How people's movements have influenced research priorities in India
Illustrative case studies

Padma Prakash[1], Padma Deosthali[2], Sangeeta Rege[2]

(1) IRIS Knowledge Foundation, India
(2) Centre for Health and Allied Themes (CEHAT), India

1 Context

The systematization of social science research in India under the state began in the 1950s and 1960s, although high-quality noteworthy research had been conducted by independent scholars for many years. The earliest institutions were those set up by central ministries essentially with the objective of conducting research in areas relevant to the county's development. The Planning Commission (now disbanded) provided the first impetus to initiating research relevant to policy making. It produced a wealth of policy-relevant research, mostly in the field of economics and management, and essentially focused on deriving policy recommendations and rarely touched on larger issues or conceptual and methodological questions. A notable exception is the large body of globally recognized poverty studies over the decades.

The Indian Council of Social Science Research (ICSSR) was set up almost 20 years after independence. Even by 2007 of a total of 417 research institutions listed by ICSSR, there were no university, ICSSR or government-funded research institutions specializing in minorities and scheduled castes and tribes, women, health-related subjects, or history. The general perception has been that the quality of research in formal institutions had deteriorated, and that there is a general reluctance to conduct independent research on critical and sensitive issues. Health-services research and health-systems research have been conducted under the Indian Council for Medical Research, the premier body funding medical and health research. But these are a small number and

mostly in medical institutions. The ICMR's focus has been on medical research rather than health care in its broad definition.

The indirect fallout of the general neglect of such research in government-funded institutions, especially in some areas, has been a proliferation of privately funded social sciences research organizations. There has been no systematic assessment of the research undertaken by NGOs and independent institutions. This research is most often glibly regarded as being of poor quality, biased by the funder's requirements, or not sufficiently rigorous. And yet it is these institutions where research has focused on issues relevant to vulnerable groups and sensitive social issues. Two major research areas that have developed in this sector are health and women's issues.

People's movements and research production — Among the earliest movements that had an impact on law, governance, and research was in Kerala on the threat to fisherfolk livelihood due to increased use of mechanized trawlers. The movement, which began in the 1970s, later broadened to include impacts of the ocean environment and fish stocks. It then catalyzed a wide-ranging research program, in universities and among independent social scientists, on the impact of trawling, purse seining, and ocean pollution and on the economic and social organization of fisheries.

In parallel, over the years young professionals, who were disenchanted with their institutional settings and their lack of engagement with the people and their needs, have established outposts outside academia to conduct socially relevant research. This is perhaps the beginning of the emergence of the concept of "lokvidya" or people's knowledge that reinforces local knowledge traditions in technology, science, arts and crafts, and society and community. Less recognized is the fact that there has been considerable thought given to the methodological, philosophical, and epistemological issues within these movements. Unfortunately, in the Indian context, these discussions have mostly remained within closed circles. They have neither as yet enhanced the knowledge base nor informed pedagogy in these fields.

The Narmada Bachao Andolan, a protest movement against the building of a series of large and small dams on the River Narmada, lead to better assessment of the needs of the displaced, dismantled the well accepted techno-economic basis of building large dams, and exposed the poor scientific understanding of hydrology and seismicity on which the decisions were based. It had a major impact on the development decisions of the Indian government, prompted the World Bank to reform how it approved grants, and because some issues were challenged in court, it produced considerable legal literature.

Within the health sector, the Medico Friend Circle (MFC) emerged in the 1970s to address the abysmal Medicare available in villages. These young medical professionals brought into focus several problems in the delivery of rural health care, in particular medicines and the unethical practices of the pharmaceutical industry. The MFC critically reviewed pharmaceutical literature, and encouraged ideological debates across the political divide on issues of medical care. MFC made many contributions to path-breaking research, and even more importantly, it consistently and systematically established the connection between people's health and their social and economic

conditions. In 2000, the health movement became more formalized as Jan Swasthya Abhiyan, which campaigned for health for all now, and viewed health as a fundamental right. It has taken up several public issues in healthcare from a rights perspective and made use of research studies from various institutions.

The women's movement has encouraged an interdisciplinary approach to the study of gender issues. Gender studies centres are mandated within all public universities, and in 1983, the Indian Association of Women's Studies was established by scholars working in universities and colleges. The Indian women's movement is one area where there has been a symbiosis of movement-led research and research emerging through formal scholarship.

Alternative knowledge streams generated by movements and their institutions have : posed a challenge to the state and markets ; produced evidence to challenge existing paradigms of development ; informed policy change ; filled gaps in knowledge to counter the deliberate silences of the establishment ; served to critique science and society connections and thereby helped to ground science in social policy ; and contributed to the formation of alternative perspectives.

2 Empirical Approach and Main Findings

Two case studies illustrate the processes and pathways of alternative knowledge creation and its influence on policy. The first demonstrates the outcome of the early coalescing of the health movement with the women's movement. The second shows research output around a recognition of how India's healthcare models and plans have consistently ignored the growing private sector.

Case Study One — The issue of violence against women became a broad public concern in the 1980s. The Forum Against Rape (now, Forum Against Oppression of Women, FAOW) undertook a qualitative research study, a first of its kind, in June 1980. Interviews of 100 working-class and middle-class women showed the wide prevalence of violence against women in their own homes across social and economic classes. The study destroyed the myth that domestic violence was a poor people's issue or that only certain communities indulged in such violence. Violence against women was shown to be widespread but well hidden, and domestic abuse of women became a public issue.

The public health system was also under considerable critical attention because of its lack of gender sensitivity when dealing with reproductive and sexual health needs of women. Both the health movement and the women's movement demanded a change in practices and attitudes. As well, they pointed out the abysmal state both of forensic procedures and of the treatment accorded to the survivors of rape and sexual assault.

The Centre for Health and Allied Themes (CEHAT) approached the issue of violence against women based on the experience of the women's and health movements. It recognized that the public health system was the first point of reference for women subject to violence, even when they did not directly report the violence. Violence leads to not just physical but psychological health consequences that bring women to the health providers seeking care. In 2001, CEHAT engaged with the health system

through a partnership with the Bombay Municipal Corporation (BMC) to set up a hospital-based crisis center (Dilaasa). This was easier said than done because it meant developing gender-sensitive training programs for the entire public hospital staff, and understanding violence as a public-health issue. Women survivors who came to the system rarely admitted to being subject to violence ; therefore, the program attempted to develop skill sets among the staff to help them identifying such women and point them to relevant care, such as immediate psychological first aid.

An important function of the crisis centre was to provide crisis-intervention services, including counselling. There was a dearth of documentation related to the counselling approach used by the women's movement ; therefore, Dilaasa developed its crisis counselling methodology from the literature published in the developed countries on feminist counselling and adapted it to the Indian context. The important issue of "attempted suicide" was located in the health setting through the crisis intervention program of Dilaasa. This was an important contribution in constructing gender-sensitive diagnostic tools for cases of "accidental consumption of poison."

An external evaluation of the Dilaasa crisis centre 10 years after its establishment (2010) showed that the location of the crisis centre within a hospital enhanced its accessibility and led to early detection of violence against women. A large number of women were identified in the first 2 years of facing abuse. Women of childbearing age had contact with the health system that made it possible for health providers to identify violence in their antenatal visits. This sustainable model has been globally recognized, and is being replicated in several states such as Meghalaya, Gujarat, Madhya Pradesh, Karnataka, and Uttar Pradesh and has been adopted by the WHO.

Another major contribution to literature and practice is in the realm of the medico-legal response to survivors of sexual violence. The women's movement in India had been voicing its concerns about the archaic methods of examination to determine whether there had been sexual assault. CEHAT approached the issue of sexual violence from a rights-based perspective. Intervention research was carried out while implementing a SAFE (sexual assault and forensic examination) kit in three municipal hospitals of Mumbai. The kit ensured the correct collection of evidence and its preservation, recording, and examination. Although this kit was developed in 1998, it took a decade of advocacy to have its use made mandatory. The collaboration of CEHAT with the BMC through the Dilaasa hospital-based crisis centre played a critical role in the system's acceptance of the kit.

Informing Research — The analysis of the medico-legal records brought to light important facts about sexual violence, the unrecognized larger health consequences of sexual violence, and the circumstances in hospital and forensic practice that resulted in the loss of medical evidence. Lack of injuries was a major reason why courts denied that sexual assault had taken place. An important finding of the study was to show that only a third of the survivors sustained genital or physical injuries due to delays in reporting to the hospital, being too scared to resist the perpetrator, and being rendered unconscious. These circumstances must inform the current medico-legal practice in India in the context of sexual violence.

Informing Practice — Armed with this rigorous analysis, CEHAT lobbied and advocated for change in the existing archaic medical practices. It has played a critical role in redrafting medico-legal protocols for the care of survivors of sexual violence under the Government of India's Ministry of Health and Family Welfare. Simultaneously, CEHAT has expanded an earlier gender review of Indian forensic textbooks.

Case Study Two — An analysis of time-series data (from 1951 for all states and the central government) on health care services revealed the gradual withdrawal of state expenditures on health care that belied the avowed policy intentions. This gave impetus to the demand for increased state resources for health care and a reassertion by the state of its welfare responsibilities. Recent studies have shown that there has been an increasing trend to private expenditure, which is largely out of pocket. Investment in the public sector for health has been inadequate, and the state has never committed more than 3.5% of its resources to the health sector.

Defining the issue through research — In the 1980s, the Foundation for Research in Community Health showed that that public spending on health had risen by only 1.1% over 30 years, while private household health expenditure was INR182 annually (7.6% of all consumption expenditures). Given that two thirds of the population lived at subsistence levels, this was huge. A series of studies on health financing and health expenditures of both the government and the private health sector showed that state policies had systematically nurtured the private health sector by offering subsidies, loans, and tax waivers, but had done little to regulate it or ensure that it was affordable and accessible. This ran parallel to the neglect and gradual withdrawal of the state from public health.

From research to advocacy — Starting in 1994, CEHAT began to focus on the lack of regulation of the private health sector and carried out research and advocacy projects to build evidence of the poor quality of care being provided by the private sector, and their apathy to any regulations. Such studies of the private health sector have informed the movement in many ways. This work has been transformed into advocacy and recommendations to governments, medical associations, and other agencies to strengthen the demand for regulations in the private sector and to make health care affordable.

3 Main messages for policy and practice

Since the 1980s a variety of people's movements have produced a rich collection of social research. Their subject matter has always been informed by the immediate needs of the movement. This study has shown that movement research has often wrested the initiative from state agencies and actors to propose and act upon innovative solutions to social challenges.

This research has produced a large body of theories, conceptualizations, and methodological innovations that have not been fully explored or addressed. Movement research has primarily been used to bring about policy change or programmatic innovations. Important as this is, it is imperative for the growth and development of the enterprise of social sciences that movement research be better recognized. For example, its

role in contextualizing and "Indianizing" concepts and theories, such as in the area of domestic violence or on the issue of large dams and water management, needs better recognition and integration into the mainstream of research and teaching.

This will not happen as a matter of course. Movement research emerges from a perspective that is by and large critical of dominant ideologies and frameworks. However, in India at least, there has been a resurgence of people's movements that are forming an alternative political platform for debate and action and nudging the state toward accommodation and transformation. Social science research emerging from people's movements needs to be explored for setting new agendas for academia. It is imperative that bridges be built to create opportunities for a symbiosis of mainstream and alternative research.

India is undergoing tremendous economic, social, and cultural change. Such large-scale and rapid change is bound to disturb conventional pathways of knowledge formation. The social context of knowledge accumulation is inevitably changing as are the terms of social and intellectual discourse. The current dissatisfaction in academia about the quality of research partly stems from the fact that social distance is widening between those who pursue social research and those who may benefit. The social contours of academia are also changing to allow for the entry of new perspectives. In these circumstances, the growth of research that challenges existing and predetermined constructs will become inevitable and lead to conceptual innovations and new theoretical understanding. In this context, platforms and processes for a genuine engagement between research in academia and within the movement must emerge.