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Understanding the conviction of Binayak Sen: Neocolonialism, political violence and the political economy of health in the central Indian tribal belt

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ABSTRACT

The health of adivasis' (Scheduled Tribes or indigenous peoples) is far worse than the general Indian population. Binayak Sen, a renowned Indian public health practitioner, has worked with adivasis in central India for over thirty years. On Christmas Eve 2010 Sen was convicted of involvement with Maoist insurgents and sentenced to life in prison. Sen's conviction has been condemned by Amnesty International and Human Rights Watch, and medical journals such as *The Lancet* and the *British Medical Journal* are campaigning for his release. This short report addresses the apparently vexing question of how such a miscarriage of justice could happen to a well-reputed physician in a country that is widely referred to as 'the world's largest democracy'. Both Sen's conviction and the health crisis among adivasis in central India are symptoms of what Paul Farmer (2005) refers to as 'deeper pathologies of power'; specifically, the neocolonial political economy in which the state is very active in dispossessing adivasis but inactive in providing benevolent functions. Thus, the case demonstrates the manner in which public health is intimately related to social, economic and political processes.

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Introduction

Binayak Sen is an Indian paediatrician and public health expert who has spent the past three decades working among adivasis (Scheduled Tribes or indigenous peoples) in the central-eastern Indian state of Chhattisgarh. His work has been nationally and internationally recognized: in 2007 the Indian Academy of Social Sciences awarded him the RR Keithan Gold medal and in 2008 he received the Jonathan Mann Award for Health and Human Rights from the Global Health Council. Sen condemned the violence perpetrated by Maoists, who have a strong presence in tribal areas of Chhattisgarh, and described their insurgency as 'an invalid and unsustainable movement' (quoted in Chaudhury, 2008). Notwithstanding, in May 2007 he was arrested and accused of involvement with the insurgents. Despite the evidence against him being full of discrepancies and contradictions on material points, Sen was convicted of sedition on Christmas Eve 2010 and sentenced to life in jail (Punwani, 2010; Verma, 2010).

Sen's conviction caused outrage domestically and internationally. In India the traditionally pro-government English language press has consistently disparaged the conviction, as have a large number of public intellectuals, including Amartya Sen (2010). It should be noted, however, that the Indian Medical Association has not condemned Sen's incarceration. Amnesty International (2010) has stated that the legal proceedings were 'politically motivated' and violated 'international fair trial standards'. Human Rights Watch (2011) has expressed similar sentiments. The case has attracted the attention of *The Lancet* (Editorial 2011) and *The British Medical Journal* (Mudur, 2010). But these short news articles merely outline the narrative of the case. They do not address the apparently vexing question of how such a miscarriage of justice could happen to a well-reputed physician in a country that is widely referred to as 'the world's largest democracy'. Nor do they consider how Sen's conviction relates to the health crisis among adivasis in central India and the work that Sen did to alleviate it. Paul Farmer (2005:7) famously argued that individual violations and ill health are not random in distribution or effect but are 'symptoms of deeper pathologies of power'. Our analysis seeks to uncover to what extent social, political and economic factors explain Sen's incarceration, and to what extent these are related to the health crisis afflicting adivasis in central India.

Binayak Sen and the health crisis in the central Indian tribal belt

A recent series in *The Lancet* (2010) argues that India is suffering a crisis in health and healthcare. The papers do not, however, note that some social groups suffer far more than others. Table 1

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Table 1
Health indicators for the total population, Scheduled Castes and Scheduled Tribes in India.

	Total Population	Scheduled Castes (Untouchables)	Scheduled Tribes (Adivasis)
Infant Mortality Rate (per 1000)	57.0	66.4	62.1
Under 5 Mortality Rate (per 1000)	74.3	88.1	95.7
% of children undernourished (weight for age)	42.5	47.9	54.5
% of children without full immunisation	56.5	60.3	68.7
% of women with anaemia	55.3	58.3	68.5
% of births not delivered by a skilled provider	54.4	59.4	74.6

Source: International Institute for Population Sciences (IIPS) and Macro International. 2007. National Family Health Survey, 2005–06. Mumbai: IIPS.

demonstrates that the health of India's 84 million adivasis (indigenous peoples or Scheduled Tribes) is significantly worse than that of the general population – even untouchables (dalits or Scheduled Castes) who lie at the bottom of the caste hierarchy (Census of India, 2001). This is consistent with the global picture: according to Stephens, Porter, Nettleton, and Willis (2006) indigenous peoples experience extreme levels of health deprivation everywhere in the world. Subramanian, Smith, and Subramanyam (2006) demonstrate that health deprivation experienced by adivasis can, in large part, be explained by socioeconomic factors. Neither of these articles, however, attempt to understand the power dynamics that explain these health – or socioeconomic – inequalities.

Adivasis' poor health can be understood in terms of the Indian political-economic system and adivasis' location within that system. Historically adivasis inhabited relatively inaccessible forested and mountainous terrain. They traded forest produce with outsiders, but sovereigns on the plains were unable to project their power into these areas. This changed over the past two centuries with the institution of the modern nation state – first in its colonial, then its independent form – which expanded into and incorporated adivasi communities and lands. This process has, with very few exceptions, been to the detriment of adivasis: it led to loss of land to immigrants from the plains, restricted access to forests and forest produce, and exploitation by non-tribal contractors and merchant-moneylenders (Guha, 2007; Padel, 2009; Sundar, 2007).

Today, adivasis are, in theory, protected by the Indian constitution and later legislation. But, unlike other minorities, such as untouchables, adivasis have had little success in pursuing their interests through institutional political channels (Guha, 2007). In practice, therefore, exploitative power structures carried over from British rule continue to determine the interaction between adivasis and non-adivasis in independent India. This has led some observers to suggest that British colonialism has merely been replaced by 'internal colonialism' (Padel, 2009:288). The government's pro-growth macroeconomic strategy is fundamentally at odds with the adivasis' way of life, which is predominantly based on low-technology agriculture. The old grievances remain and have in many cases intensified. In addition, adivasis have been increasingly harmed by industrial mining projects. The state uses colonial legislation such as the Land Acquisition Act (1894) to dispossess adivasis of their land and sell it to mining companies, both Indian and foreign (Guha, 2007; Padel, 2009; Sundar, 2007). This is apparent in Chhattisgarh's tribal regions, which have large deposits of minerals. While the state has been very active in dispossessing adivasis of their livelihoods and suppressing any discontent arising from this process, it has been far less active in providing the benevolent functions of the state, such as healthcare, education, development assistance and a functioning legal system. As a result public health provisions are often inadequate or absent and the situation in terms of broader social determinants of health is very bad (Planning Commission, 2008).

Individuals, such as Binayak Sen, have worked to improve this situation. In 1981 Sen moved to live among the mineworkers in Dalli Rajhara. With Shankar Guha Niyogi, a mineworkers' unionist, Sen helped set up the self-funded cooperative Shaheed (Martyrs') Hospital, which continues to provide affordable healthcare to mineworkers and adivasis in the surrounding area. Niyogi was murdered in 1991 and, although never proven in court, it is widely held that the shooting was ordered by mining interests that felt threatened by his activities (Guha, 2007). After leaving Dalli Rajhara, Sen and his wife founded Rupantar, a community-based Non-Governmental Organisation (NGO), which operates in twenty predominantly adivasi villages in rural Chhattisgarh. Rupantar developed a programme providing primary and preventive healthcare through volunteer health workers trained by Sen to treat and diagnose common diseases. The programme successfully reduced mortality rates, in the case of malaria by 80% in seven years (Doctors in Defence of Dr Binayak Sen, 2008). Until recently the state appreciated Sen's work. In the 2003 he was appointed to the State Advisory Committee for Public Health. The Rupantar Programme was the inspiration for the state's Mitanin (Volunteer) programme, which in turn became the model for the Accredited Social Health Activist of the National Rural Health Mission (Sen, 2010). Rupantar – which during the trial was accused of being an insurgent organisation – continues to receive funds from both the central and state governments (Punwani, 2010).

Sen has demonstrated in his work and writings a concern for the social determinants of ill health and the iniquitous neocolonial political-economic system that to a large extent explains the health crisis in the tribal belt. His work as a physician in Dalli Rajhara was part of a broader movement to organise mining labour and improve their working conditions. With Rupantar, Sen set up seed and grain banks and encouraged the use of local, disease resistant crops (Doctors in Defence of Dr Binayak Sen, 2008). He was very critical of the state when, after a promising start, the Mitanin programme failed due to the corruption of political elites, who used programme contracts as a source of patronage (Sen, 2005). In a recent commentary published in *The Lancet*, Sen (2011) criticises the state's growth-centric economic policies, which have harmed the health of those who are affected by displacement, disenfranchisement, loss of livelihood and loss of access to common property resources.

Sen joined the People's Union for Civil Liberties (PUCL) in the 1980s, but started taking an active part in the organization's activities after the formation of the state of Chhattisgarh in 2000 in order to articulate his public health concerns. At the time of his arrest he was Chhattisgarh state General Secretary and national Vice President. During Sen's trial the prosecution suggested that the PUCL was a front organisation for the insurgents (Punwani, 2010). This is false: the PUCL was founded by Jayprakash Narayan to campaign peacefully against undemocratic and sometimes violent excesses of 'the Emergency' (1975–77), when Prime Minister Indira Gandhi declared a state of emergency, suspended elections and civil liberties, and effectively ruled by decree (see Guha, 2008). In recent years the Chhattisgarh PUCL has had reason to be active: for example, Sen took part in fact-finding missions to

investigate the hunger deaths of 23 adivasis and the violent excesses committed by both the state and the Maoist insurgents (PUCL 2004, 2006).

Two interrelated points stand out from an analysis of Sen's health activities. First, he was attempting to fill a hole where state healthcare should have been, but was not due to the neocolonial nature of the political economy. Second, his work to improve the health of adivasis came to encompass broader issues concerning the underlying social and political-economic causes of ill health.

Insurgency and counterinsurgency in Chhattisgarh

Maoist insurgents have dramatically expanded their activities in India over the past two decades. Prime Minister Manmohan Singh (2006) has stated that the insurgency poses 'the single biggest internal-security challenge' India has ever faced. The insurgents are very active in the central tribal belt in general and Chhattisgarh in particular (Ministry of Tribal Affairs, 2006; Guha, 2007; Planning Commission, 2008). Chhattisgarh accounts for 2.0% of India's total population and 4.1% of its landmass (Census of India, 2001); but since 2001, 37.4% (5980 out of 15731) deaths resulting from insurgent incidents were in Chhattisgarh (Ministry of Home Affairs 2010).

The Maoists have thrived in similar conditions to those in which Binayak Sen worked. As the Ministry of Home Affairs (2009:15–16) points out, the insurgents:

> operate in the vacuum created by functional inadequacies of field level governance structures, espouse local demands, and take advantage of prevalent dissatisfaction and feelings of perceived neglect and injustice among underprivileged and remote segments of population.

The insurgent organization consists of two parts. Dalams (guerrilla squads) carry out violent activities from their bases deep in the jungle, which frequently make headlines across the world. For example, in April 2010 the insurgents ambushed and killed 76 paramilitary policemen in southern Chhattisgarh (BBC News, 2010). Sanghams (committees) live within the community and undertake non-violent activities in order to generate mass support among adivasis. The insurgents redistribute land, chase away forest guards to allow adivasis access to the forests, and pressurise employers and traders to respectively increase wages and forest produce prices (Planning Commission, 2008). People's Courts (Jan Adalats) provide an effective mechanism for addressing adivasis' grievances and targets include physicians who are frequently absent or who illegally demand payments (Sundar, 2007). Insurgent literature claims sanghams undertake substantial development work, building clinics, as well as schools, irrigation schemes and fish tanks (ibid). A human rights activist who recently spent time in insurgent-held areas in southern Chhattisgarh, described how, due to the lack of hospitals and trained doctors, the insurgents have developed a programme that bears close resemblance to that of Sen's Rupantar, in which Maoist physicians run mobile healthcare units and conduct workshops that train sangham members to identify and treat common diseases (Navlakha, 2010).

In response to the success of the insurgents in Chhattisgarh, the state intensified its counterinsurgency in 2005. Salwa Judum has been presented by the state government as a spontaneous people's movement against the insurgents in southern Chhattisgarh. But the PUCL and other groups revealed that in reality it was a state-funded militia that operated with impunity (PUCL, 2006; Independent Citizens' Initiative 2006: Asian Centre for Human Rights 2006). These allegations were later confirmed by the National Human Rights Commission (2008). With the help of regular security forces, Salwa Judum forcibly removed the populations of 600 villages in southern Chhattisgarh. At the height of the counterinsurgency between 40,000 and 50,000 people lived in roadside camps and a quarter of a million people remained in insurgent controlled territory or fled to neighbouring areas (Independent Citizens' Initiative, 2006; Sundar, 2007). The counterinsurgency led to a dramatic increase in violence. On the one side, Salwa Judum cadre burnt houses, killed suspected Maoist sympathizers and sexually assaulted women. On the other, insurgents increased their level of retaliatory violence to attack the counterinsurgents, punish those they believed were sympathizers and spread fear in the broader population (ibid).

Salwa Judum performed several functions. One was economic. The insurgents and a number of human rights activists argue that Salwa Judum is part of a 'ground clearing exercise' for mining (I. Sen, 2006). There is evidence to support these claims. Mahendra Karma, the Salwa Judum leader and erstwhile leader of the Indian National Congress opposition in Chhattisgarh parliament, also acted as an agent for Tata and Essar, two large steel corporations, in acquiring land for their projects in southern Chhattisgarh. Moreover, the state government signed agreements with Tata and Essar to build in steel plants southern Chhattisgarh on the very same day the Salwa Judum was formed. Both projects were strongly opposed by adivasis. Under Panchayat Extension Scheduled Areas Act (1996), a special law for areas with large adivasi populations, the village council can veto mining plans. But in these cases, villages were forced at gunpoint to consent (Independent Citizens' Initiative 2006: Sundar, 2007).

Second, Salwa Judum served a military purpose. A major issue in irregular warfare – in which a militarily weaker non-state actor refuses to directly engage the state and instead conducts guerrilla warfare – is identification (Kalyvas, 2006). Because of the lack of frontlines and the fragmented nature of sovereignty it is very difficult for the state to identify friend from foe. The formation of Salwa Judum and the camps solved this problem because it allowed the state to view those who obeyed and relocated to the camps as supporting the counterinsurgents, whereas those who defied Salwa Judum and remained outside the camps were regarded as insurgent supporters. Indeed, the Chief Minister of Chhattisgarh declared that 'those in the camps are with the government and those in the forests are with the Maoists' (quoted in Balagopal, 2006:2184).

This binary understanding bears little relation to the complex reality in which support can be conceptualised as a continuum that encompasses various shades of association, including neutrality. Sen stated: 'I have never condoned Maoist violence. It is an invalid and unsustainable movement… But the grievances are real' (quoted in Chaudhury, 2008). Like the insurgents he was very critical of the state's deficiencies in, inter alia, public health, as well as the violence of the counterinsurgency. But, unlike the insurgents he did not see armed revolution as the best way to improve their situation. In late 2005 the PUCL, led by Sen, undertook the fact-finding investigation that first highlighted atrocities committed by Salwa Judum against adivasis in Maoist affected areas and established the state government's complicity in the movement (PUCL, 2006). The PUCL did not endorse the Maoist strategy. It merely called for the establishment of good governance and constitutional values. Nevertheless, this nuance was lost on the state of Chhattisgarh and several weeks after the PUCL report was published the erstwhile Chhattisgarh Director General of Police, declared 'we will take care of PUCL' (Punwani, 2010:23). After drawn out legal proceedings this threat was fulfilled on Christmas Eve 2010.

At the time of writing Binayak Sen remains incarcerated and his prospects look mixed. At the state level the picture is not promising. Sen's request for bail pending a retrial was rejected by the Chhattisgarh High Court in February and Chhattisgarh state filed an appeal that challenges the Sessions Court's decision to acquit Sen of charges related to waging war against the Government of India in

March (Sharma, 2011). Sen's main hope for redress is the Supreme Court in Delhi. In March Sen requested the suspension of the lower court's verdict and to be released on bail. The Supreme Court has issued notice to the Chhattisgarh government to file its response within four weeks and Sen's supporters are hopeful that his application will be granted (Surya, 2011). But, even if Sen is released in the coming months, his case should not be seen as an aberration. Rather, it must be understood in the context of a neocolonial political economy in the central Indian tribal belt that continues to condemn the majority of adivasis to poverty and ill health.

Conclusion

The conviction of Binayak Sen provides a prism through which we can analyse broader issues relating to the health crisis in the central Indian tribal belt. That Sen was convicted of sedition, an offence introduced by the British in 1870 to suppress those who questioned the legitimacy of colonial rule, is telling. His plight – as well as the health crisis in tribal areas of central India – should be understood in the context of a neocolonial political economy in which the state cares more about minerals lying below the ground than the adivasis living above it. Thus, both Sen's conviction and the health crisis among adivasis are not random in distribution or effect, but are symptoms of deeper pathologies of power.

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