that edition carried the news on the front page. So I shall keep my comments confined to the Calcutta edition.

This is quite clearly a health issue. Whether they died literally of starvation or of malnutrition and under-nutrition induced diseases, these people clearly did not enjoy the fundamental human right to health.

On 16 July 2003 we find another news of death carried in the page on "Bengal". The headline to this news runs "Child Death Scare Returns" to report that in the district of Burdwan in West Bengal, six children have died in two days at a village about 180 km from Calcutta. In this case, there is no debate about the cause of death. It is a water-borne disease. The doctors of the area are suspecting typhoid. They are, however, withholding their diagnosis until the pathological reports arrive.

On 6 August 2002 the page "region" carried a small news where the heading read "Assam Flood Scenario Improves". The short write-up said: "After malaria, encephalitis has turned out to be a killer disease with 100 persons already dead in flood-ravaged Assam. Authorities say 40% of the deaths have occurred among children aged between one and twelve years." We do not get to know anything more about how the health care system is trying to handle the situation.

These three examples clearly indicate the spatial framing of an event. The silk-weavers who died lived in Bhagalpur, Bihar. The event of their death has been

framed as a problem of administration in Bihar and hence, from the point of view of a Calcutta edition, it falls under "national" news. Yet, the death of some children in Burdwan, a district in the state of West Bengal, does not qualify as "national" news. It is placed under "Bengal". A semantic distinction between the Nation and Bengal is at play here – even though "Bengal" is as much a part of the "Nation" as Bihar is – a distinction that has a long political history of its own.

Even more curious is the spatial category of a "region". My example shows that the news of a serious natural calamity in the state of Assam in the north-eastern part of India and the spread of epidemics in its wake has been slotted under "region". My scanning has revealed that *only* news from the north-eastern states of India – albeit events that do not have any impact on the rest of the nation – is classified under "region". While the news of starvation death of tribals in the state of Rajasthan appears under "nation", the news of striking work by doctors in a government hospital in the state of Tripura in the north-east is placed under "region". The long political history of marginalisation of the north-eastern parts of the country under the nation-state of India is clearly reflected here.

These categories therefore also foreclose any presentation of events in terms of gender difference. Of the names of the three dead silk-weavers, one is of a woman. Is this ratio, 2:1, accidental or does it have a larger social implication? But the news has been framed as "three deaths in Bhagalpur", thus making "dead" the qualifier of the three names that are clubbed together irrespective of their sexual difference. Were this news to be framed in terms of gender, we would have known something about the structure of the weaver community, the control and power wielded by the two genders within the family and within the community, the role played by the genders in the process of weaving, whether the decline of the industry has affected the genders equally and so forth.

Source

Let us turn again to our very first news story, the starvation deaths of silk weavers in Bhagalpur. The very first line of the report reads "[T]hree alleged hunger deaths *have been reported* from Bhagalpur, forcing the Rabri Devi government on the defensive" (emphasis mine).

It is to be noted that the source has not been named at all. One can understand the ethical problems in exposing one's source if one is reporting on something that concerns state-security or is politically highly sensitive. But this event seems to be already quite public given that even the district magistrate has issued a statement to the effect that the victims appear to have died of disease and not hunger. However, he has ordered a probe into the matter.

The reason for not mentioning the source in this case must therefore be that the authenticity of the source is not very important. What is important is that the

news has forced "the Rabri Devi government on the defensive". It is therefore not the absolute fact of the death but the timing of it that is being exploited here.

Some sort of a source, however, is mentioned in connection with the administration's reactions. The "Sultanganj panchayat" is quoted saying that the district administration has ordered a probe into the deaths. The district magistrate is reported to have said, "the victims appear to have died of disease, not hunger. But a probe would help get a full picture."

The reader is therefore prodded towards thinking about the politics that is unfolding around the issue of these deaths rather than the actual circumstances that led to the deaths.

We are then told that the "villagers said" Rabbani, one of the dead, contracted tuberculosis. The others were suffering from anaemia and low blood pressure. It is instructive to note that "villagers" are serving the purpose here of that of a medical source. Since it is likely that the three died without any medical attention, such medical descriptions of their affliction coming from "villagers" indeed arouses our curiosity.

The report ends with a quotation from one Jubeda Khatun saying, "We once contributed to the growth of Bhagalpur silk industry. Now most people in the villages have no work. So people are starving, falling sick and inching towards death." We are told that she told this to a "team of politicians who visited the village". She is the only woman whose voice we hear directly, but we are not told anything further about her. Her name and her voice are used as a symbolic representation of a disembodied "Bhagalpur silk weaver", with scant attention to her gender or her specific circumstances.

This brief report is exemplary of how source can be used to orient a narrative. The news, at its core, is neither about deaths of silk-weavers nor about the causes of the decline of the silk-industry in Bhagalpur; it is about a particular state government having to go on the defensive as a result of the deaths. That is why the report does not even venture to tell us how long this economic decline of the weavers' community has been in progress and if other weavers have died before of starvation/disease or if these were the first deaths caused by poverty and lack of adequate food. That is why the report opens with the deaths "having been" reported at a particular point of time, without giving us any information about how this reporting came about. It is only after suddenly drawing the curtains to dramatically reveal three deaths that the report goes on to cite a specific source, the Sultanganj panchayat and the district magistrate of Bhagalpur, to direct the story towards a debate about the possible cause of death. Because only establishment of the cause of the deaths would determine the process of pinning the political responsibility.

The sources chosen therefore determine how the story is being reported. This is in keeping with the spatial framing of news reports. As long as an "event" is defined as some spatially bound happenings rather than an "issue", it politically implies the territorial administration. An attention to gender specificity is not possible in this mode of structuring the news narrative, since the identity of the people is determined by their location under such reporting.

One of the most important health issues facing women today is that of HIV/AIDS. In my scan spanning over two years of reports I failed to find more than five that addressed this issue. And even when it did, its special significance in tilting the risk factor against women went completely unaddressed. Of all the reports, three came out following upon World AIDS Day and the other couple during the visits of celebrities like Richard Gere or Melinda Gates to promote the cause of AIDS awareness and activism in this country.

The point I am trying to make is that "source" plays a very important role in this matter. From the few reports that have appeared on this socially destructive disease, it would be fair to conclude that the newspaper does not sponsor any independent investigation into this issue, let alone carry out a direct inquiry from NGOs that are working in this area. The reports are all about particular public meetings held on some occasion like the World AIDS Day and any concrete information presented in the reports are those that are given out at those meetings.

Thus, on 2 December 2003, the day after the World AIDS Day, we find two reports covering two public announcements. One of the reports appeared under "nation" with the headline "Hope and Scepticism over Free HIV Drugs" which described an announcement by the health ministry of India that it would provide "anti-retroviral drugs free of cost to patients in the high-risk states of Tamil Nadu, Andhra Pradesh, Karnataka, Maharashtra, Nagaland and Manipur from April 1". It also included some statistics provided by the National AIDS Control Organisation (NACO) to the effect that two lakh children were suffering from the disease, but there were no estimates of infected mothers. We also learn that the total number of HIV/AIDS people in India stands at 4.85 million, making our country second only to South Africa in terms of the prevalence of the disease. We are also informed about the approximate cost of anti-retroviral treatment as it stands now and the percentage by which it is expected to be slashed.

The other report on the same topic appeared under the "Bengal" page with the headline "Awareness Agenda on AIDS Day". It covered another public meeting, this time called and organised by the government of West Bengal in collaboration with groups of sex workers who are also activists in spreading awareness of HIV/AIDS. So, the report informs us that the "government reeled out figures showing a spurt in the number of HIV positive cases in the state" but also entreated the public not to panic because, as the director of medical education had pointed out, the spurt apparently "does not necessarily indicate that this is the exact rate of

increase". The director maintained, "For that we have to find out if other reasons could have contributed to this increase which appears alarming. The government has learnt that the rate of detection used to be very low. So, even if there were HIV positive cases, the exact figure did not come out." Over the past few years, the director claimed, the availability of diagnostic facilities and awareness programmes have improved over the past few years.

As in all other reports, we do not find any in-depth coverage of the social and institutional problems that hinder the rate of detection. Nor do we know anything about the gender-specific problems that may hold people back from seeing a counsellor. Do men and women face the same level of risk and encounter the same kind of social problems when it comes to HIV/AIDS? What are the differences in the reactions of a man and a woman upon hearing that they are HIV positive? Does the sex of the infected parent affect the children differently? I have not come across any independent report in *The Telegraph* probing these questions. In such questions of public health, the only source of information, it appears, for the reporters are the public meetings organised and public statements issued by the government departments concerned. The limitations of the source define the limitations of the news.

Narrative

Having discussed how the categories and the source foreclose gender-specific reporting, let us now look at a few examples of the narrative structure of some important pieces of news that have appeared in *The Telegraph* in this period.

Over the first week of September 2002, *The Telegraph* carried out a campaign against the mismanagement, indiscipline and serious lack of infrastructural facilities in the major public hospitals in the city. The issue came to light with the reporting, on 3 September 2002, of the death of 14 children within two days at the B.C. Roy Memorial Hospital, "the only paediatric referral hospital in the state".

As we all know, anything that is considered "normal" does not qualify as news. And it was in terms of this event's relative normalcy that *The Telegraph* posed the issue as a question. Should the death of 14 children within two days be considered "normal"? Does the death of these 14 children merit a place in the newspaper's valuable columns? Let me quote from the report in *The Telegraph*: "That is normal. Ask Suryakanta Mishra, the health minister who has been promising to clean up hospitals nearly everyday since he took charge last year. 'There is nothing abnormal in the number of deaths that have taken place there in the last two days', he said."

The question *The Telegraph* posed to the public is this: Are there any valid grounds to accept Mishra's statement, that 14 deaths in two days is a normal event in

the only paediatric referral hospital in the state? If not, what are the causes for the abnormality?

Let us pick up some explanations offered by the report itself and try to unpack its narrative logic. The report goes on to say: “Too many children die here. Over 300 have died in the past 6 months. Last September too 22 died in 2 days. Nothing has changed in a year.”

It is clear that the reader is not left in any doubt about the position of the newspaper here. Clearly the situation is “abnormal” as judged by the report which flatly proclaims, “Too many children die here.” And the statistics offered in support of it are quite convincing.

So, we have to search for the cause. Yet, at this crucial point, the report veers away from looking for causes and turns towards descriptions of the event interspersed with comments from important personalities.

We thus learn that “the parents who can take their ailing children nowhere else know that too: the inevitability of death and their helplessness”; “My brain is not functioning”, as exclaimed by an “apologetic” hospital superintendent; The chief minister of the state, “too, admitted he was at a loss” because he could not get in touch with the responsible officers in question; The minister of state for health said, “periodic occurrence of multiple deaths in a day was expected, as most of the cases that came to the hospital were terminal”.

But if multiple deaths had been occurring “periodically”, how is it that this time it made the headlines? The reader is told that the parents of one two-year-old child this time raised an alarm by accusing the doctors of “killing” the child by not putting him on oxygen. The B.C. Roy Memorial Hospital was the fourth stop for the ailing child, who had ultimately been referred here. The particular case then led families of other children to join the protest and “doctors and nurses ran out of the wards in panic and the ward-boys stopped working to protest against the lack of infrastructure”. The police had to be called in to restore order.

We are told at this point that most of those who died in the last two days were suffering from respiratory problems, gastro-enteritis, meningitis or septicaemia. We are further informed that “doctors said better infrastructure could have saved some of the babies”. The reporter skips telling us if the doctors in question were working in that hospital or elsewhere, but continues to list the lack of vital infrastructure like a “neo-natal intensive care unit, an ultrasonography machine, a scanning machine, or even a ventilator”. Particularly scarce, it appears, were oxygen cylinders. While some hospital officers are quoted to have claimed that there are “*some”* cylinders, “their subordinates, however, admitted that they were too few for the 250 bed hospital”.

The report concludes with an anguished and pointed question directed to the chief minister and the health minister of the state. “Bhattacharjee and Mishra have been threatening to reform health services. How many children must die before they do it?”

The narrative is calculated to raise the reader’s anxiety level and outrage without offering them much by the way of *how* one may take a political step in remedying the situation. With repeated references to comments from administrative officials at various levels, ranging from the chief minister down to hospital officers, the reader gets the sense that the answer should rightfully come from them, and not from the civil society at large. These are the elected and selected representatives of the civic body who, apparently, have been lax in fulfilling their responsibility. The only political course open to the public therefore is to carry out a negative campaign in whatever form against the party in power. The concluding statement sums up this position. The reporter reminds the chief minister and the health minister that they have been *threatening* to reform health services, and how many children must die before *they* do it.

The use of the word “threatening” in this context is curious. Who exactly were the targets of this “threat” of a reform of the health services? Certainly not the babies and their parents. It must be those who are benefiting from the existing state of the services. The logic of the narrative thus leads the reader to wonder about the factors that may be holding the said officials back from carrying out the “threat”. A tacit suggestion is thus made of complex systemic links between the beneficiaries and the threat-givers.

Those who are completely left out of the story except as symbols of bereavement are the women/mothers. Seriously sick babies indeed have the right to adequate medical service and modern medical technology. But should the cause of these tragedies be sought not just within the hospitals but also outside of it in the larger civil society? How do children come to be seriously ill with respiratory problems, gastro-enteritis, meningitis or septicaemia? Could the basic lack of immunity of a baby have something to do with the physiological immaturity of the mother, given the very young age at which most women outside of urban India get married? How is the everyday domestic work-life of the mother structured within which she is expected to fit in care for her infant? For example, a woman living in one of the water-scarce areas of the state certainly has to spend a large part of her working day securing water for the running of the household, which must eat into the precious little time she is left with for childcare. More generally, does she live in an environment healthy enough for a baby to grow up in? Is there enough cultural-social awareness about adequate pre-natal care for the mother and post-natal care of their babies? What are the social-cultural values/norms that rule the care of an infant in families? What is the socio-economic background of the parents whose babies are admitted to the hospital in such critical condition? If most of them are coming from distant districts and villages, are there any acceptable explanations for why they

could not receive any medical help near at home at an early stage of the disease? Why are referral hospitals in the metropolis overcrowded?

The front-page headline on the next day, 4 September 2003, reads "Government Prescribes Blackout Pill". The theme of this report is the hardheaded and heartless attitude of the government and the almost totalitarian style of running the administration. The reader is informed that even as "Bengal woke up with revulsion to the death-spiral at the state-run B.C. Roy Memorial Hospital for children", the government on its part betrayed "little remorse" and "reeled off cold statistics" to back up their story. This juxtaposition of a Bengal that woke up with "revulsion" to that of an administration that betrays little remorse and reels off "cold" statistics clearly reveals the narrative agenda, which is to oppose the heartfelt, gut-level, emotional reaction of the *people* to that of the calculating, cold-hearted, remorseless government *administration*. The reader comes to know that the health minister has attributed the deaths to the "logical culmination" (another *cold* attitude) of critical diseases. Even worse, he cited *statistics* (the annual average death rate at the B.C. Roy Memorial, 3.39 per cent) to support his position of the adequacy of the hospital infrastructure. The report sought to counter Mishra's position by invoking "authorities at the hospital" who maintained that the infrastructure was "woefully inadequate" to cater to the large number of patients.

The reader is then exposed to the authoritarian and tyrannical mode of running the state administration with descriptions of how the hospital superintendent was "admonished" by his superiors for briefing reporters. Allegedly, he was instructed to stay away from the media and a circular was decided to be issued "prohibiting superintendents of government hospitals and heads of departments from interacting with the media without *permission from superiors*" (emphasis mine). The authoritarian work-culture of the administration was rubbed in when the director of health services was described in the report as "echoing" the health minister's line.

By the second day of the campaign, thus, the focus has been totally removed from probing the processes and circumstances of the deaths to explain them more contextually and more completely, to establishing how the administration is trying desperately to cover its track with a cold heartlessness and tyrannical style. The question of a gender-specific probing cannot even be raised within the narrative logic of this report.

The day after, 5 September 2003, the government showed a face that is not only cold and heartless, but also calculating and duplicitous. On this day, the front page carried the picture of a woman (of lower middle class background by her appearance) crying helplessly. The caption explains the cause for her misery: "Namita Pandey breaks down outside the hospital after her niece was denied treatment on the ground that she went on television complaining about the conditions inside. She alleged that a doctor told her to get the child treated by 'reporters you complained to'." The headline therefore prominently displayed both these news. It

was a double headline. The one on top read "Buddha's Heart Bleeds At Last" and the one below "—get reporters to treat the child".

The report minced no words in presenting to the readers what it perceived as a two-faced gesture by the government. To quote: "*Normal* metamorphosed overnight into *apalling* as Buddhadeb Bhattacharjee *woke up to the damage that 48 hours of silence has done to his enviable record as the Chief Minister*… [He] said today what Bengal had been waiting since Monday to hear: 'We are not insensitive to the deaths of so many children. It is apalling … even if a single baby dies, it is tragic'… The impassioned appeal signalled the beginning of a *stunning somersault by a government* which saw till last night 'nothing abnormal'… But the action that followed the words and the visit could not erase the *whiff of expediency* that hung around the Chief Minister's damage-control drive" (emphases mine). This report does not need any interpretation.

What is interesting though the way the report juxtaposes the visual representation of a woman as victim to this report of a governmental somersault. The picture of Namita Pandey we are shown is when she has "broken down outside the hospital", not when she was speaking to the television crew complaining about the "conditions inside". Was it her courage in the face of adversity that brought about the governmental somersault or her misery in the face of her helplessness? No doubt, the report is playing upon the connection between the supposed disclosure of the "conditions inside" to the "media outside" that forced the government on its knees. The media poses as the saviour by juxtaposing the visual and the textual and relegates the woman's agency to victimhood.

On 6 September 2002 the front-page headline announced, "CM Stick Drives Men, Not Machines". The point was that the government was trying to introduce a reign of terror inside the hospital by blocking the entry of media and then forcing the functionaries of the hospital, starting from ward boys to doctors, work harder and in a manner that the government wants them to. The concluding lines of the report ran thus: "The last word belonged to a … doctor … It was not the media that was being shut out, he felt; rather, what was happening at the hospital was a clamp down on doctors and other staff … 'What people don't realise that fear will beget extra hours out of staff, but will not be enough to ensure service from a run-down photo-therapy unit or an absent incubator', he said."

By 7 September 2002, the coverage of the issue has slipped down towards the bottom of the front page. This day for the first time we get a story covering the actual sequence of events that led a 10-day-old baby from Bhagabanpur, Bhangar, in South 24-Parganas to the B.C. Roy Memorial Hospital in Calcutta.

The title reads "From Midwife to Quack to B.C. Roy". The baby, named Ashraful, saw the lights of this earth in the hands of his maternal grandmother who was also a midwife. She brought him out with an unsterilised knife. The knife served

another purpose that evening. It was used to tonsure the newly born's head immediately after it had severed the umbilical cord. By the time he was five days old, the infection had set in seriously. His grandfather, who was a village quack, tried some of his remedies on him – unfortunately without any result. The story informs us that when Ashraful was born he weighed about 3.5 kg. By the time he was admitted to B.C. Roy hospital after 10 days with infections in places where the unsterilised knife had been used, his weight was 2.2 kg. At first the family took him to the health centre closest to home, the Jirangachha Primary Health Centre. It is instructive to know how this centre is equipped. It gets on an average 500 outpatients every day and has two doctors who attend them for a limited time. Often one of the two doctors is absent. The Centre has only three types of diagnostic equipment; one a microscope, the other two being kits to measure haemoglobin count and blood pressure. One of the doctors pointed out that given the kind of patients they get, they urgently need kits to ascertain a patient's urea-content, sugar-level, bilirubin count, a colonometer and a blood-grouping kit.

This story finally puts to the foreground of the campaign the larger social-cultural and institutional context that goes into producing a situation as in the B.C. Roy Memorial. This is where we also see how the woman and her situation are central to the entire issue. The unbalanced development between urban and rural India has produced a lopsided system where almost all facilities – human and infrastructural – are concentrated in the urban centres. But there is a limit to what even all that concentration can carry. Except for the most ordinary illness, almost every case is referred to the city-based referral hospitals, thus making the referral hospitals unmanageably overcrowded. This creates a golden opportunity for the less-than-ethically minded staff of the hospital to siphon off valuable financial and material assets at the hospitals. Further, the extremely low level of awareness as well as poverty among the rural mothers often lets an illness in a child run untreated until it becomes critical when the child is rushed to the local health centre which, severely under-equipped, refers the case to the city hospital.

It is sad to see that the visible insights from this story were not followed up in any form, unlike earlier in the campaign when any and every move of the government was dissected to expose the rot within. By 8 September 2002, the story has moved to the Metro section of the paper, a part of the paper that is primarily targeted to the readership that wants to be informed about lifestyle issues and very focused local developments as may affect them. The story in the Telegraph Metro on 8 September, titled "Neo-Natal Unit on Hi-Tech Path" starts off as, "Almost a week after 14 children died in 48 hours, the government on Saturday decided to upgrade the neo-natal unit of B.C. Roy Memorial with more sophisticated equipment."

How is it that an issue that is gendered at its core was treated almost entirely from an administrative-political perspective? I shall discuss this at greater length in the concluding section. Suffice it to say that the three discursive factors – categories, source and narrative – I had selected at the beginning of the analysis all push the

reports away from a gendered perspective to a structural-political one where any and every problem of the civil society get attributed to policies and actions of the state. This is a consequence of a nationalistic politics gone sour, but more about that in the conclusion.

Ananda Bazar Patrika

This Bengali newspaper, compared to *The Telegraph*, offers us a more extensive coverage of suburban and rural Bengal. While like the English language paper, the front page is given to news of national and metropolitan importance, the rest of the paper provides more space to the West Bengal that lies outside of Calcutta. And that is how one gets a better perspective in the Bengali paper on the complexity of the health care scene in the nation and the state.

We also find more space devoted to the news of polio vaccination and AIDS treatment policies. Both these issues need to be understood from a gendered perspective. Though, like the English paper, this one too does not take any self-consciously gendered perspective in presenting the news. But simply because of the greater amount of space devoted to them, we tend to get some glimpses of how women figure in these matters that are of crucial national and local interest.

Let us now look at the three organising factors.

Categories

The similarity lies in the fact that both the papers are organised according to spatial categories. But the Bengali newspaper breaks up its news into more detailed spatial configurations. Thus, instead of simply "Bengal" to bring together news of West Bengal outside of Calcutta, the *Ananda Bazar* breaks it up into (1) Calcutta (2) the state (3) North Bengal (4) South Bengal (5) Bardhaman (6) Purulia (7) Murshidabad (8) Medinipur (9) nation and (10) foreign. Like *The Telegraph* therefore, here, too, the gendered identity of people is suppressed in favour of the locational one.

Sources

Since *Ananda Bazar* has a more extensive coverage of the state of West Bengal, its sources are spread wider than the occasional conferences and regular official announcements. Thus, in a report titled "They stand by the rural people, so the quacks are no longer outcastes", the reader learns that while urban doctors' associations are opposed to training and using the rural quacks as "rural medical practitioners", the rural panchayats are quite in favour of them. It quotes one panchayat chief as saying, "These practitioners are our resource persons. This village has a population of 18,000 and the adjacent one 22,000. We do not have even a single registered medical practitioner in this entire area. There is only one outdoor clinic in Madanpur Auxiliary Health Centre. People do not want to go to the Khanakul Rural

Hospital for the abysmal standard of medical care there. These rural practitioners are therefore the ones we have to fall back on." The joint director of the state health and family welfare department is quoted to have said that government policy does not allow it to recognise the quacks as doctors. But they are very interested in using them as "health workers in the government health projects". We further learn from the panchayat secretary that the panchayats have a political interest in backing these "rural health practitioners", since they can serve as a link between the people of the village and the panchayat and a political base for the panchayat. These practitioners examine patients, hand them the medicines on the spot, collect blood and take it for testing when necessary, bring back the report from the testing centre on behalf of the patient, even accompany the patient to hospitals and nursing homes when required.

We thus get a more complex and relatively complete picture of the rural health scenario in West Bengal than *The Telegraph* has ever provided us as the report is based upon several sources than just one.

Another point of difference is that *The Telegraph* rarely if ever had any edit-page article on public health. *Ananda Bazar Patrika* on the other hand, in this span of two years, had six edit-page articles addressing the problem from various perspectives. We do not know if this difference should be attributed to the papers' respective editorial policies or the composition of the write-ups that land on the editor's table.

Narrative

Let us look at some of the polio and AIDS reports to find out how they are narrated.

On 28 October 2002 *Ananda Bazar* carried a report on the pulse polio drive in the state under the heading, "The health department is hiding its own negligence by blaming it on the superstitions of the villagers".

West Bengal, which in the not so recent past had one of the best polio vaccination records in the country, has slipped in the last couple of years. The reason, as we are told, lies with the large number of rural Muslim population in the state. Under the influence of orthodox and influential *maulavis*, a large percentage of people of this community are refusing to administer pulse polio to their children. Some of the stories doing the rounds are that children will go sterile if given the polio dose and it is one of the ploys of the Indian government to bring down the Muslim population in the country. The larger context of the narrative is thus the rising communal tension in the country, which is surfacing in this form in the state of West Bengal which has so far had a relatively good record of communal harmony.

Without directly raising the issue, the *Ananda Bazar* reports provide us with a view on the various responses of Muslim-dominated villages in various parts of the state. This particular report tells the story of a couple of villages in the district of

Birbhum. The first sentence reads, "It is not just superstition, negligence on the part of the health department is largely responsible for the failure of the pulse polio campaign in Muraroi – stands the allegation against the government from several quarters." One should note that the report does not dismiss the existence of "superstition", but discounts its strength as the determining factor of the failure of the drive. As the report presents it, the ex-BMOH and the panchayat chief Abdur Sukar maintains that since "almost all babies in the villages in this area are born at home, almost none of them is registered. Though the government has employed one health worker to look after four or five villages, they are too overworked to carry out this task properly". The report further quotes two young men of the village Quasim Nagar, Md Kamiuzzaman and Md Sikandar, who are very disappointed with the neglect of their village by the health department. Their complaint is that in 1995, when the countrywide pulse polio drive was conducted, the state health department had organised just a single camp in this village. That was inadequate for serving the village, which had almost 1,200 children who needed the pulse polio. The two men allege that at that time about half of those children had missed taking the dose. The secretary of the panchayat, Abdul Hannan, supported these two young men's allegation.

Though brief, the report is complex enough to merit a close look. By way of narrating some views of the people of the village, the report makes several implicit points. It helps in debunking the notion of the "Muslim community" which is opposed *as a group* to modern development. It is young members of the Muslim community who are shown to be disappointed at the marginalisation of their community. We also get a glimpse of the almost absence of modern institutional health care system in these villages as we learn from an authoritative source that most women in the village give birth at home in the hands of rural midwives. The low level of consciousness about the benefits of modern science in promoting health among the majority of the people is thus made apparent. It also gives us a flash of the situation of the women and the status of their health in the region. It is unfortunate though that the report does not make any effort to get some direct statements from some women, which would have bolstered the claim of a divided community. It is possible that the existing socio-cultural restrictions on the women barred the reporter from approaching any of them. But if even an effort was recorded, that would have brought the gendered aspect of the problem to the forefront. Finally, a more serious political problem emerges from this report: would it be wrong to imagine that the state administration, in their anxiety not to incite communal misunderstanding, is neglecting to serve a part of its citizenry with the amenities of modern medical science? It is possible that such an anxiety is justified: the orthodox mullahs and *maulavis* might seize this opportunity to fan communal discontent. On the other hand, it is also possible that the timidity of the administration is only serving in weakening and alienating the progressive forces within the community.

Let me now turn to two reports on HIV/AIDS infection. One came out on 18 November 2002 with the title "Fear of HIV Infection Posing a Hurdle for

Rehabilitation of Sex Workers". This report focuses directly on one of the major gender-specific issues of the day, the HIV/AIDS virus and the rapid spread of this deadly disease.

We are informed and alerted here of the desperate conditions of sex workers who have been infected by HIV. As it is, sex workers are socially ostracised in our world where women who sell sex get labelled as morally repugnant by people whereas the buyers most often go scot-free.

In this case we are told of those sex workers who may have succeeded in breaking out of the clutches of brothel owners and pimps but do not find the general society any more accepting than the world they are trying to escape. These are experiences of young, often still within their teens, sex workers who have been rescued or have escaped from the red-light districts to find shelter in some rescue home, either private or public. The report tells us that a government statistics has estimated the rate of HIV infection among these young women to be about 40 per cent.

But why do the younger among the sex workers have such a high rate of infection? We learn that a popular belief that sexual contact with a virgin cures one of HIV/AIDS infection is behind the surge in demand for young virgin girls in this profession. This has spawned a lucrative trade in human trafficking where virgin girls are either lured into the trade or bought from their guardians under various pretexts and then pushed into the trade. These girls in their early teens are put to work by brothel owners to satisfy clients, often double their age or even older, who are carriers of the virus.

We hear the voice of one such girl in this report: "Everyone tells us we won't get infected if we use condom. But how do you think we can enforce this on those older men? They pay extra so they won't have to use a condom, and our brothel owners force us to have unsafe sex with them. You think anyone listens to us?"

This girl has spoken from a private home run by an NGO called Sanlaap for these rescued or escaped young sex workers. But the sad experience has been that even though they have been able to free themselves from the brothels, the door to a normal social life is almost close to them. Indrani Sinha, The director of this institution, tells us that in most cases the families of these girls do not want to take them back. Even the government-run homes often refuse them entry. Yet, this same government does not provide them with any support if they want to leave the home and try to build some kind of a life for themselves outside. The Juvenile Welfare Board of the government does not permit an infected young girl to leave the home on the ground that she may endanger the larger society if she leads a life on her own. The most important requirement for these young girls, regular access to medical facilities at an affordable price, is something they are often denied by the prejudiced and ignorant hospital staff if they present themselves on their own (without the NGO representing them) to some government hospital for treatment.

These girls are thus trapped in these "homes", facing a life bereft of any hope of leading a normal life someday outside of this new prison. To be able to lead a normal life, they will have to succeed in hiding their disease from society at large. That is a near impossibility for people who need regular medical attention. The report quotes Dhruba Neogi, a representative of the School of Tropical Medicine, as saying, "The most important problem in fighting AIDS is the lack of awareness in society. In the voluntary clinic run by the School, a maximum of five people may show up voluntarily to be tested for HIV." Neogi feels that the absence of a culture of open discussion of sexuality in India is behind this lack of awareness.

Another report brought out on 2 December 2002 (World AIDS Day), titled "The Number of HIV Infected Housewives and Children is on the Rise", exposes us to the most important problem posed by the AIDS epidemic – that of the impossibility of identifying and isolating any particular social group as the most risk-prone and thereby curb the spread of the disease.

Citing a "Government-run AIDS clinic" as the source, the report presents us with the statistics that "on an average two babies are being found every month in this state who have inherited the infection from their parents. Of the number of people coming to the state AIDS clinics, recently there has been a quite perceptible rise in the number of housewives and children". Nearly 40 per cent of the cases being reported at the School of Tropical Medicine and other government-run AIDS clinics show infection of wives through their husbands and the consequent infection of the baby born to the infected woman. It has also been noticed that the rate of infection is higher in Calcutta, and in adjacent districts such as Howrah, Hooghly and the two 24-Parganas, compared to districts that are at a distance from Calcutta.

The reader is told that until now HIV infection was believed to be more or less confined to migrant labourers, sex workers, truck drivers or intravenous drug injectors, that is, people who were largely outside of the social mainstream. Hence the idea was that if people could be sensitised to avoid infectious contact with people from these groups, we could have a fighting chance against the epidemic. But now the infection is spreading in the social mainstream through infected housewives who never seek out any risk-prone sexual encounter. Neogi points out that even though in the last two-three years we have been successful in bringing down the rate of infection through blood transfusion, the rate is increasing through parental infection. He also stresses that advertisements on the nature and causes of HIV infection have largely failed in our society for its lack of openness to sexuality. Hence he is of the opinion that our strategy should be to approach the target groups directly to hold face-to-face discussions with them. He also says that they are planning to hold awareness programmes to sensitise school-going children.

Narratologically, these two reports have the woman and her gendered problems of health care at the centre. Though there is very little difference in the

nature of the suffering of an HIV infected male and a female, the women are more vulnerable for being in a state of comparative powerlessness. Most of the time the woman – be it a housewife or a sex worker – is not in a position to choose her sex partner on the grounds of comparative safety nor demand that the partner she is forced to have sex with be more responsible towards her well-being. The clear message is that empowerment of women in all strata of society has to be central to our public health programme.

Conclusion

In two wittily insightful articles in The Telegraph in October 2002, Mukul Kesavan outlines some of the characteristic features of English newspapers in India. Some of his points are pertinent to our findings.

In his 'India entire: English Newspapers in India are Chronically Pan-Indian in Their Instincts'[4] he lays out a thesis of how the reporting style and content of English newspapers in India is a product of their pan-India orientation. As he points out, the primary task of the English language newspapers in India is to *translate* the intensely hybrid, often messy, linguistically mixed reality of India into clean and clear English prose that has to make this messiness comprehensible to the image of this pan-Indian reader who is at home anywhere in India as long as she/he can understand it in English. To quote Kesavan, "The English press' understanding of India often has little to do with the alienating effect of language and everything to do with its attachment to India. Entire, the whole rather than any constituent part." In his second article, 'Country and the City: For the US Newspaper Reader the Opposition to Provincial is Metropolitan'[5], he does a comparative analysis of newspaper cultures in the US and India to argue that the urban-English cultural world of India attempts to transcend its vernacular provincialism by looking at an imagined nation through the window of their English language newspaper, while in the US the metropolitan cities are what stands opposed to local provincialism.

The central point of Kesavan's thesis, that the English language and vernacular newspapers cater to readerships with different self-images, is borne out by our findings. English is the language of the middle and the upper middle classes in India who share a pan-Indian culture through their understanding of the everyday world of India translated into English. Though this is not to argue that a connection to the world through their respective vernacular is absent for these readers. Linguistic affiliation in India is much too complex to be depicted in black and white terms. Still, the very act of choosing an English language newspaper orients the reader to a world that functions in English, uniting this class in their interest in pan-Indian institutions and culture. The local and regional specificities and complexities have therefore to be categorised – which is nothing but an act of translation – away lest the autonomy of the events there undermine the presumed unity of the nation.

We have found that in covering issues of public health, the English language *Telegraph* takes a simplistic *people vs state* position to present a rather incomplete, biased and somewhat caricatured translation of this local/vernacular world of government hospitals, their staff, the internal politics of ruling parties, rural patients, their expectations and understandings and, of course, the manner in which they function as a part of the nation-state. It would be fair to argue that the reader of the English newspaper in Calcutta belongs to a class that is on the whole critical of how the "government" is making a mess of the country and how privatisation is the only way out of the corrupt inefficiency of the government. The reports in *The Telegraph* reflect this self-positioning of its readership.

The Bengali language *Ananda Bazar*, on the other hand, is far more adept in capturing the complexly many faceted character of local situations. This is clearly traceable to the more locally rooted character of their readership. A large percentage of the readers of *Ananda Bazar* reside in the small towns and the vast rural tracts of Bengal who as a matter of their everyday life are a lot more familiar with the complexity of situations on the ground. This readership, though often not very conversant with the idea of and expectation from a government administration functioning from the metropolis, has a very shrewd understanding of the workings of the government administration at the local level and its interfaces with the local community. A representation of events to this more knowledgeable readership has to come up with a more complex and open-ended narrative.

The near absence of a gendered perspective in *The Telegraph* can therefore be understood in terms of this pan-Indian nation-centric identity of the paper. The pan-India or the "nation" is largely an abstraction except in some very limited spheres, like the economy. So, when *The Telegraph* discusses infant mortality in government hospitals in West Bengal, the imaginary point of reference is the best modern hospitals in the nation (wherever they are) and not the messy local picture composed of impoverished rural communities, life-trajectories of rural women, nearly dysfunctional rural health care systems, etc. Since the imagery of the nation can only address the genderless "citizenry", the gendered picture of the rural communities and their dealings with the urban institutionalised health care system cannot enter into the reports.

I would not, however, go very far in endorsing *Ananda Bazar* for highly gender-conscious reporting either. The evidences of a gendered-reality that we find in *Ananda Bazar* reports are primarily due to their better coverage of the local situation, and not because of an editorial policy seeking to address reality as gendered.

The other point that emerges from the review is how the newspapers conceptualise and define "news". That is also part of the reason for the conspicuous absence of gender from the representation. As we have seen, news is configured in spatial terms; an event is defined by its location. The process by which this event came to happen is thus not quite relevant for the representation. Since women are

often not involved/visible in the public formation of an event though they may be a formative part of the process, a gendered perspective gets thrown out since only the public form of an event in its locational term is presented in the report. The way to get out of this trap is to conceptualise news as *issues* and not as *events*. Thus, rather than defining an event as "14 children die in two days in B.C. Roy Memorial Hospital", if we define it as "the problem of an urban referral hospital in the context of a rural-urban divide", we would be choosing to report on the problem of "public health" rather than on just whether or not B.C. Roy Memorial lacks infrastructural facilities. This would open up the way to a gendered perspective.

Since I am suggesting defining news as *issues* rather than as *events*, it is necessary here to briefly clarify my position on the debate between the WHO definition of health as "a state of complete physical, mental and social well-being" and the people's health movement's definition of health as "absence of disease". I would support the WHO definition since, if we want to adopt a gendered perspective on public health, women's social-cultural context is often inseparable from an understanding of the status of their health.

Notes

[1] See the 'Journalism and War' debate in http://www.opendemocracy.net.

[2] Julian Baggini (2003): 'The Philosophy of Journalism': Opendemocracy.net

[3] ibid.

[4] Mukul Kesavan, 'India Entire: The English Newspapers in India are Chronically pan-Indian in their Instincts', *The Telegraph*, Kolkata, 13 October 2002.

[5] Kesavan, 'Country and the City:For the US Newspaper Reader The Opposition to Provincial is Metropolitan'. *The Telegraph,* Kolkata, 27 October 2002.

Muslim Women and the Pulse Polio Campaign

Biswajit Roy

Introduction

The Global Polio Eradication Initiative (PEI), aimed at global south, is one of the most high profile and expensive mass immunization campaign run by the World Health organization and United Nations Children's Fund in partnership with the US led Western government aid agencies and civil society organizations. India and other 'polio-endemic countries' have been participating in the Pulse Polio campaign along with Universal immunization Program. In 1988, the World Health Assembly, the governing body of WHO, adopted the goal of global eradication of poliomyelitis by the year 2000.[1] But the international community failed to attain the goal largely due to 'overt resistance and vaccine avoidance behavior or hidden resistance' to Oral Polio Vaccination mainly in some African and Asian countries. The resistance is most rampant particularly among Muslims as well as ethnic and other minorities in some countries of East and Sub-Saharan Africa and South Asia including India and Pakistan, reported the WHO, UNICEF and USAID. "Three regions (The Americas, Europe, and Western Pacific) have been declared polio-free, but despite enormous progress, Pulse Polio has not been able to meet the original goal of eradicating polio by 2000. The goal has been reset for 2005. Presently, the majority of polio cases are in three countries: India, Nigeria, and Pakistan," pointed a report commissioned by the USAID and the Academy for Educational Development (AED) in April 2004[2] Dwelling on the demography of the disease, the study noted, "the majority of polio cases are found among minority populations in countries where those communities are large, alienated from both mainstream society and national politics, and are distrustful of government services. Communities include tribal groups in Pakistan, Muslim populations in the northern provinces of Uttar Pradesh and Bihar in India, and tribal and Muslim groups in Nigeria. Making oral polio vaccine (OPV) available to these populations present daunting challenges that communication can help resolve. One of the main challenges for PEI is making OPV available to hard-to-reach populations with low rates of routine immunization. These populations have little or no access to health services, and can be classified into distinct groups: • mobile groups such as migrants and refugees in conflict areas • urban poor • cross-border populations• minorities politically isolated from the mainstream. Recent global news has been filled with reports about the opposition among Muslim communities in India and Nigeria to the PEI. Rumors and resistance are two main obstacles to interrupt circulation in polio-endemic countries in reaching these populations."[3]

These countries are now under international pressure to meet the new deadline of 2005.[4] To break the resistance in India and elsewhere, international agencies, national and provincial governments have taken up various social mobilization and interpersonal communication strategies involving religious personalities and other traditional community opinion makers, NGOs as well as madrasah teachers and students, celebrities and mass media. Campaign materials meant to dispel the 'false fears, misplaced worries, superstitions and ignorance' are abundant. "The combined interventions have yielded 'positive result and produced rich lessons on strategic communication for social change," observed UNICEF.[5] But the resistance takes new twists and turns making the government machinery, agencies and NGOs largely 'harassed and fatigued'. "Loss of morale, fatigue, and loss of confidence in the capacity to achieve polio eradication, by workers at all level, by the community, or by the partners, has the potential to cripple achievements at this critical stage and must be explicitly addressed," cautioned the apex monitoring body, India Expert Advisory Group for Polio Eradication in June 2004.[6] A multitude of 'ungrateful, stubborn, ignorant people' have been playing cat and mouse game with well-meaning and enlightened representatives of welfare state and civil society for a decade. Bitterness is now mutual. Except few sporadic efforts, no serious study has been undertaken by the central and state governments to fathom the socio-political reasons and nuances of the resistance/avoidance and frame the public health programs and social mobilization strategies accordingly, not even in Left ruled West Bengal. Academic studies in popular resistance to colonial vaccination campaigns have enriched our understanding of the encounters between the colonial state as well as Western medicine on one hand and indigenous societies and local health practices on the other. But such efforts are in wanting in post–colonial period. Our study on resistance to pulse polio vaccination is a humble step towards filling up the gap.

Objectives of the study

- We seek to understand the nature and dynamics of the polio vaccine resistance among Muslim community in West Bengal as well as Indian Muslims as a whole, in the light of historical experience of state sponsored public health and mass vaccination campaigns in colonial India.

- Identification and classification of political, religio-cultural, mass psychological reasons of resistance in the context of complex relationship between the Indian state and the mainstream civil society on the one hand and the minority and marginal communities on the other.

- Investigation into the vaccination related allegations and clash of interests between the public health service providers and client population groups.

- Exploration of the gender perspective on conflict situation involving Muslim women following vaccination of their children in the absence of resistant husband.

- Understanding the impacts of the social mobilization strategies involved in Pulse polio campaigns.

- Dissemination of the understanding for better appreciation of the issues involved in the Polio eradication campaigns.

The Background

Poliomyelitis, commonly known as polio, is a highly communicable disease, which has crippled generations of children throughout the ages. The polioviruses are three related enteroviruses; type 1, 2 and 3, causing paralysis. They are transmitted primarily through human faecal-oral route; it affects children mostly at early age.[7] Though prevalent worldwide earlier, the incidence of polio attacks has declined rapidly in many industrial countries because of the widespread use of poliovirus vaccines, mainly Oral Polio Vaccine (OPV) since 1950s. In 1994 an international commission certified the western hemisphere to be free of indigenous wild poliovirus. The number of polio cases has decreased from an estimated 350,000 in 1988 to around 1000 in 2004. The number of polio-endemic countries has dropped from 125 to seven.[8] According to the WHO, most of the 1189 confirmed wild poliovirus cases in 2004 were reported from eight countries of Africa and Asia. These countries are six neighbors in central Africa — Nigeria, Sudan, Niger, Central African Republic, Chad and Ivory Coast as well as twin sisters in our subcontinent, India and Pakistan, in 2004. This tally is second highest since 2000 and almost double of 2003 count. Nigeria still tops the list of polio victims in the world. The most populous country of Africa reported as many as 763 cases out of total 1189. World's second most populous country India and Africa's largest country Sudan with their tally of 130 and 112 respectively stand second and third in the global polio victim list. Pakistan with 48 victims follows the rank. 17 countries were under the WHO scan last year.

While Nigeria, Niger as well as India and Pakistan have been considered as 'polio endemic' nations since a decade, Afghanistan and Egypt have slipped off the infamous league in 2004 even if these countries reported few cases. But wild poliovirus has reestablished transmission routes in Egypt's neighbor Sudan and Nigeria-Niger's contiguous Chad and CAR as well as smaller neighbors Ivory Coast, Burkina Faso and Benin. some other countries, hitherto known as polio free, have reported polio cases following import of the virus.

All the major affected African countries have substantial Muslim population — Nigeria 55%, Niger 85%, Sudan 71%, Chad 50%. different tribal groups having

faith in traditional beliefs are also sizable in number. For example, 60% of CAR population are traditional believers. But what is more important to note that all these countries are either reeling under ethno-religious-regionalist civil war (Sudan, Chad) or undergoing acute tensions on same issues between the Central and regional governments (Nigeria, CAR). The opposition to polio vaccination in Muslim dominated Nigerian northern states was more a result of ongoing political tension with Christian dominated south. Both religious and regional factors are instrumental in this ongoing clash.

It is also notable that Islamic Bangladesh as well as other Muslim dominated countries like Indonesia, Iran and Iraq witnessed no major resistance. No polio cases have been reported from these countries for years together, said the WHO expert Housam Latif to this researcher. Sudan born Latif has followed the pulse polio programs in Indian sub continent as well as in other countries. "Afghan refugees in Pakistan eagerly participated the polio immunization programs as there was lack of public health services in refugee camps. In predominantly Muslim Egypt and pre-war Iraq as well as Islamic Iran there was no opposition to immunizations including pulse polio." These experiences indicate that the a good section of Muslim community turned resistant in countries where they are in minority or contesting the political space with other ethno-religious groups. The fear of sterilization in the guise of immunization is also rampant. In an obvious reference to India, the USP report noted that "another conspiracy theory emerged regarding this issue and was widespread in the 1970s during the country's 'emergency' exercise of state power in the name of population control." "Vaccines also have been associated with negative beliefs about family planning in some countries in South America."[9] "In some countries, introduction of foreign vaccines has raised concern about national boundaries and a sense of moral geography. Fears have been expressed about violation of national security through collection of computerized data on the genetic makeup of the population," it recorded.[10]

Internal political factors are no less important. Overt or covert ethno-centrism became the birth-signs of most of post-colonial nation-states. Ethnocracy has hegemonized a large section of the 'national' civil societies and ethnic cleansing has found legitimacy among 'mainstreams' during the globalization onslaught. Forced homogenization and construction of a tailored 'nation' have alienated various kinds of minorities fueling sectarian clashes and civil wars. The elite groups within minorities use popular apprehensions about polio and other immunizations to bargain with national government as well as international community, as it happened in Nigeria, Sudan and Angola.

The North-South clash in Nigeria and Sudan, the deep antagonism between Islamabad and frontier tribes in Pakistan, civil wars in Somalia, Sudan, Chad, Angola and Afghanistan — all contributed in the resistance. Refugees of civil wars, forced migrants and internally displaced population are considered not only most vulnerable to the infectious diseases but to the "resistance syndrome" also. Frustrated over the

"irrational fears and illogical resistance", extreme coercive steps have been taken in some countries of global south. In late 2002, military was sent to Soumarana in Niger to surround the village while vaccinators were there. However, it was counterproductive, reported a 2003 evaluation paper co-sponsored by WHO and Niger government.[11]

In Indian subcontinent, Bangladesh is considered a success story in polio eradication. While Delhi-Dhaka row over 'Bangladeshi infiltration' and 'shelter to Indian ultras' have made the bilateral relation frosty, PEI partners feared different kind of infiltration and subversion from Indian side. Why Bangladesh fared better in comparison to India? Better performance in comprehensive child vaccination much before the polio eradication campaign, much smaller and cohesive society, extensive social mobilization at grassroot level by NGOs and huge external fund support – all seemed to have contributed in the chemistry. "Bangladesh has made phenomenal progress since 1985 when coverage was less than 10 per cent. Universal Children Immunization program was adopted as a high priority by the government and strongly supported by donor community. The Expanded Programme for Immunization was expanded from eight upazilas in 1986 to all 460 by the end of 1989. Extensive social mobilization was the focus of the activities, which emphasized reducing drop out rates and completing the full series before the first birthday. Many non-governmental organizations, in addition to the family planning network, provided extensive support. By 1990 entire areas of the country exceeded global goals and overall coverage exceeded 60 per cent."[12]

I

The Indian scenario

India's 'health for all' policy, dubbed as 'health for too many', suffered ill preparation before the introduction of PEI in 1995. "Despite the implementation of a universal Immunization program for many years, only 35.4 per cent of the babies between 12-23 months had received all vaccines in the schedule and only 53.4 per cent had received all the three doses of the Oral Polio Vaccine in the early nineties."[13] Even in 2000-01, Government of India report conceded that only 43.6 per cent of children were immunized before 12 months at all India level while 49.8 per cent children were considered' fully immunized. Only 70.4 per cent of children have received third dose of the OPV.[14] Country's child population has swelled 93 million in 1995 to 167 million in 2003.[15] In view of the sheer number, it is a gigantic task to immunize all the children aged 0-5.

Even if "India has made extraordinary progress towards polio eradication in 2004,"[16] the country still stands second highest in the tally-sheet of the world's polio victims. One of the major reasons is pathetic condition of the basic health care

infrastructure. The IEAG December 2004 report pointed out that 40-20 per cent of the medical officer positions were vacant in high risk areas in UP and Bihar.[17]

PEI has achieved moderate success in India since it has been launched in1995 in the country. The country recorded 1934 polio cases in 1998. The number had gone down to 268 in 2001. So India Expert Advisory Group for Polio Eradication (IEAG) hoped to "reach near the goal of total eradication" in 2002. However, the program suffered a 'setback' in 2002 due to major outbreak in UP and spillover transmission in other neighboring states. From 268 cases in eleven states in 63 districts in 2001, the cases rose to 1600 in sixteen states in 159 districts. Reworked strategies increased number of National Immunisation Days and SNIDs (Sub-national) followed by intensive house immunization activities. These contributed in reducing the number of cases to 225 acroos 87 districts in 2003.[18] A WHO report, however put the 2003 tally at 220. In 2004, the number was 130. In 2004, in addition 130 confirmed cases in the country, the WHO report showed as many as 100 cases of "wild virus reported from other sources", which meant "wild viruses from environmental samples, contacts and other non-AFP sources".

Most affected states are UP and Bihar. "Majority of the cases-80 per cent-were traceable to UP in northern India, a state that had never in history disentangled itself from polio and alone accounted for 66 per cent of the world cases. And within UP it was communities concentrated in the densely populated, industrialized west, that formed the world's epicenter for polio."[19] UP has been the worst reservoir of the wild poliovirus as well as the home of most of the polio victims in the country According to the IEAG December 2004 report, almost all the recent polio cases in the country had origin in western UP. More than 50 per cent of the Bihar cases, virus was originated in the region while two each cases reported from Mumbai and West Bengal had the same source. Sixteen districts in western UP and 13 districts in central-north Bihar have been identified as 'high risk'.[20]

NPSP figures pointed out UP tops the list of the victims since 1998. Out of 1934 cases in 1998, 881 were in UP. In 1999-2000-2001-2002, the corresponding figures for the state were 773-179-216-1242. In 2003–04, the record was still unbroken. In 2003, the UP tally was 88 while it stood at 78 in 2004.[21]

UP is followed by neighboring Bihar (39), more than double of its 2003 tally (18). Karnataka and West Bengal which had reported 36 and 28 cases respectively in 2003, came down to one and two successively in 2004. Delhi, the national capital as well as Maharashtra, Haryana Andhra, Tamilnadu and Uttaranchal also recorded polio cases in 2004. According to the IEAG report, Western UP and Bihar are still principal risk areas. However other 'potential risk areas' for ongoing transmission of wild poliovirus include central and eastern UP, West Bengal (particularly Kolkata and surrounding areas) and greater Mumbai. Wild poliovirus has been isolated in Mumbai sewage for a substantial period, from December 2003 to July 2004. As long

as wild poliovirus circulates anywhere, all other areas of India remain at the risk of importation, particularly those with large immunity gaps such as Assam, noted IEAG in June 2004.[22]

"India is now faced with a serious challenge to eradicate poliovirus in the shortest period of time. Global attention is now focused on how soon India will be able to complete the task," cautioned the NPSP-GOI guidelines 2004.

Victims are not Muslims alone

The National Polio Surveillance Project (NPSP) in India, a WHO-GOI collaboration, as well as UNICEF has pointed out that overwhelming majority of polio victim children in India are Muslims. The IEAG also "stresses that continued attention must be given in accessing underserved Muslim population in the highest risk areas through specific strategies, both in operations and communications"[23] But contrary to the media reports and general impression, these official records also revealed the fact that children from Hindu families too have substantial share among the victims. The UNICEF working paper on UP also noted that apart from Muslims, "Scheduled Caste Hindus, Scheduled Tribes and the poor that are deprived of access to basic services have moulded a resistant attitude against the free polio vaccination service." During 2000-04 Muslim Children comprised 54-69-57-52-62 per cent of the victims respectively in the successive five years.

A comparative study of NPSP data on UP, Bihar, Karnataka and West Bengal also reveals that there is no uniform pattern in the community-wise distribution of polio cases. In UP (excluding Uttaranchal districts in 2000), the percentage of Muslim children among victims were 62-74-59-68-79 per cent during 2000-04. Hindus were 38-26-41-32-21 per cent during the same time. But the pattern was found to be reverse in Bihar. During 2000-04 (excluding Jharkhand districts in 2000), Muslims comprised 6-33-37-50-28 per cent while Hindus counted for 94-67-63-50-72 per cent of polio victims during those successive five years. In Karnataka, 62-94-100 (2000-03-04) per cent of victims were Hindu. In contrast, West Bengal recorded 62-100-98-100-100 per cent Muslims among victim children during 2000-04. In absolute numbers, 47 out of 49 in 2002 and all 28 in 2003 were Muslim children. In 2004, Sk Afridi and Muskan Khatoon were two male children who were recorded as polio victims in the state.[24]

According to the NPSP as well as IEAG reports, immunity gaps between the Hindu and Muslim children have been narrowing following social mobilization efforts since 2000.The number of Muslim children insufficiently vaccinated in western UP had gone down from 29 per cent to 25 per cent in 2004 and among Hindu children, from 14 to 2 per cent over the same period.[25] In west Bengal also, NPSP claimed on the basis of a sample survey that total per centage of immunized children has gone up to 96 per cent in 2004 from 87 per cent in 2003. The percentage

of total 'zero dose' children has decreased from two per cent to one cent between 2003 and 2004. The immunity gaps between Hindu and Muslim children have also narrowed down. In 2003 two per cent of Muslim and one per cent of Hindu sample reported 'zero dose' while seven per cent of Hindu and 14 per cent of Muslim children missed 1-3 doses of OPV. In contrast, the immunity gap in zero dose group has come down to one per cent for Hindus and two per cent for Muslims. In the 1-3 doses group, it was seven per cent for Muslims and one per cent for Hindus till the 43rd week in 2004.

Resistance

Nevertheless, why majority of India's polio victims are Muslim Children under 2 years of age? "Many of these children's immunity wall can not be fortressed, for doors are shut from vaccinators, allowing the virus to stay alive, intrude and strike," Observed the UNICEF report. The UNI agency commissioned an EPOS study in districts in Western UP. The study found the reasons behind resistance "multifold and complex". Fear of sterilization in disguise of immunization is one of them.

"The repeated rounds of NID and SNID, with eradication rationale not readily understood by many, especially the illiterate, have created the impression that the polio drops are used to control population growth. The association is particularly strong among the underserved Muslims and scheduled caste Hindus who known for spawning offspring above the national average of three have been high target of birth control. When OPV becomes the next most visible and available free public health service other than condoms, contraceptives and vasectomy, the two appear to add up. Rumours start spreading, and spread like wildfire."[26] "Many Muslims took the infertility rumour seriously primarily due to their bitter experience with the family planning as well as some kind of minority complex," the paper quoted a Unani physician in Meerut.[27]

The study clearly reflected that there was no resistance to the OPV per se on the ground of "religious superstition" as commonly believed. But it underlined minority community's political and mass psychological fear of a being besieged and threatened. "Earlier, we used to give vaccine so our children would not get polio. But now we will not give the vaccine because the entire mohallah is saying that they are adulterating the vaccine and there is now a concoction for making our children infertile… we are also told that there is different colored medicines for Hindus and Muslims," said a Muslim mother.[28]

The study also revealed another secular face of the resistance that is hardly acknowledged by official India. The sheer 'despondency 'of the underserved communities, irrespective of caste and creed, with the public health service and other civic amenities found virulent expression government health and other machinery suddenly turned benevolent on pulse polio days.[29] According to a preliminary survey

by Aligarh Muslim University, the underserved resistant Muslim '*zats*' or castes included "largely illiterate Qureshis(Butchers) Ansaris (weavers, Gaddis (milkmen) as well as some Scheduled Caste people among Hindus." While the 'infertility rumor' provoked the resistance, it runs deeper and is intricately linked to resentment over the paucity of support for their need of basic services and public utilities.[30]

"A common perception was that the administrative authority was 'gaining something' out of the polio program, and it was 'their' program, and they gave community nothing back in turn. In Some cases this perception was reinforced by the community's ability to use polio as bargaining point for getting the services they need."[31]

According to the NPSP officials who have worked in UP as well as in West Bengal, there is certain difference in the resistance in the two states. Even if the resistance to pulse polio campaign is substantial and more widespread in UP, it is still more covert. "In UP, the XR population or resistant families are 5-6 fold higher than west Bengal, Muslims are not in a position to oppose any government-run public health campaigns overtly. In West Bengal, people are more politicalised and high officials cannot go unchallenged even in remote villages unlike UP. In UP, Muslims, for that matter, common villagers hardly dares to confront the authorities. So their resistance is far less expressed than their west Bengal counterparts," said one NPSP expert.

Contrary to prevailing trends in West Bengal, the UP resistance is not cemented around developmental issues. "Perhaps it's better to face a resistance related to development. At least it is negotiable. Facing irrational fears, we feel like entering into a blind alley," he observed. "It is unlikely that Muslims and scheduled caste Hindus would boycott pulse polio or routine immunization on developmental issues in UP, he added. Political commitment to the pulse polio campaign is much lower in UP, he felt. "Chief minister Mulayam Singh Yadav has written a letter to all concerned to make the PEI a success, but there is hardly any popular political and institutional mechanism like elected panchayati raj to translate that message in reality," said the expert.

Not only Muslims and some SCs in UP but tribals in south Rajasthan's Dungerpur district resisted polio vaccine fearing their children would become sterile. In Jaipur upper caste Hindus too complained of post-vaccination death. Kolis in Gujarat refused polio vaccine on the ground of safety. From Gujarat to West Bengal people refused the same alleging vaccine associated polio paralysis. Some groups having general distrust of Allopathic medicine or vaccines also refused. In south Bihar, Tena Bhagat tribe's association with anti-Western, anti-colonial agitation is continued today in its rejection of Western medicine Not only poor, minorities and marginals, but also middle class and affluents in both rural and urban areas too refused pulse polio expressing doubts about the quality of the OPV drops. In Bhind-Morena at UP-MP border, affluent Thakurs refused to let their children be given the

drops unless they are from new ampoule. The fear of contamination by lower caste children was clear.[32]

Re-run of the colonial experience?

The resistance to polio vaccine in Muslim mahallahs has reinforced the dominant discourse that "inherent backwardness and conservatism" of the community has made it misfit in modern world. Also 'their' resistance has endangered 'our' children crippling the future generation of 'mainstream' India.

But earlier studies showed that Hindus, Muslims as well as 'westernized Parsis' joined native resistance to colonial vaccination campaigns during Plague, cholera and small pox epidemic in nineteenth century. The native opposition to smallpox vaccination provoked British medical officers to castigate Hindus for being "naturally averse to all innovations". They denounced the 'prejudices and indolences of the natives' and the "doctrines of fatalism, which inculcate resignation to the ravages of the small pox, blamed native's astonishing indifference to the very great blessing that government offers to them through vaccination". In 1840, the British in-charge of the vaccination campaign rebuked Hindus and "the trammels of a degrading religion by which their thoughts are chained, their reasoning faculties hoodwinked and their mutual affections thwarted".[33]

In 1896-1900, British government's plague policy provoked fierce resistance, often violent. The administration deployed police and army to comb out plague suspects from native homes, ordered forced hospitalization and quarantine of natives irrespective of caste and religion in different parts of country. The 'seizure' of women and their removal to camps, medical examination of men and women at public places like railway station, compulsory autopsy and intervention in last rites of plague victims as well as racial contempt of European doctors and troops added fuel to native anger. "Outright resistance" as well as "evasion and concealment of plague corpses" became common.[34]

The colonial administration justified the drastic measures in the greater interest of containing the epidemic. But the native press like Tilak's paper *Marhatta* protested against the "unprecedented, systematic interference with domestic, social and religious habits of the people". Infuriated, the Chapekar brothers assassinated Pune's plague commissioner Rand. His colleague Lt Ayerst was also killed earlier.[35] The English press and government deplored the Chapekars as "fanatic and superstitious Brahmins" but they are still revered as great freedom fighters.

Official reports commonly referred to "illiteracy and superstition as the primary preventive to the acceptance of vaccination" and "generalizations" about "backward society's incapability to recognize the value of modern science". But many colonial officials presented "extremely complex analyses of the practical

difficulties" and great credence was given to the "secular bases for opposing vaccination" and therefore "finding ways to mitigate these problems".[36] "Underlying almost all rumor was an assumption of British self-interest and spite, a readiness to victimize and sacrifice Indians for preservation of British power," observed David Arnold. "A deep suspicion of the nature and methods of Western medicine" only compounded the resistance. The larger socio-political issues like devastating effects of famines, talk of overpopulation, British geo-political interests in its competition with other imperial powers, growing political opposition to British rule offered the thread to the fragments of fear. A coherent pattern in the "nonsensical, irrational popular discourse" and "rumor informed actions" were also found.[37] To use Daniel Headrick's famous phrase, medicine was considered as a "tool of empire" in popular perception. As Rosemary Fitzegerald has pointed out, native Hindus and Muslims considered even missionary medicine as "clinical Christianity".[38]

The political consequences of the resistance led the British administration to change most coercive and unpopular aspects of the plague policy. A colonial social mobilization strategy was introduced with greater reliance on "leading men" or respectable native gentry as well as Brahmin Tikadars, religious leaders, Hakims and Vaids. A similar quest for influence through community leaders characterized the protracted campaign to bring small pox vaccination to the four million Farazis of eastern Bengal.[39] Though most of the "anti-vaccination rioting" was done by the 'lowly people, native landed gentry and rising middle class reaped the harvest of resistance. Local elites, the forerunners of today's civil society, contended for legitimization of their social and political authority in native affairs as well as recognition of their traditional privileges in class and caste hierarchy even as plague or small pox victims.[40]

Today, it appears to be almost a re-run of the colonial experience. The government bureaucracy and mainstream middle class civil society is scornful of "ignorant and superstitious masses" even if many of them skipped polio vaccination to their own children (example, East Midnapur district in-charge of pulse polio campaign in October 2004). The community religious and other opinion leaders have been engaged to social mobilization to break the resistance to pulse polio, as long as they are politically correct. When the traditional leaders are ineffective in pursuing the masses on non- traditional issues and failed to break the new kinds of resistance, both carrots and sticks are used to tackle the situation.

Sterilization fears among Indian Muslims

Free Indian state with its founding belief in unity in diversity as well as parliamentary polity was not expected to witness the resistance to polio vaccination as in Nigeria. Despite the top –heavy approach and failure of 'delivery mechanism', no major clustered political resistance to immunization and government sponsored public health initiatives was reported till early seventies.

But Nashbandi or forced sterilization drive under population control program during Emergency made the community highly suspicious and resistant to subsequent state sponsored public health and family planning programs. "Unfortunately, this had unleashed excesses such as forcible sterilization on men — young and old alike, within a general atmosphere of muscle power in northern India. Tragically a sizable segment of India's intelligentsia supported this approach which included punitive action against the persons with dissident."[41]

However, researchers like Emma Tarlo have pointed out that not only Muslims alone, but also people of lowest socio-economic strata of other communities were target of the regime's two edged policies of controlling body and space-Nashbandi and demolition of unauthorized dwellings in Delhi. "The fact that such citizens generally refer to the Emergency as Nashbandi ka waqt (the sterilization time)and that some even think that the term emergency means 'sterilization' gives an atmosphere of the time," Tarlo observed[42] When civil society elites considered it a "temporary eclipse" of Indian democracy. The Nashbandi trauma became ingrained in the collective memory of Indian Muslims following riots and carnages of eighties and post–Babri-Ram Janambhoomi riots and carnages. "During my research from 1995 to 97, conversation about the Emergency often included reference to this recent violence, particularly in the Muslim–dominated section of the colony (resettlement colony of the emergency victims) where some thirty people had allegedly lost their lives and where homes, shops, mosques and markets had been violated," she recalled.[43]

"Mistrust reappears in the 1990s, a time of increased ethnic and religious tensions and while clinical trials were being conducted on a new anti-fertility vaccine in the country," observed the US Pharmacopoeia report in an oblique reference to Indian situation.[44] Finally the post Godhra-Gujarat massacre reinforced the fears and insecurity-induced alienation and mistrust among a large section of Indian Muslims. This has adverse impact on recent rounds of pulse polio campaigns too. Even in Left ruled West Bengal where minorities have not been affected by major riots, some Muslim villagers at Magrahat in South 24-Parganas complained about "Gujarat-like sinister designs to exterminate Muslims" following two post-vaccination deaths in second half of 2004.

The NPSP experts noted that the special drives of intensive pulse polio campaigns targeting Muslim Mahallahs in UP with BJP led government at the center till May 2004 and BJP rule in some BIMARU states had resurrected the fears of *the nasbandi* period. "Our *mahallahs* experienced same kind of sudden attention of the politicians and bureaucrats, high-ups visiting our dingy homes to egg on us, so much campaigns around our areas. All these reminds me *nashbandi* days," one NPSP expert quoted an elderly Muslim in Aligarh. Post-9/11 anti-American sentiments also contributed greatly reinforcing the minority discourse of "conspiracy to depopulate or

decrease the procreation ability of Muslim children". Even in late 2004, some of our respondents in Left ruled West Bengal expressed the same kind of fears. However, the government authorities and international agencies shy away from acknowledging the political aspects of the resistance. But they take pains to reassure the Muslim masses that UNICEF and WHO are procuring polio vaccines from predominantly Muslim countries like Indonesia. Even if the vaccines are also procured from multiple sources including Western and local companies, the half-truths are justified "in the greater public interest".

But the image of UN agencies has been badly eroded in the eyes of the common respondents. "We don't believe in the UN after Palestine and Iraq," said an educated young Muslim father in East Midnapur in October 2004. He refused to allow OPV to his children after a Bengali daily had published a PTI report over OPV export from Britain, allegedly made of serum collected from bovines suffering from Mad Cow disease. This report affected pulse polio in October-November rounds badly in several districts in West Bengal.[45] The abovementioned report or 'follow-up story' was published in several vernacular and English newspapers also. The controversy was four years old. WHO Geneva office had already issued clarification denying procurement of such contaminated OPV vials for global PEI . But this hardly reassured the people at the ground level as the reaction of the person revealed.The publication of Bengali translation of Nigerian scientist Haruna Kaita's interview in a limited circulation community periodical *Kalam* in August 2004[46] stiffened the resistance to pulse polio and panicked the fence-sitters in some south Bengal districts. The periodical changed the tune later, presumably under pressure. The central and state governments as well as country offices of the WHO and UNICEF choose to 'ignore' the publication and subsequent adverse campaign among target population. But many an insiders felt that the silence only made the allegations credible in the eyes of the commoners.

Social Mobilization Strategies

Much before the Global Polio Eradication Initiative, the need for elaborate social mobilization plans were felt during WHO-sponsored Expanded Programme on Immunization (EPI) to protect children against tuberculosis, measles, diptheria, whooping cough (pertussis), tetanus and polio in 1974. It was estimated that approximately five million children died each year during the late seventies from these six diseases.

"The quest for Universal Children's Immunization forced the health systems in many countries to initiate collaboration outside the health sector, often for the first time. Wide and innovative use was made of the influence and goodwill of religious leaders to promote immunization. From Moslem leaders in the Middle East and Asia to Christian priests in South America and Buddhist monks in Asia, religious leaders have played a key role in convincing parents of their responsibility to immunize

children. Promotional materials have been developed on the basis of religious texts and teachings."[47]

Role of mass media as well as puppetry and other traditional form of entertainments were explored to reach out to communities. Celebrities in all walks of life as well as politicians, intellectuals, teachers and opinion leaders were engaged in educating and motivating people. PEI should have inherited the rich experience.

Instead, PEI's original strategy mainly viewed communication as having an informational role. The underlying premise was that making vaccines available would be sufficient to get children immunized. It was implicitly assumed that motivation to vaccinate children already existed.

Role of Muslim Religious Leaders in India

Unlike Nigerian Ulemas, Indian Muslim religious authorities did not oppose polio vaccination campaign openly even though they harbored suspicions about the "sterilization conspiracy", particularly after 9/11. A good number of them lend their support to the social mobilization campaigns initiated by the UNICEF with the help of the central and state governments. The community educational institutions like madrasahs, and universities like Aligarh Muslim University, Jamia Millia Islamia, Jamia Hamdard as well as Milli Council were involved in UP, the worst-affected state. From AMU the UNICEF and its partners roped in Vice-chancellor to local mosque Imams. "The alliance with partners in Muslim world of UP is closely linked to another strategy: the social mobilization network made of over 3000 community mobilizers work in sync with a host of international and national partners and NGOs."[48]

The initial hiccups notwithstanding, the Left Front government in West Bengal also accepted the need to involve religious leaders following 2002 polio outbreak in the state. Ulemas, from revered scholars to village mosque Imams, madrasah teachers and students as well as other community opinion makers have been involved. A number of UNICEF-supported NGOs like Amanat Foundation Trust (AFT), Catholic Charities Krishnagar (CCK), Child in Need Institute (CINI) and Ramakrisna Mission Lok Shiksha Parisad affiliated Guchha Samitis have been pressed into action in minority-dominated districts.The Marxist ministers and ruling party leaders too shared podiums with the religious leaders. A sizable section of Ulemas, both in UP and West Bengal disproved the stereotypes about "Mullahs".

Interestingly, though pulse polio advocacy by the religious leaders was couched in the religious parlance, they did not question the hegemony of Western medicine like their predecessors in colonial India. They maintained that the prophet of Islam had always asked his followers to take care of the children's health and prevention against diseases. So there is no hitch between Islamic teaching and medical science. But their position was not uncritical. They dispelled the misgiving

that the OPV would lead to sterilization but made it clear that they are not in favour of state-sponsored family planning. "Children are Allah's blessings to us. As long as Western vaccines make their lives safe, we will welcome it. But family planning bogey is an American-Western conspiracy to usurp world resources from rest of the mankind," said Dr Raisuddin, Jamate-e-Islami leader in West Bengal.[49]

In UP as well as in West Bengal, advocacy booklets were prepared in vernaculars to elucidate health in the context of Islam. Various verses of the Quran are quoted to elicit parent's sense of responsibility for their children's health. Series of sensitization, brainstorming and planning workshops were held involving Imams, Moulavis, Qazis, Hafez and Qaris. They were inspired to develop Islamic-oriented polio communication materials. To dispel fear about polio drops, CDs, video and audio cassettes, pamphlets, posters etc that carried messages from religious and other respected community leaders were distributed among target population along with messages from cine or cricket celebes. Imams were urged to motivate believers to accept OPV administration or announce dates of next pulse polio round after the Friday prayers at mosques and Idgahs. Religious authorities like leaders of Darul Uloom in Deoband or Mahajir ul Uloom in UP and Imam of Kolkata's Nakhoda Mosque and Imam of Id congregation at Red Road in the city became instrumental in encouraging lower levels of Islamic clergy and others to lend their support to Pulse polio campaigns. Pulse polio booths were set up at many mosques and other community institutions like madrasahs.

It is interesting that PEI partners in UP also roped in a good number of influential Unani physicians for their support. The Islamic traditional medical practice that had contested the hegemony of western medicine along with other indigenous medicines in colonial India still retains some impact on popular health practices in the state.[50] Since the hegemony is globally accomplished, WHO-UNICEF-CIDA could afford to co-opt some "practitioners of some local medicine", at least on tactical ground.

Similar efforts were made in West Bengal to wean over the army of 'quack doctors', mostly holders of bogus or unrecognized medical degrees, who mint money by dispensing allopathic treatment to villagers and slum dwellers. Some of them had supported the pulse polio programs while many proved to be fence-sitters, disfavouring polio drops in private. In some areas, these quacks as well as a number of Homeopath practitioners, both Hindus and Muslims, put additional impediment to pulse polio campaigns. A good section of villagers had been greatly influenced by their opposition to OPV. When persuasion did not work, coercive steps including administrative –political pressures were exercised to "neutralize" them. Even one person was arrested in North 24-Parganas during the January 2005 round.[51]

The opposition of Md Salim, a homeopath as well as the CPM state committee member and former secretary of the Birbhum district committee, is an

example in this context. “I am a homeopath. Polio drop should not be given to chlidren without blood test. I am opposed to the Pulse polio campaign,” Salim argued while refusing to allow the vaccination of four children in his family during November 2004 round. Few other families in his village also cited his instance as ground for their refusal. Since media highlighted his opposition and political rivals tried to earn brownie point over CPM on this issue, the party state leadership condemned Salim’s “unscientific attitude”. In January 2005 round, Salim succumbed to the pressure.[52]

In West Bengal, UNICEF supported Muslim community NGO Amana Foundation Trust is instrumental in mobilizing religious support for Pulse polio. The organization played a significant role in development as well as dissemination of a community public health discourse based on fusion of Islamic scriptural guidance with Western scientific modernity. Important individual like Quri Failure Raman, the Imam of Red Road prayer congregation, Dr Raisuddin, the leader of the state unit of Jamat-e-Islami and Twaha Siddiqi, a scion of influential Pir sect of Phurphura Sarif joined AFT’s campaign.

AFT project director for PEI and intellectual Abdur Rauf highlighted traditional importance of the Imams, Maulanas and Mouvies as popular mass communicator and community educators. The AFT main organizer Shah Alam quoted from different Hadis, Fiqah as well as holy Quran to draw his point home. He regretted that despite Islam wanted its followers to adopt preventive measures to check diseases, immunization campaigns are still not popular among Muslims. He urged the Imams to teach believers about the importance of immunizations as well as general health care and environmental awareness.

“Islam does not concern about spirituality alone. It is a complete guideline about the earthly life too. What we will answer to our future generation if they turn into polio victims due to our misplaced fear and ignorance? Vaccination was not invented at the time of the holy prophet but he always cared for the secure and healthy growth of the children. There is no clash between the modern technology if they are used for public welfare,” Alam explained. The social significance of the workshop was self-evident as a large number of Imams and ulemas participated in vibrant discussions throughout the day. The motivation of the participating Ulemas was evident as they asked the UNICEF consultants to continue their discussions despite the call for the afternoon prayers. It was another matter that the all male workshop pondered over the problems of making the breastfeeding popular among mothers for better growth of children.

There the skeptics within NPSP-UNICEF and outside questioned the wisdom behind the legitimization of “Mullah authority”. There are other skeptics too. “The religious leaders helped us a lot in the immunization campaign after outbreak in Mursidabad. However, some Maulanas are quite smart. They are running with the hares while hunting with the dogs,” said a state health official in West Bengal. For

the majority of religious leaders, the motivations were two-fold. Recognition from the government and international agencies as traditional community opinion leaders is similar to the aspirations of native leaders during plague, small pox and cholera vaccination campaigns in Raj days. Secondly, recovery of the traditional ground from the political parties and panchayat leaders, the new rural elites, is also rewarding.

But not all the religious organizations and personalities have joined the UNICEF sponsored SM. While fear of American conspiracy to sterilize Muslims was reason for some of them to suspect the PEI, political allegiance, personality clash and inter-organization rivalries are also rampant. Jamate Islami and Jamate Ullemah-e- Hind or organisations of theAhale-Hadis sect has not joined organizationally. Since UNICEF is funding only Amanat among the Muslim organizations, others seems to have not taken it kindly

While the state controlled Madrasah Board has been instrumental in involving Madrasah teachers and students of 508 recognized Madrasahs as social mobilizers, they distance themselves from their counterparts in vast number of private madrasahs. These Kharizi or Nijamia madrasahs are in thousands and located in remote areas. The state government officials suspect these madrasah are source of some clandestine resistance. But they could not offer any evidence to substantiate that. Some of the Board officials observed that many of these private madrasahs were eager to join the 'mainstream' both by accepting the Board syllabus as well as join Pulse polio campaign. While official campaign managers have courted some influential Maulanas associated with these private madrasas, no warm overture were made to the whole group as it would legitimize their demand for share in social leadership as well as government recognition and grants. The reasons are as political as financial.

The cautions

But some observers pointed out to the limitations of community leaders. Village Imams are considered opinion leaders of the community at the grass root level. Many of them were approached by the governments, UNICEF and NGOs to ask the believers to accept OPV and PP during their *Khutba* after prayers. But most of the Imams are actually poor employee of the Mosque committee, getting salary of Rs 600-1200 PM and two square meals from the well-to-do families. They are more dependent on the influential and moneyed members of the committees or village 'Murubbis' "Many a Imams told us that he would advocate immunization only if the Murubbies are ready to accept. They have the fear of loosing their jobs," said Amanat south Bengal co-coordinator Sumsur Mallik.

Others focused on the inability of the religious leaders to break new kinds of resistance which is more related to bargaining between the state-civil society collaboration and non civil society people on developmental and citizenship rights issues. " I have been trying hard to dispel fears about polio drops at every occasion.

But that alone cannot convince the people. The government has to take care of economic and job related grievances of Muslim community. I told the chief minister that the government only turns up to us only when it faces trouble. But if keep mum on material problems, people would question our legitimacy,'' admitted Quri Fazlur Rahman.

The dilemma was summed up by Abdur Rauf. "The residents of the underdeveloped and underserved areas now want to take the advantage of the government's attention as well as compulsion to air their grievances and press for their demands. Unfortunately, Muslims constitute majority of these underserved people. In this situation, the initial success of Amanat foundation in gathering a positive public opinion has received a jolt. Having faced the new kind of resistance, the activists are feeling somehow helpless." [53]

This admission underlines the fact that the social mobilization campaigns for the PEI, despite gigantic efforts, huge expenditure and commendable involvement of community leaders, cannot be considered an end in itself. The effective communication is always a two way traffic, a dialogue. But the official SM managers are in a mood to "educate the ignorant masses" and want the community leaders to fit the surrogate role, thus turning the SM essentially a monologue. The politically correct professionals, bureaucrats hardly want to fathom the popular multi-layered fears and grievances but keen to "manage the local resistance problems" either by giving some illusive assurances on issues close to people's hearts or by resorting manipulative-coercive steps. "We live by rounds," commented an UNICEF official candidly. Target population, once responsive, tend to view the SM people including community leaders as establishment men after few rounds and turn their backs.

The Waisboard report called these "missed opportunities" to promote immunization programs and other health goals. Communicating about polio campaigns also presented rare opportunities to promote other vaccines, other health information and practices, and other development programs. Most communities have had numerous, long-standing unsatisfied needs. In some cases, NIDs have been used to promote other immunization and health services, basically to have "pull-in factors" to attract populations. However, the provision of OPV through campaigns could have been used more regularly and systematically to promote the value of vaccination in general and to raise awareness about other services and healthy practices. NIDs could have been conceived as mini-health camps to build awareness about other issues (nutrition, maternal health, etc.). Having other programs and services to attract populations and maintain participation in NIDs could have benefited PE, too. Some services have been offered such as immunization, health services (malaria prevention, ORS, vitamin A, reproductive health), birth registration, or educational programs to increase synergy among programs. However, a wide set of services has not been offered sufficiently, particularly in communities that demanded other services in addition to OPV or questioned why OPV was the only service available."[54]

A UNICEF report, too, recognized the problem. "The return of a people's movement to the polio immunization program, albeit on a smaller scale and involving mostly the Muslim community, is currently felt. It marks a good start to the endgame to eradicate the disease. But the goodwill and support garnered should not be taken for granted, for the minority has demonstrated through the epidemic outcome that they play a vital role in fulfilling a goal of national and global interest. Their needs must be heeded, their voices heard, and their contributions recognized."[55]

II

Resistance in West Bengal

The decision to concentrate the field studies on West Bengal, my home state, is for obvious reasons. I could not visit UP and Bihar because of fund constraints. Secondly, West Bengal is one of the high-risk states that had been just behind UP and Bihar in the national list of polio victims till 2003. Thirdly, Muslim community comprises 25-26 per cent of the state's population. The majority of the polio victims in the state are from the same community. Further, the study of resistance in west Bengal is politically more significant in view of the secular credentials of the ruling Left Front as well as decentralization of power institutionalized through three-tier panchayati raj.

Though media reported many incidents of resistance to pulse polio on different grounds and officials are full of anecdotes on it, no comprehensive study of the resistance has been initiated by the state government so far. Nor any state-specific mobilization strategy and policy guidelines are in vogue. In fact, the UP guidelines have been implemented in West Bengal on ad hoc basis.

I have not come across any comprehensive study in West Bengal to ascertain whether the parents of polio victims were really resistant/reluctant or they failed to avail routine/PP immunization due to other factors like lack of awareness, illiteracy as well as lack of access to information about immunization dates and places, locational disadvantages or distance from the health centres, workloads, poverty and priorities for sustenance, etc.

Experts working with international agencies as well as state government officials felt that the 'polio outbreak' in 2002, mainly in minority-dominated Murshidabad, evoked a knee-jerk reaction from the state government. Goaded by the international agencies, a top-down propaganda campaign has been launched since then to curb the resistance. It has been acknowledged privately by the state health officials as well as the WHO/UNICEF officials that the government's immunization programs as well as health care apparatus failed to reach out many a rural household during the earlier rounds. This has also contributed in facilitating the proliferation of wild poliovirus.

But no honest and comprehensive efforts were made to identify the reasons for that system failure either. At least they are not placed in the public domain.

The Tip Of The Iceberg

Since the resistance to oral polio vaccination is not politically correct, neither governmental health bureaucracy nor the international agencies collect and collate database to ascertain the size of resistant population, both overt and covert, at state or national level. There is no reliable database to estimate the size of resistant population even in Left ruled West Bengal. The official tendency is to belittle the resistance or "avoidance behaviour" as "local problems" despite its clear general patterns across the state and national boundaries.

Nevertheless, resistant blocs and villages even such families in some areas have been identified and mapped mainly by the two international agencies, WHO and UNICEF with the inputs from lower-rung health department staff and NGOs. District task forces headed by DMs have been formed to coordinate all agencies. Sporadic notes on reasons behind the resistance in particular areas, prepared by enthusiast government or WHO-UNICEF officials, have been in circulation in the DTF meetings. But these notes hardly provide tangible helps in developing a macro database as well as comprehensive social mapping of the resistance at the state level.

The WHO-UNICEF codification for unimmunized and vaccinated children is as follows:

X — household where all children are not vaccinated
XR — overt refusal of vaccination
XO — no one is at home, there may be eligible children
XL — door is locked, there may be eligible children
PO — no eligible children in the house
P — children in the house are all vaccinated[56]

Officially, parents of 'left out children' or XO/XL households are not considered resistant. But unofficially, chronic XO/XL houses, families sending their children to "maternal uncle's home" regularly on pulse polio days as well as defaulters avoiding OPV on "child sickness" ground or rounds together are considered part of the "hidden resistance". In that case, the number of resistant population will shoot up manifold. The WHO-UNICEF-NPSP experts and state health officials admitted. But number of such families is never recorded officially. The official consolidated reports from the states do not even mention XR population but only reports the number of the X houses generated by the vaccinator teams and number of such houses converted to P and finally number of the households left after the activity at the end of the round. The NPSP-GOI official operational guideline for the PPI programe also mentioned some behaviors as manifestation of hidden resistance but did not codify them.

"Few districts maintain the figures on their own for the sake of shaping local level strategies. We do not collate or tabulate these figures at the state or national level since the reasons as well as locations of vaccination avoidance or resistance vary in each rounds," argued the officials. But the real reason for avoiding the exercise is simple. "We do not concentrate on this aspect of the total activity. After all, government high ups and donor agencies are not interested in nitty-gritty of resistance but in total immunization," they admitted. In this situation, the piecemeal official estimate about the resistant population seems to be the tip of the iceberg.

Consider the examples from the districts of South 24 Parganas and East Midnapur. The official number of total left out children after the August '04 round in South 24-Parganas district was 13764 which was much higher than the number of XR houses/families 2488, a "marginal fall" from the earlier round. While experts felt that absence of large numbers of seasonal migrant workers may explain the higher number of Left-out children. But the existence of left-outs in the range of 13000-14000 in successive rounds despite the influx of migrant working families in the brick clines as well as increase in the total number of immunized children had baffled them.

In East Midnapur, the picture was more clear and transparent. During July '04 round, total official number of X houses was 17577 while the XR families were 6,723. But when the number of absent families (6,676) and number of house locked (3,503) are added to the XR figure, it comes to 16,902. Further analysis shows that the total number of missed children left (Child refused+child absent+ locked house) is 16,424 which more close to the number of cases pertaining to all kinds of overt and covert avoidance/resistance. The analysis of sub-divisional figures on children of X houses in Contai, Egra and Haldia showed that the number of 'absent' and 'house locked' moved up and down in tune with the number of the refusal in between February and July 2004.

During our field study, we found that many a families reported that they children have gone to "*mamar bari*" or maternal uncle's home. On the other hand, some "mamar bari" families refused OPV on the ground that children could not be vaccinated without permission from the son-in-law or his family. Ground-level health workers and NGO workers maintained that this was a "new tactic" of the resistant families to avoid increasing administrative-political pressure to accept OPV.

Analysis of the information collected by the NGOs in different districts also confirms that number of absent children in villages on the day of house to house mop up was huge in comparison to the number of XR families expressing overt refusal. For example, AFT's report from Samserganj bloc in July 2004 recorded only seven children whose families overtly refused polio drops on 4 July in Nimtita area. In contrast, it also mentioned that 74 children were absent in the area on the same day.In Suti- II, 62 children were reported 'not willing to take the drops'. In addition to that,

81 children were absent. In Maldah's Harishchandrapur-I, only 14 children were recorded as 'unwilling' during the same period. In contrast 179 children were reported 'absent'. In Ratua I, no children were found 'unwilling'. But 119 children were reported 'absent'. WHO/UNICEF/government officials as well as NGOs maintained that the resistance had been reduced substantially, thanks to the tireless and concerted efforts for social mobilization and intensive vaccination campaigns throughout the year. But analysis of figures of booth coverage as well as house-to-house mop-ups in the last few pulse polio rounds showed that the total number of vaccinated children in 19 districts has gone down substantially in two rounds in November 2004.

Methodology

Nevertheless, we conducted our survey among 400 parents in 30 villages across five most "problematic" districts in West Bengal, namely South 24-Paragans, Howrah, East Midnapore, Murshidabad and Maldah and three wards of the Maheshtala municipality at the outskirt of Kolkata. Apart of Maheshtala, we covered eight villages close to five municipal areas in aforesaid districts. Out of 134 cases reported during 2000-04, most were reported from South 24 Parganas (38) and Murshidabad (37), apart from East Midnapore (11), Howrah (7) Birbhum (12) and Kolkata (9). The field study was conducted during pulse polio programmes between August and November 2004.

Most of our respondents are Muslims. We came across and recorded resistance among a section of scheduled caste Hindus also, particularly those who stay close to minority families. Since our study wanted to explore the gender perspective also, almost half of the respondents were women, mostly mothers. We also interacted with a large number of religious leaders, community social mobilisers as well as grass-root level health assistants, ICDS workers, doctors, WHO-NPSP-UNICEF and state government health officials and experts too. Group and interpersonal discussions as well as participatory observations during door-to door vaccination drives were among other tools that we had employed in our field study.

We had codified 12 factors behind overt and covert resistance, based on interactions with community leaders and experts. The survey was done to record the reason or reasons for refusal/avoidance, according to the stress given by respondents without citing the factors beforehand. The factors were:

1) Fear of post vaccination health hazard claiming sickness of the children as ground for refusal/avoidance
2) Fear of sterilization in the guise of immunization
3) Fear of US conspiracy and western medicine
4) Fear and suspicion of government's "sudden benevolence and over–enthusiasm"
5) Religious sanctions against polio vaccination
6) Grievances over government-run health care system and lack of post-vaccination medical support

7) Boycott of polio vaccination as a weapon of protest against actions and inactions of authorities as well as to press for developmental demands
8) Fear of family discord and domestic violence
9) Fear of social and religious boycott
10) Fear of overdose and fatigue over repeated polio vaccination rounds for years together
11) Fear of child death following post-vaccination death in the area
12) Others

Major Reasons for Refusal

Our study shows that reasons for refusal are multi-layered as most of the respondents cited multiple factors. However, the fear of health hazards, loss of limb, partial paralysis, vaccine-induced polio, even death following reports of such incidents were the most common ones. It reinforced the suspicion about the government's sudden benevolence. Grievances over government health care system and lack of post vaccination medical support also contributed largely. Grievances over developmental issues are and repetition fatigue were the most cited reasons among the respondents who did not focused on health related fears and complaints.

Fear of post vaccination health hazards

"We are not averse to polio drops. But my child is suffering from fever, cough and loose motion. Let him (or her) recover first," was the common refrain among the resistant/reluctant families, both in urban and rural areas. Others complained that their child fell ill or sporadic loose motion turned into severe diarrhoea after the pulse polio doses. It's not only Muslims but also Hindus do share same apprehensions about "adverse reactions" of the polio vaccine on an "already sick" child.

Like in other states, parents in West Bengal, too, declined to allow OPV to new-borns and toddlers. According to a NPSP analysis, 41 and 39 per cent of the polio victims in the state in 2002 (total 49) and 2003 (total 28) respectively were in the 1-2 years age group, when children most vulnerable to poliovirus attack. In 2004, both the victims were in the same group.

The UNICEF-WHO as well as government health officials, however, called the child's reported illness as well as post-vaccination health hazards as "mere alibis and most widespread manifestation of covert resistance". The NPSP-GOI Operational Guidelines for Pulse Polio Immunization Program also rubbished these fears as baseless. "OPV does not have any side effects and it does not lead to any illness. Many children get sick due to different diseases and if these diseases occur after mass OPV campaigns it is mere coincidence," declared the Operational Guidelines 2004. "OPV drops must be given to all children even those who have diarrhoea or other sickness. Administration of OPV does not interfere with

administration of other drugs or antibiotics. There is no danger of overdose. Multiple does do not cause adverse reactions," it emphasized.

Answering to the queries why do children get polio even after getting OPV, it said, "As any other vaccine or medicine, OPV is not 100 per cent effective. While adequate immunity will develop in most children receiving the vaccine, few will still remain unprotected after receiving repeated doses…The fact that some children may get polio even after receiving polio drops emphasizes the need to eradicate the poliovirus quickly."

However, we have seen during our study that WHO and UNICEF experts as well as health services doctors, ANMs and other vaccinators have confusions whether the OPV drops should be given to the children who are suffering from acute diarrhoea or high fever. While some doctors preferred to stick to the official guidelines, others thought that it would be at the least "ineffective" as the vaccine will be purged with the stool.

Credible medical literature like US Pharmacopeia did not support this attitude. "In general, OPV can be given to a child who has mild diarrhoea," said a US Pharmacopeia information collection titled 'Poliomyelitis, OPV and Misconceptions on Vaccinations', prepared with support from USAID, a US government agency and a major doner to the Global Polio Eradication Programme.

"The decision about whether or not to vaccinate a child with a concurrent illness depends on severity of the illness. (1) Mild to moderate febrile (feverish) illness not requiring hospitalisation is not a contraindication to the use of OPV. Children who are hospitalised should receive OPV before being discharged from the hospital," advised the USP literature which was also circulated by the WHO-NPSP among experts.[57] This proves that the avoidance of OPV on the ground of illness and fears of post-vaccination health hazards are common to denizens of first as well as third world.

Almost all of our respondents stressed on fear of post-vaccination illness as their reasons for refusal. While this factor was common to all other variations of responses which led to refusal/avoidance. The analysis of the micro level resistance assessment information collected by the NPSP–UNICEF representatives in districts as well as NGOs like AFT, CCK and CINI also underlined the same trend. According to the figures collected by AFT in Murshidabad during July round, parents of 158 out of 365 Left out children in four GP area (Jagtai, Lakhsmipur, Bajitpur and Kashimnagar) avoided/refused Pulse polio drops on the ground of illness of the child. In Samserganj, 16 out of 22 children reported the same. In Maldah, 25 out of 56 Left outs in four GPs of Kaliachak II reported the same. In south Bengal districts, the pattern was similar. In Magrahat, South 24-Parganas 29 out of 56 reported the illness, during July round in Mandirbazar 10 out of 38, in Hooghly's Jangipara 14 out of 35 offered the same ground for their refusal.

During August round, at Majhipara of ward No. 25 in Maheshtala at outskirt of Kolkata municipality, vaccinator team including local municipal female health worker as well as this researcher faced an irate family of CPM worker Bhola Majhi or Jahirul Haque on 22 August, the booth day. "My son was administered the pulse polio does twice. He has been suffering from memory loss as well as gastric problems and diarrhoea since then. We have complained to the party but in vain. Why do you force us every time?" said one of Majhi's wives. Local CPI(M) cultural activist and bank employee Anwar Mondol tried to reason with the family but failed.

The fear is so persistent that mother of Halima Khatoon, a neighbour, also refused citing example of Haques. Another neighbor Rekha bibi also claimed that her four-year-old elder son developed more weakness of limbs as well as speech problem following polio vaccination. She also believed that polio vaccine bad omen to her impoverished family as her daughter gulped down kerosene when she had gone to join an altercation with the vaccinators earlier. Her grimfaced husband nodded in agreement. Hazi Kalam's family as well as Taldna Mollahbari in the same ward also expressed the fear of vaccine-induced polio attacks.The fear is widespread as our experience in several districts showed. At Damodarpur in Uluberia-I, Howrah, 20 out of 30 resistant families whom we met, either refused on the ground of child's illness or complained post vaccination health hazards. "We have allowed polio drops to our children earlier. But our younger child fell ill after vaccination last time and suffered from chronic loose motion. We had to admit in nursing home and paid through our nose for his treatment," said a stubborn Asraf Ali Mollah and his wife.

Even visiting health service doctor could not convince him. He refused to allow the doctor to examine his child. "Government doctors would never divulge the truth to us since they are government servants. Even private doctors have been asked to suppress," maintained a sullen faced Mollah. "Come what may, we won't budge this time," declared his wife. At the fag end of the village, Anwara Bibi was found fleeing from her shanty with a child. Her angry husband showed us their younger son after much persuasion. "This child cannot walk after he was given polio dose in earlier round," he complained to the doctor accompanying the team. He, too, was not in mood to believe in the visiting doctors' words as he tried to reason him that the child had been suffering from malnutrition. "The government does not help the poor. Is it the way government wants to help us by crippling our children," shouted a bitter Anwara who had taken shelter at the back of her shanty.

At Amrapara Maqtab in Nandigram II of East Midnapore in October round, vaccinators and officials played a cat-and-mouse game with resistant/reluctant families. Khadija Bibi was visibly frustratrated and miffed as she could not succeed to hide her child in the cowshed. "I would get my child vaccinated after he gets well. But you are forcing it on the sick child. You will never come back and admit responsibility if his condition turns critical," shouted Khadija. In another *mahallah* of the same village, Habiba Bibi thrown away the ICDS immunization card as the mop

up team continued to pursue her to allow vaccination to her baby boy. “My elder daughter fell ill after polio vaccinations. She cannot walk properly. I cannot afford to experiment with my son,” she argued. Another mother took her child in arms while taking a dip in the pond and shooed the vaccinators. Others either fled away, locked themselves in rooms or abused the vaccinators for pestering them.

Not only Muslims but also Hindus share the same apprehensions about “adverse reactions” of the polio vaccine on an “already sick” child. Our visit to the twin village of Alampur and Jamalpur in Magrahat I in South 24-Parganas district underlines the fact. There was poor turn out of children at polio booths in both the villages and villagers did not attend the meeting organized by the BMOH at Alampur. Alampur is wholly Muslim, while Jamapur is dominated by backward caste Hindus. Out of 38 families we could meet during October round, 27 reported sickness of child or fears of post-OPV health hazards. Among them 12 were Hindus.The vaccinator team led by a health service doctor and a senior UNICEF official found that most of the children were suffering of cough and cold as well as gastro infections, a result of poor hygiene, low nutrition, lack of gap among the births of siblings and environmental dampness, etc. They managed to administer polio doses to 34 children. “You have imbibed the Mollah’s fears by staying close to them,” joked Rahima Kazi, the local ANM with the Jamalpur Hindu villagers. Not only in South 24-Parganas but also in Howrah, Murshidabad and East Midnapore some Hindus, too, expressed the same fears.

Vaccine Associated Polio Paralysis: a False or Real Alarm?

We found that allegations about Vaccine Associated Polio Paralysis (VAPP) paralysis induced by vaccine virus were also widespread among the resistant and reluctant families across the state. While the NPSP-GOI operational guidelines or UNICEF documents are silent on this, NPSP experts called it a far-fetched and misplaced fear to justify the vaccine refusal. However, they admitted it as a possibility though rarest of its kind. “It is a possibility in one out of eight to 10 million OPV doses. The official guideline is meant for operational planners and common vaccinators. The mention of the possibility in it will only panic them and help canard-mongers to fuel further resistance,” reasoned one of the NPSP experts.

CDC Atlanta expert Washington told this researcher that American government had to cough up a huge compensation to the parents of a child there when he developed OPV induced polio attack few years back. OPV has been discarded in favour of IPV (injectable) in the US since then. But IPV is not recommended in countries like India as it would not only involve huge expenditure but also not instrumental in developing group or ‘herd immunity’ like the OPV, argued the WHO experts. According to US Pharmacopoeia, the advantages of OPV are that it rapidly induces a long-lasting immunity including high degree of gastro-intestinal immunity, which, suppress excretion of wild poliovirus. It also induces high level of population immunity, thereby reducing transmission of wild poliovirus.

This helps to develop 'herd' or community immunity. It is cheap and easy to administer. But disadvantages include poor thermo-stability, reported sub-optimal erocoversion in tropical developing countries. Finally, there is a possibility of VAAP, though it is "extremely rare".[58]

According to one estimate published in EPW, India has 570 VAPP cases which is more 6.2 times the risk of getting a wild poliovirus infection. The estimate is based on the risk factor calculated by Kohlars and others. Since 130-150 million children are vaccinated for three rounds per year in India, over a 350-450 million exposures to vaccine viruses occur. By that logic, around 30-40 VAPP cases are expected. "What makes us unhappy is the absolute magnitude of the cases. When a large number of vaccine associated polio cases are occurring, many more than anticipated, we should stop for a while and think." The article also criticized the national polio eradication campaign managers for keeping mum on VAPP. "We appreciate the implementors of the programme for displaying information on distribution of the wild polio virus on India. Why have we failed to bring out information on the distribution of vaccine associated polio cases in the country?"[59]

But NPSP, the WHO-GOI collaboration that monitors polio cases in the country, claimed that they do not monitor VAPP 'formally'. "We do not monitor VAPP. It will be an issue for us only after the zero polio status in the country. Same thing happened in America, too. The threat of wild virus is much more than the vaccine virus. Secondly, NPSP cannot replace the government health ministry or departments. It is basically their job to monitor VAPP," argued an NPSP official. He also questioned the source of the estimate of VAPP cases in India. According to him, the issue came to highlight as some MNCs tried to sell costly injectable polio vaccine replacing cheap OPV.

The presence of such vaccine virus was primarily proved in case of two children in problematic district of Howrah, one each in Pachla and Uluberia recently. The vaccine-virus was reportedly found in the excreta of these two children who have developed non-polio paralysis or partial paralysis, said the WHO experts. The tests are awaited in the case of another child in Moina bloc of East Midnapore. In Garsafat, mason Sirajul Khan's child Murtoz Khan has developed signs of paralysis. WHO is waiting for the test reports for final declaration. NPSP and other experts have welcomed the spread of vaccine virus, needed to fight the wild virus in the environment. The practise of excreting outside home has been instrumental in transmitting poliovirus via faecal-oral route of human children. The wild virus finds its natural reservoir in Human progenies alone. It has a 'half-life of infectivity' of 48 hours in the environment after excreted by the infected child. It multiplies in the intestines and spreads rapidly by the time of paralysis onset.

It is an irony that the same practice is now considered helpful in spreading vaccine virus in the environment underlining the success of vaccination campaigns along with poor sanitation in Indian villages and urban slums.

Post-vaccination Deaths: Official Indifference

Our study shows that the official handling of the few incidents of child deaths after routine vaccinations or during the pulse polio rounds only reinforced the existing fears and resistance. Three such deaths in South 24-Parganas damaged the efforts of the social mobilizers and district administration during August-October 2004. Contrary to USP and other international guidelines, the cases of such deaths are hardly investigated by medical expert teams despite governmental provisions for that. The country offices of UNICEF-WHO did not press for such investigation for the sake of scientific transparency and public accountability even if the professionals working for these agencies advocated it in private. "You will miss the wood if you count the trees," was the official attitude, be it local or international.

Though doctors, agencies and NGOs vigorously denied any relation between these deaths and vaccination, they failed to convince the people. The lack of proper follow-up action on such "accidental deaths" also raised the level of resistance.

"Investigations concerning adverse reactions to the vaccines should be released to the public but accompanied by information on how these adverse reactions could have been prevented or under what special circumstance they occurred," said the USP guideline. Contrary to this advice, we found, the cases of such deaths are hardly recorded and investigated by the medical experts even though Government of India as well as government of West Bengal. Though a Standing Committee to monitor and investigate Adverse Event Following Immunization (AEFI) is supposed to be functional both at the central and state level, it hardly functions. According to a senior epidemiologist K. Mukherjee who had headed the AEFI investigation committee in West Bengal, the committee managed to function despite all problems till 1997.

"We had investigated lot of cases related to deaths following BCG, measles, DPT vaccinations in places across the state from Purulia to B.C. Roy children's hospital in Kolkata. We also came across complaints regarding growth of post-vaccination abscesses. We spoke to the aggrieved families, examined the infected children. We recommended suspension and other disciplinary actions in some cases while stressed on preventive measures including better sterilization infrastructure," said the expert. However, he had no idea of what happened to their recommendations. "The committee stopped operating. Perhaps high ups did not like it. Members too may not find it comfortable to visit places around the states to investigate into the complaints," he observed.

Now the government machinery and their supportive agencies insist that child deaths during routine or pulse polio campaigns are "accidental" or "freak incidence of children's sudden death syndrome" and in no way related to the vaccine

or vaccination process and instruments. They maintained that it would be gross injustice and insensitivity to great dedication of the army of the public health providers and the massive human resource mobilization efforts needed for each round of pulse polio campaigns if media highlighted these few deaths. You would miss the wood for the tree. Treat these deaths as collateral damage, they argue.

However, experts in NPSP and UNICEF admit in private that the tendency to hush up or play down the deaths, fearing adverse impact on Pulse Polio campaign, proved counterproductive.

For example, one death in Howrah's Damodarpur village during the April 2004 round, two deaths in Rangilabad in Magrahat I before and during August round and one death in Falta area of South 24 parganas in October contributed to stiffening of resistance and consequent poor coverage in the two districts. No medical expert investigation was conducted in case of baby Nazira Laskar and Biswajit Khamrui, neighbours at Rangilabad GP area. We spoke to Naziar's father, young embroidery worker Nazir as well as ANM Rahima Kazi who had vaccinated his child and the local bloc Medical Offiicer Dr Arun Das during our visit to Alampur-Jamalpur, a constituent of the GP.

According to Nazir, he had always taken his six-month-old baby for routine vaccinations and OPV to the sub-centre as well as pulse polio booths. He complained that the "playful" baby developed convulsions after getting DPT injection from Kazi at the sub-centre. The family rushed to the local quack doctor who pronounced her dead. As the agitated family members and villagers gheroed the BPSC and demanded the arrest of the ANM accusing her of causing the death due to negligence, police took away the child's body for post-mortem according to rules.The district magistrate prevented the arrest, fearing that it would demoralize the vaccinators all over the state and thus affect the pulse polio campaign. He also referred to recent Supreme Court directive that medicos should not be arrested just on the ground of allegation in the cases of negligence deaths.

Meanwhile, the traumatized family declined to go for autopsy as it would not only strain them emotionally more but also drain them financially too. Any visitor to government hospital and police morgues will vouch for the fact that these are veritable hells and no human dignity is honoured while stacking the dead, old or infant. The medico-legal post-mortem and discharge of 'dead-body' thereafter involves massive corruption and mindless red-tapism causing harassment to bereaved families anywhere in West Bengal and possibly all over the country. So, often families of victims of violent deaths prefer to avoid the nightmare. Nazir's family was one of them.

The UNICEF and WHO officials, however, felt that Nazira might have died from toxic reaction of the anti-purtossis vaccine, a component of the DPT injection, a possibility cited in similar cases earlier. Biswajit, they speculated, might have choked

because of faulty posture or neck position during his vaccination. The drop might have gone to the infant's respiratory track. "Often I told the vaccinators not to be in haste and vaccinate the child in faulty position while struggling with a reluctant or a fearful mother," confided a senior UNICEF consultant. But the vaccinators, chasing a target to finish within a short time, hardly afford to follow the copybook instructions. The hapless parents are now at the receiving end.

Rahima informed that villagers have stopped taking routine immunisation following two deaths. UNICEF-WHO and government health service high-ups in the district held village-level meeting and tried their best to dispel the fears and resistance to OPV following the deaths. According to them, Hindu villagers in Biswajit's village harbour no grudge about the deaths and accepted the doses after some persuation. But Muslim villagers in Alampur and other villages opposed it. But our visit to Alampur and its twin village Jamalpur proved that villagers, irrespective of their religion or political beliefs or social status are still haunted by these deaths. 23 out of 38 families we met at the twin villages, referred to the deaths as reasons for their reluctance/resiatnce. 11 of them were Hindus .

"It's not your child. So it will never hurt you the way it pains us. We cannot console Naziar's mother," said a neighbouring mother refusing polio drops to her child. "We thought of facing bullets but resist further vaccinations. But we have cooled down as we are helpless. Give us some time to forget the bitterness," commented an anguised youth of the village in a pleading tone. Nazir himself, however, sounded cool. "Even if I have lost my child, I am not against polio or any other vaccination. My only demand is that vaccines should be administered by the doctors only to ensure the safety of the children," he reasoned.

At Damodarpur, villagers complained that one of twin children of a poor villager died after polio vaccination in April 2004. "The child did not receive medical attention in time. The doctors and didimonies who had trooped in to administer Polio vaccine to our children did not turn up after the child fell ill. This incident made us more frightened and bitter," said one of them. Ten out of 29 families referred to the death.

Sk Sirajul, brother of the local CHG, however, contested that version. "I took the child to hospital. She was suffering from acute malnutrition and had sores over her body. These sores got infected as the child was exposed to dirt and squalor around. She died after a month of polio vaccination. Her death is no way related to the pulse polio," he said. Sultana Mallick, a middle-aged housewife who has got all her children vaccinated and herself had undergone ligetion, also supported Sirajul. Further interactions with the health services doctors and ANMs underlined the gulf between the official version and the dominant village version of the death. While the officials, visibly exasperated after all well-meaning reasoning, called the village "beyond redemption".

This study has no intention to belittle the importance and urgency of the Intensive Pulse polio campaign or sow more fear and confusions among people's mind. But one can not overlook the haughty, semi-colonial attitude that brush aside the rustic fears as "fictions" or "superstitions and ignorance". Since this kind self-righteous, self-congratulatory approach within government health machinery and supportive international agencies only help the section of quacks and homeopaths, who are more close to the people in the villages and urban slums, to exploit the parents' confusions and fears.

Routine Immunization and Primary Health Care

Our study also indicates that the interrelation between the resistance and the fear of illness is not straightjacket. The fear seems to be multi-layered. It is partly the reflection of the faulty vaccination, lack of post-vaccination medical follow-up as well as resultant erosion of faith in the government health service, based on the bitter experience of harassment and rising cost of treatment in government health centres and hospitals.

A large number of our respondents, developed fear of vaccines following faulty BCG and DPT injections, mainly due to use of unsterilized syringes at village health sub centers, The infections led to painful abscess or septicemia on children's thighs and arms. In some cases, partial or temporary loss of limb developed a paranoia and bitterness against any vaccinations, routine immunization or pulse polio. The subsequent harassment, lack of post-vaccination medical support and huge expenditure incurred for the treatment at private hospitals and nursing homes made the bitterness worse. Meanwhile, incidents of death and sickness following "wrong doses" of Filaria tablets in Murshidabad and Birbhum only complicated the situation further. These affected routine immunization adversely. "You doctorbabus from Kolkata or Maldah rush to our villages only when we refuse polio doses. But you never bother when your recklessness almost kills our children," said an angry farmer Hefazuddin at Nimgachi village under Chahchal bloc in Maldah. According to him, his daughter suffered from infection after immunization injections at the local health sub-centre. The lack of proper treatment and nursing made the boil and sore worst. "I had to pay through my nose to save my daughter's leg. She is still immobilized. None of the government doctors and high-ups helped me during the crisis." The middle-aged marginal peasant still blames the "polio injection" for her daughter's injury and refused to believe that polio vaccines are being administered through oral doses.

Some of his neighbours have become resistant following the traumatic experience. Many others shared his anger and fear even if they have accepted OPV. "We have accepted it under pressure since we were told that ration cards and birth certificates would be issued after the vaccination. But we still fear the after-effect. In any case we will allow those injections to our children anymore. Is the government would take care of our children if they become crippled due to such injections?" said Nurul Islam, another farmer. Alauddin and other villagers complained of similar kind

of post-immunisation abscess and partial crippling of children in the village as well as in the vicinity. They accused village ANM Sulieman of being untrained one.

At Maldah's Gayeshbari, two-and-a-half year old Washim Sheikh is a confirmed case of polio. His young mother Selina said that she took her child to polio booths since he was six months of age. As the child developed high fever following DPT/BCG injections at the local sub-centre, she took him for medicine at the center on a pulse polio day. The health staffs administered polio drops too. Paralysis set on after four days. "Government and WHO officials came to see the child after his stool examination confirmed the polio attack. But neither the officials nor the local pancayats have helped the poor family anymore. They have been left for fending themselves," said local sub-centre employee Mahmuda Bibi.

At Namopara in Kaliachak-II, AFT Social Mobiliser young Jaida bibi and Mira bibi complained of harassment and abuse by some villagers after few child suffered from post DPT infection and partial crippling at the sub-centre. At Mirjapur village in BelangaI bloc of Murshidabad, small businessman Asarul Sheikh was adamant in his refusal to pulse polio. "First you make sure that the injection-affected children can walk properly. Otherwise, we will not allow polio vaccine in our area," he said. The whole *mahallah* cited the case of Manirul Baksh, son of Rasul Baksh. According to Baksh, his son's lower limbs were crippled after "polio injection" was given to him at the local sub-centre in 97-98. "I have sold my small savings to take the child to Kolkata and Vellore," said the blacksmith. In fact, many affected parents have confused polio and DPT/BCG/Measles injections. "The government introduced polio drops after people refused to take polio injections anymore," reasoned many of them.

At Majhampur in Mirzapur II GP, almost an entire gram panchayat has been boycotting pulse polio since the last few rounds. One of the reasons is the death of 12-year-old Saddam Hussein following administration of anti-Fileria tablet. "The health centre staff distributed the tablets to the entire village at wrong doses. While many of the villagers fell sick, the young lad could not survive as he was asked to swallow four tablets at one go. He suffered from high fever and internal inflammation," said his father. AFT volunteers as well as other villagers too complained that health department officials tried to hush up the incident.

"They did not look into the callousness of their staffs. Instead, they tried to convince us that the child died of some unknown disease," they said. But the damage was already done and the faith in government health providers is now completely shaken. Incidentally, the cases of Fileria related health hazards were reported from Birbhum and other parts of the state by the NGOs as well as lower-level government helath staff.

"Lack of sterilization infrastructure at the sub-centres and reach out camps only increased the chance of infection. Worse, lack of timely and proper medical

attention often leads to abscess and partial crippling. This leads to avoidance of the injections," admitted UNICEF officials. Much before the pulse polio, the Extended Program on Immunization stressed on "extensive attention to sterilization of injection equipment as well as other health equipments to protect against spread of AIDS and hepatitis". 'Autodestruct' syringes were introduced in EPI around the world.[60] The GOI-UNICEF public information pamphlets also admitted that use of unsterilized syringes leads to infection and painful abscess. It claimed to have introduced auto-disposable glass syringe along with the Hepatitis B vaccination to avoid the problems.

But ground reality is completely different. The ANMs or sub- center health workers also admitted the use of one syringe to vaccinate many children with little sterilization. But they expressed their "helplessness" too. "It's tremendous pressure on us us as we are catering to five to nine thousand people with meager infrastructure. Post-BCG/DPT infection and formation of abscess is always a possibility. Government do not supply us disposable syringes. Even fund for kerosene to boil water for sterilization of used syringes is always in wanting. You cannot expect us to buy kerosene on our own every time," reasoned one of them.

The top guns of the state health bureaucracy must have noticed the comments made by the writers of the West Bengal Human Development Report 2004, prepared in collaboration with UN agencies at the instance of the state government, in this context.

"What is much more disturbing is the evidence on routine immunization coverage. The state has a low rank in terms of coverage of vaccines such as DPT, OPV and measles. Furthermore, there is a high dropout rate with respect to successive immunisazation for DPT and OPV, which has obvious effects on the efficacy of the vaccination. Furthermore, a quick camparison of the four rounds of intensified Pulse Polio Immunization Program indicates that the coverage has reduced in the more recent rounds in the early months of 2003. This type of reduction is critical and needs urgent attention. Similarly, the dropout rate in immunization is quite high."[61]

According to the WBHDR 2004, West Bengal performed better that the national average but lagged behind many a states. Only 50.3 per cent of the children below 12 months are immunized in the state. This is better performance than the national rate of 43.6 per cent but the state stood 18th among 35 states in this account. 56.1 per cent of the children in the state are fully immunized as against national rate of 43.3. But again, 23 other states performed better.

While national rates of DPT 1, DPT2 and DPT3 acceptance are 71.1, 67.4 and 63.6 per cent respectively, West Bengal recorded 85.8, 77.7 and 69.6 per cent. The state stood at 8th, 22th and 24th position respectively among 35 states in this

account. In case of OPV1, OPV2 and OPV3, West Bengal recorded 85.1, 79.7and 68.6 per cent respectively in comparison to national-level acceptance of 78.2, 74.7 and 70.4 per cent successively. This record puts the state at 17th, 20th and 27th position respectively. Similar kind of performance was recorded in accounts of acceptance or delivery of BCG, measles injections as well as Vitamin A drops [62]

Reports from NGOs also underlines that the sorry state of routine immunization and primary health care affects pulse polio campaigns. CINI, CCK and AFT reports on status of routine immunization in Murshidabad villages are quite telling. Another CCK study on 22 'priority/high risk villages' in Farraka, Khargram, Baharampur, Hariharpara blocs in Murshidabad, conducted in September-November 2004, revealed the pathetic conditions of basic infrastructure including health. In Laharia, a village in Farakka bloc, both health sub-centre and primary health centre are 5 KM away while nearest bus stop is 10 km from it. There is no safe drinking water supply except hand pumps. Four quacks practise there, but no ANM is available at the government sub-centre. Only 30 per cent of the one-year-old children are fully immunized. There are 40 families who are resistant to the Pulse polio. Similarly, in Nimaitak, the sub-centre is 1.5 km away while PHC is 13 k m from the village. Highway/bus stop is 17 km. There is neither any doctor and ANM in the village, nor any dispensary. Neither there is any safe driking water supply nor any hand pump. Only 40 per cent of children aged one year are fully immunized. Nevertheless, 95 per cent of the children were given polio drops on a NID day during the survey period. In this situation, it is quite natural that the villagers would not share government enthusiasm about repeated rounds of pulse polio.

The WBHDR 2004 also focused on the infrastructural inadequacies. "Obviously, the total physical infrastructure available for health care in the state is still inadequate relative to the requirement, and it has already been noted that there are also problems with the quality of the health service delivery in several key areas. Clearly, there is need to improve the physical infrastructure conditions with respect to preventive and curative health."[64]

The state health department officials are also aware of the stark mismatch between the pathetic state of primary health care, both preventive and curative and the hype created by pulse polio campaigns. "We have many a shortcomings definitely. In many places there are no sub-center. If center is there, ANMs or doctors are not available. People do not get other regular health care services. Pulse polio campaign has heightened the peoples expectations and demands. That is why the government has decided to hold fortnightly health camps to reach out to the underserved people in nine districts — East and West Midnapore, North and South 24-Parganas, Murshidabad, Maldah, Howrah, Birbhum, Bankura and Purulia. Each camp received Rs 600. More funds will be provided after evaluation of their performance," said ADHS Dr Chaki. However, the state government focuses on its "fiscal constraints" to meet up the peoples basic health needs. Reflecting that

position, WBHDR report focused on the "recent global and macro-economic process that has effectively reduced the ability of the state government to ensure access of the people to safe, timely and effective health care". The government's "ability to make much-needed health expenditure", both in preventive and curative health, has been compromised. Not only equipment and medicines, but also adequate staff needed for "health service delivery" could not be recruited.[65]

But it is not money alone which matters. This crisis of faith in government public health system and lack of trust and empathy between the health care providers and 'client population' have deeply affected the common people's "health seeking behaviour" including attitude towards vaccinations. "My children do not get any other health services within walking distance, yet we get polio drops we don't need. Why do you keep on knocking at my door for polio drops when there are so many problems in my family," the UNICEF report quoted resistant families in Aligarh.

The popular perceptions in Left-ruled West Bengal is no way different. "Why is the government so keen on pulse polio when are children are suffering from other chronic diseases? Why this sudden benevolence when we have to cough up money for every single thing at government health centers and hospitals? Why the government doctors and officials are so much bothered about our children's health while they treat us as animals at health centers and hospitals? There must be something sinister behind this," commented most of our respondents both in rural and urban areas. "You officers and doctors are getting hefty amount to keep mum over ill-effects of the polio vaccine. Better you share some of the money with us before lecturing us on child health. You harrass and misbehave with us when we visit you. Now it's our turn." These mocking comments were heard in West Bengal districts.

The bitterness and indignation is not one sided. "These ignorant people do not deserve our patience and empathy. The government is unnecessarily spending so much money on convincing them. These are hazards of democracy. They only deserve military rule and whips," growled many angry health and administrative personnel after they faced resistance during house-to-house polio vaccinations.

The polio eradication programe suffered due to this mutual bitterness, particularly in the global South. "Lack of understanding (bordering on suspicion as to the rational behind the NIDs are accentuated by the fact that vaccines given during NIDs were free and that health workers actually come to the door to vaccinate children. By comparison, participants interpreted fees paid at the health centres for sick and well child consultations to be payment for vaccines even through NIDs and vaccines that were not perceived to be free of charge (at health centre) fuelled suspicions and misinformation.

Sterilization Fears Pushed to Back

In West Bengal, not many of our respondents have expressed the fear of sterilization as reasons for his or her resistance. But village health assistants and NGO activists reported the fear as the most common ground for refusal in earlier rounds. Experts attribute the relatively low manifestation of this fear in resistance discourse to the massive campaign by the government, religious leaders and NGOs. "But this is deceptive. The sterilization fear is more hidden now. It is still a major factor behind other excuses," said UNICEF-WHO experts.

We also found that suspicions of the government motives were deep-rooted. But the fear and apprehension that lurk behind in their minds came out in so many words. "Why the government is so keen on pulse polio? Why so much insistence? Why the government doctors and officials are so much bothered about our children's health when they do not care for us otherwise? Why government doctors and health staffs are visiting our homes repeatedly when one does not get a human treatment at hospitals and health centers? Why they are doling out free medicines along with OPV/PP while one has to cough up money for every single thing at health centers and hospitals? There must be something behind this benevolence and overdrive," commented the villagers everywhere. All others involved in the PE campaigns identified these popular refrains with the fear of sterilization in the guise of immunization.

Some Sections of Hindus are Also Resistant/Reluctant

NPSP and UNICEF reports, NGO records as well as our own study revealed certain resistance among Hindus' particularly Scheduled Caste and OBC people not only in states like UP, but also in West Bengal. This resistance among SC-OBC population has class/caste/ proximity factors, particularly if they are neighbors to the resistant Muslim families.

We have earlier quoted the fear induced resistance/ reluctance among Muslim and Hindu villagers in twin villages of Jamalpur and Alampur in South 24-Parganas following post-vaccination deaths of two children of both communities in August 2004. We had similar kind of experiences in Char Kabilpur in Murshidabad's Sagardighi where some families of impoverished Hindu daily-wage labourers expressed the same fear and suspicions, vented the same indignation to the government's selective health care. They defended their stubborn refusal eloquently. The resistance monitoring reports of NGOs like CCK and AFT also reveals that Hindus, mainly SC/OBC villagers, also continued to refuse OPV for several pulse polio rounds in Murshidabad. Cases of refusal by upper caste and educated middle-class Hindus in Tamluk and other district towns were also reported by NGOs like Guchha Samiti affiliated to RKM LSP.

Some lower caste Hindu religious cults and groups in West Bengal also declined to accept any routine immunization. We have come across a cult in East Midnapore called Manik Kali, whose followers are still opposed to any immunization and allopathic medicine. Based in Moyna bloc and spread over Nandakumar, Tamluk, Mahisadal,Narghat, Balichak, Nikashi as well in West Midnapore's Pingla and other blocs, the cult is now divided in groups.

According to the scions of the Gosainbari in Paramanandapur in Moyna, the cult is named after Manik Kali, a lower caste farmer's son in Khageswardham village of Bhagabanpur bloc. Kali was believed to the reincarnation of Hrideram, an 'avatar' of Sri Chaityanyadeva. Indicating a peasant genesis, the cult members claimed that Hrideram's supernatural powers were revealed when he refused to pay rent to the zamindar and helped his tenant father to outsmart the landlord's armed henchmen. Even today, most of the followers of the order are Mahishyas and Dhibars. These castes are not placed among the upper ones in Hindu caste hierarchy, despite the considerable upward mobility of the Mahishyas particularly.

This cult worships their guru as the manifestation of Kali, the primordial mother goddess as well as two of the holy Hindu Trinity, Shiva the divine destroyer and Vishnu the divine creator. Photos of the departed gurus are installed at Hrideram-Manik Kali temple as part of the pantheon. But the cult is an interesting mix of the Shakta and Vaishnavite traditions who wear *Tulsi katir mala* in their neck and do not eat egg, onion and garlic but offer *bhog* of fish preparations to the reigning deities. The scriptures of the cult include hand-written *punthis* containing the sermons and instructions of Hrideram-Manikram as well as part of the Srimadbhagwat. The cult which claims to be 279 years old (since Hrideram's birth in the Bengali year of 1132) does not have any printed book on its history as its founding fathers reportedly prohibited any printing fearing sacrilege of the holy scriptures.

The Gosainbari and its temple is situated amid paddy fields at Paramanandapur just off the Narghat bridge which connects divided Midnapore. The non-descript temple is part of the middle peasant household with cowshed and half-finished unplastered two-storeyed pucca building around. "We still drink boiled water collected from ponds. *Bhogs* offered to gurus are cooked with that water only. We have never taken any medicine as we believe that the creator and his avatars would protect us from all illness. Gurus have given '*mantrahputa tel-jal*' to believers when they had insisted for that. It helped to cure cancer cases miraculously. I myself suffered from malaria but recovered without medicine," claimed guru Abhayram Das. He admitted that none of the children in the family had ever taken any immunization including polio vaccine. Their in-laws are also co-believers. His mother and sisters, present during the interview, vouched for it. "We have been unfaltering in our faith and many of our followers also share our beliefs in taboos. But we never insist them to follow us at least on the questions of medicine," Das maintained.

Nevertheless, Gosainbari remained an impediment to the success of the intensive pulse polio campaign in Midnapore, said the district officials as well as UNICEF-WHO monitors. Many of the cult followers are still resistant. Neither persuasive nor coersive measures seemed to have worked with Gosainbari. According to Das, a woman official of West Midnapore stormed into their house in search of the child of his sister who had fled her in-laws' home to avoid pulse polio vaccination a few months back. "The officer abused me and even threatened to beat me. I told her I would rather be ready to be behind bars than waver in our faith," he said.

But not everybody is immune to change. A breakway group led by Subhas and Kanai Hajra of the same village has erected a different temple at their place. "They are averse to the maintenance of our tradition and are in favour breaking the community taboos. They are advising our people to take vaccinations includsing pulse polio and other medicines. But you can see the strength of both the groups during the Akshay Tritiya congregation," said Das and his family members. "We respect Goshaibari people but can not follow them in every matter. I have allowed health workers to adminsier polio doses to my daughter this time," a resident of the village. But the position of the descendants of santosh kali, the descendant of Manikram at Khageswardham is known. "We used to send tributes to them earlier. But now we stopped it since we spend whole collection here for annual congregation," Das added.

People bargaining with the state

The government's keenness to make Intensive pulse polio campaign successful has provided underserved people an opportunity to turn the table on the political-official establishment and compel them to deliver. It's virtually an unintended empowerment, never planned by even most ardent votary of decentralization of power. Villagers, even those had not resistant earlier, boycotted pulse polio vaccination to register their frustration and anger over basic amenities as well as developmental issues.

"There is no majority-minority division in the incidents of boycott on developmental issues. Since the people have realized that the government is keen to make the pulse polio campaign a success, they are pressing for fulfillment of promises made earlier. Demands are mostly related to supply of drinking water, electricity, roads, schools, health centers etc. The trend has spread to almost entire south Bengal. In last several rounds we received reports of such boycotts from Purulia, Birbhum, Maldah, South and North 24-Parganas, Howrah, Hooghly and Burdwan. But health department cannot fulfill these demands. We are trying to co-ordinate with the panchayat and other departments," said Dr J.M. Chaki, the additional director of state health service and former in-charge of extended immunization program.

We found that the demands related to basic amenities like inadequate and unsafe drinking water supply, repairing of defunct tube-well, village roads, power connections, malfunctioning of the government health centers, primary schools were most common issues for pulse polio boycott in villages across class and caste division.But demands for ration cards, birth certificates, enlistment in BPL list to ensure entitlement to supply of subsidized foodgrains and Kerosine as well as regular free lunch of khichri for children at ICDS centers or distribution of equal amount of foodgrains are more popular among poor villagers. They also pressed for demands like establishment of new ICDS centers and rural health sub-centers.If demands for better roads, power and telephone connections indicate affluence of new rural middle class in West Bengal, the demands for subsidized food and fuel underlined the desperateness of a large section of the village population. It is interesting to note that most of the village or para level polio boycotts were organized by the middle class people with political connection. They garnered the support of village underdogs by co-opting their demands.

It appears that the global discourse of development through market empowerment appears to have reached its logical conclusion. Both vaccination-resistant and non-resistant people are using their bargaining power to press for developmental demands after 'market-friendly' reforms and corollary hikes in fees, charges and introduction of rural taxes by the governments. 'Freebies' are no more available in government health centers and hospitals. Villagers have to cough up money for drinking water, rural electrification and road constructions. With the gradual withdrawal of old-styled welfare state and intrusion of market forces in health and civic services as well as infrastructural developments is a fait accompli to most of the villagers. The popular bargaining combines the anguish over the loss of protectionist umbrella of the state in the wake of aggressive market fundamentalism as well as the urges to attain better market connectivity and compatibility. While the poor and marginalized supporters of polio boycott identify with the former, middle class organizers of the boycotts represent the latter.

It seemed the minority mood has influenced their Hindu neighbors in the village. "The people of Hindu paras are now arguing that they would also boycott polio vaccine on development issues like Muslim *mahallahs*," she said. The villagers at Mirpara, mostly agricultural labours and marginal peasants, though claimed that most of them have vaccinated their children, they did not hide their grievances over water crisis. "Take a sip of the saline water from the last surviving tube-well of the village and consider yourself whether it is for human consumption," said the villager. "Is it wrong to boycott to draw attention to our plight?" asked an anguished young man. The emaciated villagers however did not fail to show their hospitality and offered green coconuts to the visiting UNICEF official and this researcher. "You will throw up if you take that tube-well water," they grinned.

The local BDO made it very clear to the visiting UNICEF officials that it would not be possible to repair around 100 defunct tube wells strewn over the whole

GP area. “A minimum fund of Rs 7-8 lakh is needed to repair 100 tube-wells while the govt had provided fund only to repair 4-5 of them. The whole bloc needs at least 250 tube-wells. As the area is the gateway of Sundarbans, deep boring for each tube-well needs Rs 70000-Rs 80000 to get the sweet subterranean water. Water supply lines can be linked to the villages in sajal scheme of the central government. But we could not avail the scheme since it requires a village to be declared as ‘nirmal gram’,” he said.

“This means every household should have sanitary toilet. Only Achintyanagar Mouza, out of total 92 mouzas in the bloc, has fulfilled the criteria. People are not ready to cough up rs 270 to avail the subsidy for installing the toilet. Neither the government is prepare to dole out the money,” informed the official. Moreover, there is no electric supply in the entire block of 92 villages except “two and a half”. Even the BDO office cannot afford that luxury. “A supply sub-station was installed spending Rs 10 lakh. But the plan seems to have been shelved now,” commented the hapless official. “This time I had to take the help of musclemen to prevail upon the villagers but I can’t do this thing next time. I’m afraid more & more villages will be infected with this tube-well mania and roadophobia,” remarked the BDO.

In many villages supporters across the political divide decided together to boycott the pulse polio doses to press for their demands related to development and basic amenities. At Gura Nabapalli in Murshidabad’s Nabagram, residents of an entire *mahalla* of Gura village, had boycotted pulse polio in October round cutting across political lines. The villagers closed down not only the polio booth but also the village primary schhol and ICDS centre. They demanded repair of 1.5 km long kuccha road and covering it with pebbles or bricks, power supply as well as telephone connection. According to Abdus Salam, a local teacher and Congress supporter, the entire population of the Mahallah have migrated from another flood-affected village in 1991.“We have never boycotted polio drops. But politicians and bureaucrats compelled us to do it. We have been petitioning and pleading panchayats, district administration, MLA-MPs as well as party leaders since that time. The main road cutting across the village turns into a veritable hell in mansoon. There is no power connection even if rest of the village has supply.” CPM supporter Esll Sheikh nodded in support.

“We decided the boycott jointly as we failed to draw the attention to our problems. The villagers asked for written assurance from the local authorities to look into their demands before ending the boycott. It was withdrawn after AFT bloc organizer Ramzan Ali took initiative to arrange a meeting between the local Bloc development Officer and the representatives of the villagers. The BDO issued an written assurance. The boycott succeeded in drawing their attention. The road development has bagan” said Salam.

What happens if the job is left half done after polio campaigns are over? "Don't worry. We will resort to poll boycotts in next polls. We have five hundred voters among us. The leaders have to come to our doors again. We have learnt how to compel them," said Sheikh. Salam, evidently more well off than others, also included the demand for telephone connections to the list. But others were found more interested in construction of road and electrification. Don't you feel the polio boycott would endanger your children and they will pay dearly even if road is constructed at their cost? "We will take risk of polio attack to one child for the sake of better life of others," commented Salam rather bluntly.

Chandmoni, a riverine village in Maldah's Ratua I bloc, came to limelight when the coffin of a Kargil martyr reached home. As the vehicle carrying the fallen army Jawan's corpse had to negotiate the knee-deep sludge, the pathetic condition of the 4-5 Km long road that connects the village with rest of the word came to the notice of the officials. But this hardly changed the situation and the road continued to be an apology for it. Furthermore, two health sub-centres at the village had no staffs for long. The desperate villagers, organized by the local youths across political line, decided to boycott Pulse polio in October. Two Hindu teacher of local primary school led the boycott.

"The village was never resistant. But only 17 out of 592 children took the polio drops in October. The local SDO visited the village and admitted the legitimacy of the demands. He also assured to allot fund for the road repair from the MPLAD. But he pleaded not to use polio boycott as a weapon to extract concession from the government. But villagers said they want the government to begin the road construction. They would wait for two years for its completion," said Pabitra Nandi, the district social mobilisation officer for pulse polio and other immunization projects.

The Ration Cards and Birth Certificates: Key to Survival and Identity

"If you do not leave right now, I will beat you. Leave our children alone," shouted an angry Md Farooq, a resident of a Garsafat village in Moina bloc of East Midnapur. As his rage subsided following the patient but firm intervention by WHO official and this researcher, the middle-aged mason revealed the reasons for his outburst. "Our children are given polio drops many a time. But everybody turned deaf ears to my applications for ration cards. I have eight children. None of them has ration cards. I will shoo away the vote-mongers next time," he said. Farooq is one of the construction workers in the area who are seasonal migrants to Mumbai, Delhi, as well as Nepal. His neighbours, an agricultural labourer family also complained of not getting the birth certificates and ration cards. "Your only worry is pulse polio. You forget us as soon as drops are given to our children," said a bitter elderly women.

The widespread demand for ration cards and birth certificates is significant in two aspects. These documents not only entitle holders right to get subsidized food and other benefits, they are also key to the citizenship rights and voting rights. In a country paranoid with the silent Islamic invasion and a sinister design to create a Muslim labensraum, thanks to Sangh Parivar campaign, these documents are also keys to the survival of the minority community members across the country.

The Bengali Muslim's identity crisis is more acute as many of the migrant workers and artisans from west Bengal were hounded out of Mumbai, Delhi and parts of Gujarat as Bangadeshi in recent past. Many of them faced deportation. Even in bordering areas of West Bengal, specially, Muslim villagers are required to produce these documents on demand of the BSF search parties or else face consequences. The cry for these documents should be judged in this context.

The political bickering among rival parties also contributed in such boycotts. In South 24-Parganas, a CPI(M)-led panchayat samiti refused to allocate fund for TMC run Gangadharpur panchayat. Moreover they declined to join the all-party team in persuading the CPM supporters in Mirpara-kansarichak, the minority muhallah in the same village. It was a Tit for Tat as the TMC leaders had done the same thing when they were not in power (refer to Raihana/ Gangadharpur panchayat pradhan's interview). At Merrigunge, a remote village in Kultoli bloc and Barakamaria in Joynagar bloc, fear and suspicion induced resistance has become complicated due to political oneupmanship. According to district officials and UNICEF observers, the panchayat pradhan of Merrigunge Trinamul supporter, did not take initiative to break the resistance among villagers complaining 'step-motherly' attitude of CPI(M)-run pancahayat samiti. Similarly, influencial SUCI leaders in the latter village dragged cold feet over the request to help the officials to convince resistant families, apparently in a bid to settle score with the CPI(M)-led panchayat. At Mathurapur Sheikpara in Murshidabd's Sagardighi, grievances over the distribution of ICDS foodgrains to children led to partial boycott. While the grumbling was common , a Trinamul Congress supporter and aspirant for a pancahayat post, tried to settle score with new Congress pardhan of the gram panchayat. "The family members of pancyahat members have been recruited as polio vaccinators. Their parents are looting the panchayat resources. How can we accept polio drops from the wards of the traitors?" said the hide-merchant in obvious reference to college-going Aisbira Khatoon, daughter of pradhan Ahsan Malik and Enamul Haque, relative of another panchayat member. Aisbira, an outspoken girl, became upset and declined to work unless administration intervenes.

The growing mood to bargain with the political-official bureaucratic establishment on development issues seems to underline twin trends. First, it reflects the extension of democratic consciousness in rural Bengal in the wake of 25 years long highly institutionalized panchayat rule. "The development related polio boycotts are unique to India, to be more precise, to West Bengal mainly," said Hausam Latif, WHO expert.

The Bargaining is Not One Sided

In many areas, panchayats and government health officials have told the resistant or defaulter families would not get ration cards or birth certificates if they fail to produce the routine immunization cards as well as pulse polio cards bearing the proof of vaccinations. “This is only way we can put pressure on these resistant/reluctant families,” said a female health worker at Garsafat. “We have not issued immunization card to 25 families who had refused to take Pulse polio doses,” said the IPPS-8 workers at Satghara Junior high school polio booth at No. 25 ward in Maheshtala municipality. “If you want birth certificate for your child, you better allow the vaccination first,” said the female ANM to a reluctant family in Arakpur in Bordra GP in Bhangar. “Panchayat people told us that the birth certificates ration cards or BPL certificates will be issued after we would produce the immunization certificates. This is the way government is trying force to twist our arms. So we have accepted it grudgingly,” complained Md Rashid Ali and his friends at Jharerait-Jirerghacha area of Bhangar -II. Even Krisahk sabha also choose this easy way to coerce the villagers instead of painstaking door-to-door awareness campaign, they said.

This has led to tension, bitterness between the community and the state. “I was told by pancahayat and BPHC people that birth certificate to my child would not be issued unless I produce immunization certificate. I told them that I would vaccinate my child by a proper doctor at his chamber. But they were adamant. So I have decided to not to allow polio doses to my child. Any way, I have obtained the birth certificate. You know, there are a hundred ways to secure it if you spend money. Now I will see what they can do,” said an angry Jahir Ali, a zari artisan and tea stall owner at Damodarpur, in Uluberia I, Howrah.

Maniul Mallick, another educated young man in the village is more “politically conscious”. “The forcible immunization is against democratic norms. The government is denying us our fundamental right to health and education as well as basic civic amenities. There is no other development, no proper treatment in hospitals, any walkable roads, and water supply. They are turning deaf ears to our every other plea but spending crores on polio. This is a sham democracy,” rued the Madhyamik pass unemployed youth.

He seemed to be an opinion leader in the village as others in the crowd of young men shared his anger. He was particularly furious over the ‘threat’ of disconnection of hooked electric lines in the village by a senior district administration official during his visit. “He did not bother to appreciate our grievances but tried to administer pulse polio by bullying us. We refused to cower down. Let him disconnect the line,” he said. The visiting ANMs however, informed that the well-meaning officer was annoyed when a villager mockingly asked for Rs 2000 before allowing polio drops to her two children.

"The government officers, doctors even NGOs are being paid to make us accept the polio drops. So share it with us,'' said villagers. "How do you dare to mock me? Do you know who I am? I draw a salary of Rs 30000 per month and you have to wait for a fortnight before you are allowed to meet me at my office," the ANMs quoted the thundering officer whose colonial wrath only amused the villagers more.

The "unofficial" bargaining between the pulse polio campaign managers and the resistant/reluctant families is likely to continue within the limits of 'democratic' manipulations and intimidations. Nevertheless, it reveals the gap between the welfare state and the non-civil society denizens as well as the growing frustration of the ruling elites who have failed to bridge the gap.

Politics of selective health care contested

The truth is gradually dawning among the participants in polio eradication social mobilization campaigners that resistance to pulse polio as well as the eradication of the disease should not be seen in isolation. They felt that the problems would not be resolved without a holistic approach to it's all aspects — political as well as social and psychological. They realized that no lectures on hygiene and immunizations, nutrition and child health would be meaningful unless supply of safe drinking water, proper sanitation in villages and slums, adequate food to children, access to regular and safe immunization, proper health care and treatment facilities as well as basic amenities are ensured. Strategies for comprehensive primary health care, both preventive and curative, have to be developed and implemented by ensuring active involvement of the communities at all level. True democratization of public health system is the essential prerequisite for the popular participation.

But this demands major paradigm shifts in the approach and working of the national and international public health regimes. Unfortunately, the governmental or supra governmental public health planners, still don the clock of the benevolent redeemers to the 'backward' population groups. These experts expect local conformity often without bothering to interact with the communities and understand their health related priorities and prevalent health practises before embarking on grand campaigns. Despite their communitarian vocabularies, the terms and conditions of the relationships between health service providers and target populations are always determined by the former, irrespective of their nomenclature—government health staffs, international agencies and civil society organizations.

Unless and until this practice changes, the "underserved" communities are likely to continue to contest the dominant discourse of national-global politics of selective health care by their own "irrational and unscientific" discourse of fears and resistance. The absence and denial of prescribed forms of "health-seeking behaviour" among the "superstitious" masses will continue to frustrate and enrage them. Also the

growing privatization and cut in social sector spending including public health cares services made the majority members of the communities more vulnerable to the pressures of market forces. This has further narrowed down the scope for popular control over health care resources and community participation in public health programs. "Growing reliance on private curative health care, even by the poorer people, indicates the inability of the state system to cope up with the requirements, and points to the disturbing possibility that in future even more people will be denied health care because of their inability to pay," noted the WBHDR 2004. This process will only make the underserved communities more restive and resistant.

Vaccine resistance, Muslim women and domestic violence: beyond binaries

The resistance to polio vaccination among Muslims has once again focused on the gender issue, rather on the question of gender suppression within the community. It was triggered by media reports on domestic violence and divorce of Muslim women after they had allowed health workers to administer OPV dose to their children in absence or against the wishes of their husbands.

Since mothers are generally more concerned about the health and illness of their children, Pulse Polio campaign planners as well as participants considered Muslim women as more open and amenable to immunization drives. Though no official gender-specific social mobilization strategy is in vogue, often the grass-root mass vaccination "tactics" consider Muslim women a "soft target" among targeted resistant population. Considering Muslim women more "flexible and willing" collaborator to the state sponsored health programme, stories are galore how the vaccinator- moblisers weaned the confidence the fearful mothers and "persuaded" them to allow vaccination to children. In some cases, the vaccinators skipped compulsory marking of vaccination on children's fingertip to avoid detection and subsequent violence on Muslim others by their enraged husbands.

This narrative posited those Muslim women as victims of conservative males evoking the empathy of persuasive state and enlightened civil society, mostly Hindu bhadrolok and bhadramahilas. "Though most of the Muslim mothers are willing to administer polio drops to their children, it is difficult to mobilize them separately. It has little value in the community. Their women live under the fear of Talaq," commented Dr Chaki.

Talaq or fear of it: In our study, we too came across some Muslim women who had faced violence even Talaq or threat of it after the 'vaccination by persuasion' in absence of husband. At Gayeshbari in Maldah's Sujapur, young Salena Bibi was in tears while holding her polio-infected two and half year old son Wamim. "I took my child to polio booth as well as sub-centre against the wish of my husband. He feared polio vaccine will cripple my child. Now worst has happned. He now beats me holding me responsible for the misfortune. We are poor people and nobody

helped us for the treatment of the child. He now threats to leave me," said the young mother who is staying at her mother's place.

In Hudshi of Murshidaba's Raninagar, an agricultural labour actually given talaq to his wife after health workers administered the OPV to their child who was in her lap. "The matter was later settled with the intervention of Imam of local mosque. He persuaded the man to bring back his wife. After all it was not her fault," said the local AFT organiser Anisur Rahman. At Sujapur's Gainpara, Sayema Bibi was tearful as pleaded with vaccinators not to force her. "My husband has already threated to give me Talaq.If I allow you to give polio drops to children against his wishes, he will throw me out," she said.

At Khidirpur of Murshidabad's Hariharpara, another mother reported that her husband had beaten her after their elder child developed partial paralysis following routine vaccine injections. "He did not object much earlier when I took the child for vaccination. But now angry over huge expenditure of treatment, he beats me for succumbing to health Didi's words," she said. Around 10 per cent of our respondents among Muslim women reported post vaccination domestic violence.

'Husband's order': Many other Muslim women refused Pulse polio vaccination to their children on the ground that they do not have "husband's order" to do so. They even called the children as their husband's property. "It is his child. I have only given birth. My husband says I did not bring them from my father's place," reasoned another mother at Kaliachak's Namopara. "Would you save me if my husband gives talaq?" asked Anoara bibi as she was fleeing from the vaccinator team at Damodarpur, a "hard-core resistant" village at Uluberia II Bloc in Howrah district. "Let my husband come back and decide. What will happen to me if he throws me out after I allow you to vaccinate in his absence," reasoned Abu Kamal's wife Tanuja at the same village.

Contrary to the outsiders' expectations, these women hardly resented their husband's domination. At Barisha in Kola-1 GP under Panskura II bloc in east Midnapur, Asma bibi was stubborn in her refusal during the October round fearing husband's wrath. "Last time my husband had beaten up me black and blue after Didis persuaded me to allow polio does to my daughters. Since he is the master of the home, his decision is final. You cannot leave me in a soup every time," said the mother of two daughters. Her carpenter husband did not mind to take her to doctor to give her 'tet-vac' or anti-titenus injection before child birth at home. But he is stubborn in his refusal to allow any kind of vaccination to their children.

Some women even cited religious bindings to follow their 'husband's order.' Rupshana, a frail young mother has learnt to read Quran at home. She was at her parent's place in Damodaorpur as her zari worker husband had left for Mumbai. "My husband as well as in-laws has asked me not to give polio drops to my child. Quran teaches us to obey our husbands. Islam says that if you do not obey your husband, the

blessings of the prophet you will be denied to you. And Allah would not accept your prayers if you do not go by the prophet's teachings," argued the girl while refusing OPV vaccination to her child.

Some female vaccinators tried to reason that that women should not abide by their husband's "ill-informed and unscientific" dictates particularly when health security of their children are involved. But this feminist persuasion failed to gain ground. "I will oppose my husband only when he goes wrong," maintained Rupsana. However, her ultimate reason for refusal was the fear of divorce. "Have not you read newspaper reports that women were divorced after they allowed polio vaccination of their children?" she shot back.

Some women were willing to accept polio vaccines for their children but could not prevail upon or argue with their husbands. It was found that husband and male in-laws overruled the reluctant women if vaccinators succeeded to persuade the former. But this hardly happened in case women were willing but males were not. Most of young Muslim wome have a subservient role in the family decision making process as they are strictly ruled by patriarchal norms and values.

"I understand that the vaccination is needed for safety of the child. I too had taken anti-tetenus injection before the labour. But what can I do? It is my husband and the father-in-law to decide and you better try to convince them," said a young mother Rozina bibi, a secondary school drop-out at Barkhoda village in the outskirt of Tamluk town, the district headquarter of East Midnapur. "Since you are offering free-of-cost vaccination, people are not believing your bonafide intentions. They would rather go to private clinics and pay for it," she observed sarcastically even while her mother-in-law send a relative to snatch her child from her.

At Damodarpur near Uluberia town, Jahir Ali's wife was visibly upset about her husband's stubborn attitude. "What can I do if he does not allow me to bring the child," she said. This researcher met young Ruhul Amin and his wife when they were taking their six-month-old child to a local quack. She has received no immunization, not even BCG. Ruhul kept mum as he was egged on to reveal the real reason behind his refusal to accept polio vaccine.

As his wife expressed her willingness, he stared hard to her. Jahir Ali's wife at the same village was persuaded by the arguments of the vaccinator team. She was visibly upset, as her husband was stubborn in his refusal. The ANMs and ICDS staffs decided to approach these 'willing women' when their husbands are not around.

At Kashaibari of Damodarpur, when the patriarch was convinced by the visiting doctor, his elder son though himself reluctant, brought his one child to be vaccinated overruling his first wife who was apprehensive about the ill-effect of the dose to her sick child. "These jahel (ignornant) women always cry on one pretext or another," he said. But, paradoxically he had hidden both his second wife and her

young male child. When enthusiastic ANMs discovered the child and his mother a closed room, the man became furious.

While our findings may be used to reinforce the stereotypes, we want to put it in overall social- cultural perspective.

Wife-beating is not culture or community specific neither in West Bengal nor in the country as a whole. According to the National Family Health Survey 2, while one in five women in India experiences violence since age 15, as many as 23 per cent women in west Bengal (though much lower than the estimated 56 per cent for India as a whole) accept at least one reason as justification for wife-beating. While 20.3 per cent among 3285 Hindu women interviewed supported it, 29.3 per cent among 1007 Muslim women did the same during the survey. Rural women (26 per cent) accepted it more than their urban counterparts (11 per cent), the survey said.

On the question of women's autonomy in household decision-making, NFHS-2 revealed that though 70 per cent of women in west Bengal enjoys autonomy about what to cook at home, most of them still need permission to go to market or visit relatives. 53.4 per cent rural and 38.2 per cent women reported that the decision about obtaining health care for herself was taken by their husbands. Given this overall scenario, Muslim women have lesser freedom of movement as well as lesser autonomy in personal health care (42.3 per cent) than her Hindu sisters (46 per cent) in the state.[66]

Few instances of willing mothers hardly makes ground to posit the "enlightened" Muslim women against their "conservative" men. The overwhelming number of our respondents among Muslim mothers harboured the same apprehensions about pulse polio as their husbands. Our field experience reveals the nuances of "acceptance" of OPV. In many instances, the "persuasion of amenable mothers" was bordered on verbal coercion by the vaccinator-mobilizer teams in the absence of males. These women became bitter and stubborn on subsequent rounds. At Amrapara Maqtab in Nandigram II in East Midnapore, a stubborn Salema Bibi played cat and mouse with the vaccinators and officials. "My husband had beaten up me to make accept the polio drop. But I have refused to budge since I believe polio drops will harm my child," said a sullen Salema after both threats of forcible vaccination and soothing words failed to convince her. "This is my child. Who the hell are you to force me?" reacted an angry mother who had shielded her child in her lap in a bid to evade the vaccinators while taking refuse in the village pond in the same village.

Her neighbour Khadija bibi was visibly frustratrated and miffed as she could not succeed to hide her child in the cowshed. "I would get my child vaccinated after he gets well. But you are forcing it on the sick child. You will never come back and admit responsibility if he becomes more sick," growled Khadija. In another mahallah of the same village, Habiba bibi thrown away the ICDS immunization card as the

mop up team continued to pursue her to allow vaccination to her baby boy. “My elder daughter fell ill after polio vaccinations. She cannot walk properly. I cannot afford to experiment with my son,” she argued. “This is a women led resistance. It is very deep-rooted as they have some irrational fears that polio drops might harm their child,” commented UNICEF consultant Dibyendu Sarkar who tried his best to make the vaccination mission successful. However, only 17 children could be vaccinated. The “left out figure far surpassed the success rate,” Sarkar recalled.

At Damodarpur village close to Uluberia town in Howrah, Makasuda Bibi and her husband Rashid Mian were stubborn in their refusal. “Our elder daughter is born crippled. We spent our whole savings to cure her illness but in vein. So we decided not to immunize the rest of the children. Let us face our fate,” said Maqsuda showing her daughter who is now a lump of bones. “Nobody helped us, neither panchayats, nor hospital doctors. We had to pay for even an injection syringe at hospitals. Even imposters duped us by assuring certificates for physically challenged,” added Rashid. Their school-going second daughter kept mum when asked to judge her parents’ decision.

As Anaora bibi fled their shanty at the fag end of the village, her angry husband showed us their younger child of one and half years after much persuasion. “This child cannot walk after he was given polio dose in the earlier round,” he complained to the doctor accompanying the team. He was not in mood to believe in the visiting doctors’ words as he tried to reason him that the child had been suffering from malnutrition. “The government does not help the poor. Is it the way government wants to help us by crippling our children,” shouted a bitter Anoara who had taken shelter at the back of her shanty. The same woman had earlier refused polio drops on the ground of threats of Talaq.

In a more well to do quarter of the village, Asraf Ali Mollah and his wife both claimed that their youngest child suffered from severe diarrhea after receiving OPV. “We had to admit him in nursing home and paid through our noses to save him,” said Mollah. He too refused to listen to the visiting doctors arguments. “Doctors are in unison and they would not tell the truth since the government has asked them to suppress it,” he commented. “Come what may, we won’t budge this time,” declared her wife. The visiting ANMs, however, called it a popular ‘alibi’ for resistant families and maintained that the Mollah family had always refused vaccinations.

It’s not always the fear of heath hazards alone that provoked minority women to oppose polio vaccination. Most of our women respondents gave vent to most elemental worries of the families as well as political-economic grievances of the community too. They asked for jobs for their men and complained of discrimination against Muslims in government jobs. They blasted panchayat members, politicians and bureaucrats for nepotism, corruption and arrogance. In many cases, wives supported her husband’s decision or claimed to have taken the decision together.

"Doctors and officials are now visiting our homes following pressures from the top. Otherwise nobody bothers for us. The government is not giving jobs to educated Muslims. Hindus are getting the largest share of the cake. My husband is graduate and taught in vacancy at a government run Madrashah. However, he was not regularized. Now he has joined a job of a book-keeper for a cattle merchant. Imagine the humiliation," said Mainuddin's young wife at Howrah's Damodarpur. herself an educated women who has passed Maddhyamik examination, the mother of two refused to vaccinate her younger son. Her school-going elder son mocked the vaccinator team. "I am a Hindu, I do not need vaccine," he grinned. "Let the government declare that free medical treatment would be provided to the families who had accepted vaccines," she added.

At Basantchak village in East Midnapore's Moyna bloc, Kaderun Bibi, a madyamik passed young mother and her "post-graduate" husband Nurul, are opposed to any kind of vaccinations. They have given neither BCG or DTP to their three children. Like many others, her opposition has multiple layers. First she cited her acute thyroid related problems as source of her children's vulnerability to diseases. This fear led her husband to prohibit vaccines and medicines to the whole family.

But she divulged another aspect of the couple's sense of insecurity and discontent later. "Neither luck nor government helped us. Both of us are unemployed. He hawks saris now while I failed to get a para-teacher's job at the village shishu Sikhsa Kendra. Unless you have a solid catch in the party, you won't get a job. If government do not care for our bread, let it not bother for our children," she reasoned.

This kind of reasoning only miffed the officials and politicians who found it "queer and irrational". But in village after village we had to confront this kind of "opportunist attitude".

"If the government is so caring about our children, why don't you take pains to foot the bills for our children's education including private tuition? We pay through our nose for it," said a caustic Jahanara Begam at Amrapara maqtab. The mother of three daughters, herself a secondary school dropout, is keen to educate her girls.

Girl child among victims: Some of the vaccinator/social mobilisers that we interacted with felt that resistant \reluctant parents among Muslims preferred to allow pulse polio vaccination to their daughters while hiding the male children in view of the sterilization fear. We too came across few such instances during our participatory observations. But there is no substantial and supportive data to call it a dominant social trend across the country, which many would have considered a boon in guise for the girl child. But NPSP national list of polio victims for 2004 showed that 40 out of total 130 were girls. 14 of them were from Hindus families. 27 were from UP

(total 78),10 from Bihar (total 39). Analysis on the sex distribution of polio victims in West Bengal during 2002-03 noted that 57 per cent of the victim children in 2002 (total 49) were girls. But it came down to 32 per cent in next year (total 28). In 2004, one victim of the two in the state, Muskan khatoon is a girl child.

The quality of the rural health care system in the state became abysmally bad despite pumping huge money loaned from World Bank and other foreigns sources. The allegations of doctors and paramedics skipping rural posting as well as infrastructural problems are rampant. The Left Front government has empowered panchayats to supervise the rural health sub-centres, in an apparent bid to make the first post of the huge health hierarchy accountable to villagers. Auxiliary nurses and midwives, mainly female health assistants working in sub-centres, are the main public interface of the department catering to the basic health need of the villagers. And most of them are women.

According to experts, women's participation in the Polio vaccination teams has been increased to ensure better access to target households and effective rapport. According to a WHO report, West Bengal is ahead of Bihar but lagged behind Orissa, Andhra and UP where at least one female was included in the vaccinator teams. 91.92 per cent of the teams in west Bengal reported such inclusion in July 2004 as against Bihar's 57.02 per cent and 96.08 of Orissa and 96.57 and 93.44 per cents of Andhra and Up respectively. WB's record shows the inclusion has fallen since January this year (93.66%).

Both the NPSP and UNICEF experts pointed out that the government run rural health care as well as immunization system actually rests on the shoulders of the ANMs, particularly the female health assistants. Though there is provision for periodic visit of the Bloc health center doctors to the sub-centres, it is hardly followed. The field experience of this researcher too corroborate to the fact.

In village after village, these women are the most visible and accessible representative of the government health bureaucracy. The government of India introduced the cadre to man the rural health sub-centres in the eighties as part of building new four tier rural health infrastructure, to ensure intensive coverage of rural population and better interface between the government health machinery and villagers. Trained in rudimentary public hygiene, preventive health care and as well as midwifery in addition to minimum school leaving degree, these health assistants are supposed to have a rural background. With each sub center covering at least 5000 population, the ANMs ensure the routine immunizations under Universal Immunization Porgramme, distribute medicines for diseases like TB, leprosy, Doherria, fileria and care for health of mother and children as well as records childbirth in their command area. In addition, they work as supervisors as well as vaccinators during national and sub-national immunization day or pulse polio rounds. While a pair of male and female ANMs or health assistants.

The ICDS centres are poor people's kindergarten-cum-creshes where children below five get rudimentary education and most importantly, a free lunch of khichri. In many villages, children are given a ration of rice and gram in lieu of cooked khichri. The khichri or proportionate rice and gram are the main attraction for both the children and as well as their parents, particularly among the poor. In their daily interaction with the mothers and children, the ICDS workers enjoy access to almost every household in the villages that help them to gather information about the vaccination status as well as influence the parent's attitude to it. The UNICEF and the government deployed them as polio vaccinators as well as social mobilisers during the pulse polio campaigns. The use of Anganwari centers at Polio booth and distribution of Khchri there on Polio Sundays have been proved to be a major attraction in districts like South 24 parganas and East Midnapur. In many places, villagers boycotted Pulse polio demanding new sub-centres and IDCS centres or protesting the removal, closure or lack of proper supply and inadequate manpower in existing centres.

"It's true, sometimes these women land in soup due to us. One's husband had pressed the hot iron to her wife's cheek after he came to know about the vaccination. Another was beaten up and denied food for few days. One was thrown out of home. But we have our compulsion too," admitted Sutapa, one of female ANMs in Howrah. Some ANM and IDCS women themselves faced violence while trying to break the resistance. But mothers as well as some of community leaders complained that some of these lower level health staffs tried "some dirty tricks" or acted highhandedly when they failed to convince the people.

Despite their close contacts and rapport with Muslim women in villages, these low-paid health and child-care staff, mostly from Hindu middle-class background, could not cross the religious and class divide. "Every time you say that you would launch with us, but I know you are not going to share our food," commented Phulbanu, a smiling Muslim mother to a team of Hindu female ANM and panchayat member at Naora-arakpur in Bodra GP under Bhangar II in South 24-Parganas. Exasperated with the resistance in Muslim villages, many of the ANMs have pleaded for transfer to Hindu areas.

These lower-rung women representatives of the state machinery too yield some "power" and exercise it to pressurize the vaccine-resistant or reluctant families. "If you do not accept the polio drops or DPT injections, panchayat pradhan and BDO saheb told us not to issue the birth certificates to your children," said ANMs to resistant villagers. "Even your child would not get khichri," added the ICDS worker. According to them, the government officials and panchayat leaders have decided to use this "tactics of counter-pressure" in the wake of "boycotts and blackmails" by resistant villagers.

The resultant tension is palpable in the words of these women health workers. "We are under the cross-fire. The officials scold us in case there is a

detection of false P or false sign of immunization at households. They insist us to fulfill the quota of child immunization, ensure maximum coverage in our booths or else we will face disciplinary actions. But resistant villagers have come to understand the meaning of our signs. They change the mark from X to P as soon as we move away. Some even do it in front of us and threatened us of dire consequences if we report it to the authorities," they complained.

No Social Mobilization Strategies for Women

Even if international agencies like WHO/UNICEF as well as GOI and state governments have greatly cared for social mobilization strategies to reach resistant families in the minority community, they approached religious and secular community leaders including politicians and professionals. But no mobilization strategies for women have been articulated so far. Neither there is any social-cultural back up programs for NGOs to help the women who face conflict situation at home following their children's vaccination in male absence, either by persuasion or by coercion by vaccinators.

Apparently, the official PEI campaign managers fear that it would invite adverse reaction from the "male conservatives within the community" and spoil the precious gains made in bridging gaps with them. Some called it "impractical" in view of the prevalent patriarchal culture. This approach actually denies to see pluralism within the community and considers it as a male monolith, thus reinforcing the dominant stereotype of the Muslim community constructed by the Western Orientalists and Hindutva vision of its 'Other'. Some of the WHO/UNICEF officials admitted the need for such gender-specific mutilation strategies. "In Pakistan also we found women are reluctant to vaccinate in absence of their men. They declined to incur their men's wrath. We have so far tried to convince the men through their opinion leaders. But there is need to focus on the women too," said WHO expert Latif. We also found senior UNICEF consultants like Ranjit Mukherjee or Somen Dhar were keen to mobilise women, particularly mothers, in immunization and other health-related campaigns to break the resistance in problematic districts like South 24-Parganas and Murshidabad.

However, some other experts felt strongly against any gender-specific strategy to break resistance in the minority community. "It is the pseudo-seculars and feminist mafia shedding crocodile tears for Muslim women," said an otherwise dedicated UNICEF official, herself a foreign educated Muslim woman. She was bitter about her experience with the women's organizations and their party bosses. "I spoke to leaders of Ganatantric Mahila Samiti, Pragatishil Mahila Samiti and so on. All of them promised to help us in the pulse polio campaign but did not turn up."

The UNICEF supported cmmunity NGOs like AFT are yet to reach out to Muslim women and develop a gender-specific advocacy campaign. It was male-dominated mindset of the larger community seems to be deterrent for them too as

gender segregation at public place is a custom. In a UNICEF-AFT jointly organized workshop on hygiene, immunization and awareness to make breastfeeding popular, the vibrant and spontaneous involvement of large number of Imams and Ulemas were encouraging in many ways. But it was an all male affairs where males were found discussing the nitty-gritty of the breastfeeding. The workshop, however, ended with the resolution to organize mothers meeting, at the instance of the UNICEF representative Mukherjee. "Though Amanat has recruited some women activists within the community, all of its senior staffs and most of the ground-level workers are males. It reflects both the objective and subjective limitations of our initial recruitment drive," said Abdur Rauf, the NGO's Polio campaign project co-ordinator.

The experience of grass-root social mobilizers like Sirajul Islam, Young AFT ward coordinator in Maheshtala municipality shows that the change-agents from within the community should also include Muslim women. The community public space for women must be explored more both by reclaiming the traditional ground (as espouseded by Bagum Rokeya and Fatia Mernisi) even for the sake of success of the public health campaigns.

Public Space for Muslim Women is Unfolding

A good number of Muslim women volunteers have been recruited by the NGOs to ensure better empathy with community. But it's not easy for the female Muslim NGO activists either to convince the resistant men and women to accept the vaccination. "You cannot fool me this time. Last time you persuaded me to accept the polio dose when my husband was not around. He thrashed me after he came back home," said a rueful Muslim housewife at Sherpur in Magrahat-II bloc to Raihana Khatoon, Amanat Foundation's bloc organizer.

Nevertheless, undergraduate student Raihana, the mother of a three-and-a-half year old child, represents a new generation of young educated Muslim girls who retained their moorings in the community. This is also indicative of the emergence of a new middle class among Bengali Muslims, filling a post-Partition void. "My husband is learning computer networking. Neither my parents nor my in-laws had opposed me when I joined this job. My sister-in-law is also active in this awareness campaign," she said.

Samiara in Maheshtala and Fazila at Bhangar are two other young, educated girls who have joined the awareness campaign. "Some of the local influential people resented our activities and tried to prevail upon our parents to desist us. Some families also abused us. But we insist that we are actually serving the community for a better future," said Fazila. "They can not shrug off us easily as we belong to the village and the community," said Samiara.

Our field experience also shows a public sphere is unfolding for Muslim women in the course of their involvement in social mobilization campaigns for

immunization programs. It is also observed that Muslim women, even in poor households, received more school education than their husbands. While many of them had to dropout to marriage in early age, they are quite concerned about the education of their children. The rising middle class among Bengali Muslims in West Bengal does care about their girls' education. Majority of women social mobilizers, animators and volunteers recruited State Madrasah Board and NGOs in Muslim-dominated Murshidabad are Muslim women. Most of them have passed Madyamik or secondary examination.

While the conservatives within the community still resent and grudge women's growing public exposure and importance in hitherto exclusive male domains, change in social attitude is quite unmistakable. The abovementioned Board workshop witnessed the same. While young girls and mothers along with children attended the deliberations, some of their spouses and fathers were found waiting patiently at the rear of the conference hall. "It indicates changing social mood. However, it is still difficult to make the orthodox males within the community accept the public role of the educated girls," observed the Board's director in charge of routine immunisation, Md Refatullah.

The participants themselves revealed the tension. "People of older generation even some young people ridicule and abuse us when we approached them for support in public health campaigns like pulse polio and ligation for women. They say girls have become doctors.We wanted us go home and manage our domestic chores," said Lovely Yasmin of Domkal. "But housewives are eager to speak to us since they can bare their general and reproductive health worries to fellow women. Many of them are asking us to take them to ligation camps after four or five babies," said Firdousi Rahman.

Merina Parvin and Nargis parvin were two married sisters from Beldanga who attended the workshop. Both studying HS while their hubbies have stopped study. Since their job as social mobilisers is likely to add to the social and political mobility of their CPI(M) supporter family, their in-laws did not oppose it Our own study also revealed that many of our women respondents are more educated than their husbands.

But class divide and gender intolerance are still rampant. In Mirzapur of Murshidabad's Beldanga, one Haradhan Sheikh refused to allow a local girl to administer polio drop to her child. "The girl's mother happened to work as a domestic help in the household," said Lutfar Rahman, the AFT Murshidabad district orgainser. Rashida Bibi, a primary educated housewife of marginal peasant family and the CCK volunteer at Hariharpara's Khidirpur village faced the ire of some local youth. "Villagers have no faith in the skill and knowledge of women who are hardly literate," said village graduate and son of a Maulana, Rabiul Awal. "I have been abused in more filthy languages by some resistant villagers, both male and females," said a grim-faced Rashida. The CCK activists said that Rashida volunteered to do the

unpleasant and tiresome job of visiting resistant and reluctant families after local club leaders declined to continue the legwork.

Notes

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