Rebel Health Services in South Asia: Comparing Maoist-led Conflicts in India and Nepal

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Abstract

This is the first paper comparing Indian and Nepali Maoist rebels providing health services and health promotion to the communities under their influence. The paper presents the key provisions either made by rebel health workers themselves or by putting political pressure on government health workers to deliver better services in the areas controlled by rebels. The paper is based on a mixed-method approach comprising 15 interviews and a questionnaire survey with 197 Nepalese Maoist health workers and a secondary analysis of policy documents and other published materials on the Maoist health services of India. The paper suggests that rebel health services in India and Nepal followed a fairly similar approach to what and how they offered health care services to local populations. Maoists becoming a government party changed the political landscape for the rebel health workers in Nepal. However, not incorporating the Maoist rebel health workers into the government health system was a missed opportunity. There are lessons that India and Nepal can learn from each other. Should the Maoist rebels and the Government of India come to an agreement, potential for rebel health workers to be integrated in the official health care system should be considered.

I

Introduction

Of the many conflicts across the globe a minority is ideological, often based on left-wing ideologies. The Heidelberg Report (2009) suggested that nearly 20% of all 365 conflicts identified had ideological or systemic roots. The proportion of the latter is higher in Asia and Oceania than elsewhere as one-third of the conflicts in Asia and Oceania are guerrilla wars motivated by communist ideologies, including those in India, the Philippines and Nepal. In India the rebel party is the Communist Party of India-Maoist (CPI-Maoist), popularly known as Naxalites, whilst in Nepal the rebellion in the late twentieth century was led by the Communist Party of Nepal-Maoist (CPN-M).

India and Nepal have a number of common features as well as such a unique distinguishing element. Nepal is a land-locked country with only two neighbours, Tibet/China in the north and India in the west, south and east. Apart from being neighbours similarities between India and Nepal include having: (a) a predominantly Hindu population; (b) a large proportion of its population living in rural areas; (c) a shortage of health facilities and health workers in the rural areas; (d) a parliamentary democracy; and (e) a presence of Maoist rebels or a recent experience of Marxist rebellion within their borders. Differences include: (a) a different history of colonisation; whilst India was the Jewel in the Crown of the British Empire, Nepal was never colonised by any European country; b) government; Nepal was ruled by monarchy for over 240 years until 1990 while India has been a much longer experience of being a republic and the largest democracy (population-wise) in the world. Although both countries now have a similar system of government, Nepal only became a parliamentary democracy in 1990 before that it was the only Hindu kingdom in the world; and (c) level of economic development, India has a much

more developed economy with a Gross Domestic Product (GDP) per capita three times higher than Nepal. The Central Intelligence Agency (2013) which produced comparative statistics for most countries estimates that the 2012 GDP for India was US$ 3,900 and for Nepal was US$ 1,300 per capita.

India and Nepal have an open border, meaning that their citizens can easily travel between the two countries. For example, many thousands of Indian pilgrims visit Nepal's Hindu temples and festivals or Buddha's birthplace in Lumbini each year. In 2012 nearly 170,000 tourists came to Nepal from India (Ministry of Tourism & Civil Aviation 2013). The Nepal Institute of Development Studies estimates that over two million Nepalese are (seasonal) migrant workers in India (NIDS 2011). All major rivers from Nepal flow into India. Pushpita Das (2008: 879) argued that the open-border policy has been largely beneficial but that it is misused 'by smugglers, drugs and arms traffickers, terrorists and insurgents, petty criminals, etc.' Due to their common cultures, religion and family relationships, and the open border, ties exist between the Marxists/Maoist rebel groups in both countries. Sapkota (2010: 211) noted that 'the Indian ruling class viewed Nepali Maoists as 'common challenge' of India and Nepal.' These factors have facilitated formation of the so-called red corridor from Andhra Pradesh in the South of India to the Himalayas in the north of Nepal (Gayer and Jafffrelot, 2009: 47; Shah and Pettigrew, 2009: 225; Sapkota 2010: 211). In Nepal, the main Maoist rebel group CPN-Maoist currently known as United Communist Party of Nepal-Maoist (UCPN-Maoist), participated in the peace process which resulted in the 2006 Peace Agreement and an interim government which included the former rebels. At the same time the Indian Maoist rebels continue their fight against the Indian Government for meeting their 'revolutionary' goal.

Health care provision is below standards in large parts of rural India and Nepal. In both

countries the recruitment and retention of health care workers in rural areas is a major problem even without any major violent conflict. The problem of providing health care workers, or more precisely coping with the shortage of it, is a serious problem in countries disrupted by armed conflicts (Pavignani 2011). Perhaps we can learn lessons from Nepal and India's rebel movement including their health care provisions and use them for establishing peace and improving health of people living in conflict prone areas.

The paper focuses on rebel health services in the context of Maoist insurgency in India and Nepal. While examining the health services organised by the Maoists in India and Nepal, the authors have made efforts to answer the following questions in a comparative perspective: (a) What rebel health services exist in India and Nepal?; (b) What was the effect on the health of the people living in the conflict zones?; and (c) What lessons can be learnt at policy level? Here rebel health services means health-related services such as diagnosing the disease, making medicines available free of cost, counselling patients and educating them regarding the dose of medicine, duration of treatment and importance of basic hygiene and boiled drinking water, etc. provided by the trained Naxalite or Maoist cadres in their areas of operation. Local youth belonging to the Maoist or Naxalite organisation have been given basic training for around a couple of weeks by the professional health workers associated with the Naxalite organisations or sympathetic to their cause to provide such health services.

Including this introduction, this paper is divided into eight sections. The following section is about the methods. This section details the sources of data, the techniques of data collection and the comparative approach that we have adopted in our understanding of the issue. The third and fourth sections present a brief introduction to the Maoist rebellion in India and

followed by that in Nepal respectively. The fifth and sixth sections are about the rebel health services in India and in Nepal in that order. These two sections detail the abysmal condition of health services in the Maoist-affected areas and the methods used by the Maoists to alleviate the condition of health services. The subsequent section draws the Indian and Nepalese experiences together and puts forward a comparison of rebel health services in India and in Nepal. The last section presents the paper's conclusions.

II

Methods

In order to study differences and similarities in approaches to health care provision between Maoist rebels in the two neighbouring countries we employed a comparative approach (Ragin 1987; Clasen 2004; Helen et al. 2014). Such comparative research helped the researchers to examine the issue from a new perspective based on in-sights originally gained in the separate country-based analysis of rebel health provisions in India and Nepal. Like others making cross-national comparisons in the health field we are aware 'we do not show processes of health care practice in detail' (Kümpers et al. 2002: 343). Our comparative analysis also brings a multi-disciplinary approach founded on the disciplines of sociology, social policy and public health. Comparative approaches like ours have taken analytical concepts from one academic field such as medical sociology and employed these in another field or vice versa (van Teijlingen and Pitchforth 2010).

Since Maoist organisations are banned organisations in India and therefore difficult to establish direct interactions with them for the purpose of data collection, the data about Indian

Maoist organisations, Naxalites and their provision of health services were collected from the published Maoist literature, studies by human rights activists and scholars, discussion with Naxalite/Maoist functionaries and sympathisers and health experts, and government reports.

The individual data for Nepal were collected as part of a mixed-method study: interviews were conducted with 15 Maoist health workers (female=6; male=9), mostly from rural areas and from the Maoist provisional cantonments in 2007-2008 (Devkota and van Teijlingen 2012) and administered a questionnaire study with 197 Maoist health care workers (Devkota and van Teijlingen 2010a). The data were supplemented by a review of the published literature in the field. The Nepal Health Research Council granted ethical permission for the study while the Health Division of the UCPN-M and All Nepal Public Health Worker's Association (ANPHWA)-Maoist sister wing, facilitated access to their health workers (Devkota and van Teijlingen 2010a, 2010b). The findings and conclusions dealt in this paper are informed based on the findings of the interviews as well as the personal observations of the authors and review of the available literature.

III

Naxalist/Maoist rebellion in India

In India Marxist rebels are often referred to as Naxalites. The term originates from Naxalbari, a village in Darjeeling district of West Bengal, which became the epicentre of tribal-peasant revolt in 1967 (Dasgupta 1974). The Naxalites are non-state or anti-state groups consisting of landless agricultural labourers, peasants, tribal and lower caste people or dalits. They follow a Marxism-Leninism ideology highlighting the exploitation of poor peasants and agricultural workers as

well as the exploitation and displacement of the tribes or adivasis from their homeland (Roy 1975; Ray 1988).

Initially, most Naxalites were either members or sympathisers of the Communist Party of India (Marxist). However, soon after the 1967 Naxalbari uprising they broke away and constituted the All India Coordination Committee of Communist Revolutionaries (AICCCR). In 1969, the AICCCR gave birth to the most notable Naxalite organisation, the Communist Party of India (Marxist-Leninist) [CPI(ML)] and focussed on 'seizure of power through an agrarian revolution'. Initially its strategy was focused on the elimination of the feudal order, and land reforms and social justice. The CPI-(ML) promoted guerrilla warfare against the landlords. The party planned a strong resistance against the police and tried to establish 'liberated zones' in different parts of the country that would eventually coalesce into a territory under Naxalite control (Singh 1995; Simeon 2010).

Charu Majumdar, the main Naxalite ideologue, was captured from his hide-out in Calcutta on 16 July 1972. He was imprisoned in Lal Bazar lock-up and after 12 days he died there. Soon after his death the movement fell apart. By 1980 there were around 30 Naxalite groups across India (Banerjee 1984; Singh 1995). However, the fragmentation did not weaken Naxalism as an ideology; it remained a potent political force and kept on spreading into other states. Today, Naxalite organisations are active in around 170 of the country's 604 administrative zones, affecting about 40% of India’s landmass and 35% of its population (Ramakrishnan 2005; Home Ministry’s Annual Report, 2010). A media report suggests that 10,000 deaths were caused by Naxalites in the five-year period from 2005 to 2010 (DNA 2010). Of these deaths, the security forces accounted for around 1,500 and also around 1500 Naxalites were killed by the security forces during this period (Bhaumik 2010; Burke 2010). There have also been a significant

number of killings due to the Maoist insurgency and counter insurgency between 1967 and 2004. However, there is no systematically collected data available for this period.

With the spread of Naxalim into different parts of India and its fragmentation into different groups, the movement changed organisationally and politically, but the focus on revolution in rural India and its ideology did not change. In the recent past the Naxalite organisations have come together to form CPI (Maoist) in 2004 (Harriss 2010); a unification which Sapkota (2010: 240) claims was 'inspired by Nepal's People's War.'

Chitralekha (2010: 314) argues that it is understandable why people join the rebels considering the hard lives of the locals in Mahuadabr who have 'no electricity, limited water resources, no public healthcare and no high school—it is predictably fertile recruitment ground for *dastas* (armed Naxalite units).' Owing to the issues they pursue, the Naxalites have a social base that sustains their movement despite a variety of repressive measures pursued by the state. The continuity and sustenance of the Naxalites can be explained by the persistence of the basic causes that gave its birth – feudal exploitation and oppression of the rural poor and the problems relating to land rights, social justice, displacement and rehabilitation (Navlakha 2010; Shah and Pettigrew 2009; Roy 2010a; Narayan et al. 2000).

IV

Maoist rebellion in Nepal

Various left-wing groups, based on a Marxist/Maoist ideology, have been active in Nepal since the 1960s. Nepal at that time was a very traditional and largely agricultural society. For nearly two centuries it had an oligarchic system with a royal family at the top. At the time Maoist ideas

and ideology appeared to have travelled generally to Nepal from India rather than from the Maoist People's Republic of China. Despite minor constitutional changes not much changed until a multiparty constitutional monarchy was established in 1990. As the democratically elected government in 1991 did not deliver services as per people's rising expectations, the former Communist Party of Nepal-Maoist (CPN-M) took this opportunity to start an insurgency against the state in 1996 which turned into a decade-long rebellion in the form of a violent conflict. The insurgents' early success has been ascribed to the combination of a lack of government response and the popularity of their strategy among the impoverished and exploited locals (Shakya 2009: 139). Quy-Toan Do and Lakshmi Iyer (2010) concluded that the poorer the district the greater the number of conflict-related deaths in that district. In other words, the Maoist found a fertile ground among the rural poor. In Nepal this decade-long period of insurgency is referred to as Janayuddha or the 'People's War'. During the Janayuddha Maoist rebels sheltered regularly over the border in India and established communication posts there. Nepali rebels used the open border to their advantage as Sapkota (2010: 170) noted: 'contact persons were placed in neighbouring Indian states like Bihar, West Bengal and Uttar Pradesh.'

When the king took over the control of the country from parliament and gained absolute power in 2003, it created an environment which united the UCPN-M with other political parties against his regime. The popular protest that followed in 2005 turned into peace negotiations and a peace agreement in 2006. This was followed by national elections for an interim government. In the elections the Maoists emerged as the largest elected party and thereafter it headed the first coalition government in 2008 which ultimately led to the abdication of the king and the start of a new republic.

During the Janayuddha over 13,000 people died, at least 1,200 disappeared, thousands of

Nepalis were disabled and many more displaced (Devkota and van Teijlingen 2010a). Also during the rebellion over one thousand rural health posts were destroyed (Mukhida 2006), health workers were kidnapped by rebels, prosecuted by the warring forces or threatened by both the rebels and the state parties, and at least a dozen were killed (Devkota and van Teijlingen 2010a). It aggravated the already poor health services as one third of Nepal's health centres are in rural areas and often operate without health staff (Devkota2005:25). The conflict affected health programmes implemented by some non-governmental organisations. Four international agencies suspended their programmes in western Nepal in May 2005, because of rebel attacks on aid workers (Kievelitz and Polzer, 2002). Many other development organisations had to suspend their activities due to pressure from the government or the rebels.

V

Rebel health care in India

Naxalite organisations claim that they have been trying to resolve long-standing fundamental problems faced by the poorest section of society in India by actively taking up the issues that reflect their basic needs and expectations. One of those issues is concerned with basic health services. The fact that the Naxalites made health care one of the nine departments of the People's Government formed by the Maoists illustrates its importance (Kishenji 2009; Roy 2010a). The People's Government is known by different names such as Janta Sarkar or Janatana Sarkar, each is elected by a cluster of villages with about 5,000 people.

It is widely accepted that the health system in India is quite insensitive to the needs of rural people and especially the poor (Pinto 2012). Despite it having 'a political tradition that sees

health as best safeguarded and realised through the achievements of social justice' (Ram 2014: 1188-1189), in reality many of the poorest Indians, especially those in rural areas, do not even receive basic healthcare, let alone hospital care, and two-thirds have no access to essential drugs. Still, the poor spend a relatively high percentage of their income on health care. Moreover, there is a rural-urban divide in the health system in India. Although around three-fourths Indians live in villages, more than three-quarters of doctors and pharmacists and about sixty percent of hospitals are located in urban areas (Baru et al. 2010). The marginalisation of the poor is likely to increase with the unregulated privatisation of health services in contemporary India (Qadeer et al. 2001; Selvaraj and Karan 2009). Key government health policies including its flagship public health programme, the National Rural Health Mission, have not been able to end inequality in access that deprives the poorest from health services (Dasgupta and Qadeer 2005; Husain 2011). This situation is worst in the Naxalite dominated areas as illustrated here in detail by Arundhati Roy, a human rights activist visiting Dandakaranya:

> On the grounds I run into Comrade Doctor. He's been running a little medical camp on the edge of the dance floor. …. I ask him what it's looking like, the health of Dandakaranya. His reply makes my blood run cold. Most of the people he has seen, he says, including those in the PLGA (People's Liberation Guerrilla Army), have a haemoglobin count that's between five and six (when the standard for Indian women is 11.) There's TB caused by more than two years of chronic anaemia. Young children are suffering from Protein Energy Malnutrition Grade II, in medical terminology called Kwashiorkor. (I looked it up later. It's a word derived from the Ga language of Coastal Ghana and means 'the sickness a

baby gets when the new baby comes'. Basically the old baby stops getting mother's milk, and there's not enough food to provide it nutrition.) 'It's an epidemic here, like in Biafra,' Comrade Doctor says, 'I have worked in villages before, but I've never seen anything like this.'

Apart from this, there's malaria, osteoporosis, tapeworm, severe ear and tooth infections and primary amenorrhea—which is when malnutrition during puberty causes a woman's menstrual cycle to disappear, or never appear in the first place.

'There are no clinics in this forest apart from one or two in Gadchiroli. No doctors. No medicines.'

He's off now, with his little team, on an eight-day trek to Abujhmad. He's in 'dress' too, Comrade Doctor. So, if they find him, they'll kill him (Roy 2010a: 53-54).

Visiting Bastar, a Naxalite dominated area, Satnam reported that '… in the villages, you won't find many elderly men or women – our people rarely reach the age of fifty …. Death begins chasing us as we approach fifty years of age' (Satnam 2010: 42).

Against this background, the Naxalite or Maoist organisations have tried to address the health-related problems of the poor, particularly their sympathisers. The media, including the publications by the Maoists, report that in the Naxalite affected areas the doctors or health workers associated with government facilities, who previously delivered poor or no services to the poor have been attending to poor patients. In the past doctors may have used excuses such as lack of time, over engagement, and long waiting list of patients to fob off the poor. These

patients are no longer facing humiliation or frustration in the public health centres. Even in their private consulting room, many doctors in Naxalite controlled areas take care of these patients and either do not charge or charge minimal fees. Local private doctors also display similar behaviour towards patients associated with Naxalite organisations. This change in the behaviour of health workers happened primarily because of the fear generated by the Naxalites or Maoists. The health workers are very well aware that, if they do not attend and treat the poor or Naxalites well, they can be punished. Consequently, the poor patients, unlike in the past, now receive basic subsidised medicines from government public health centres. However, this development has not significantly contributed to improvement of population-health status. The Naxalite-affected areas are the least developed areas of India in every sense; consequently there are no public health centres or the available ones are in very bad shape (Roy 2010b; Sen 2011). Hence, the Naxalite organisations have developed some innovative means of resolving the health-problems faced by their members or sympathisers as Naxalites have developed a health care system that consists of very informal and provisional health centres and it reaches most villages in the areas they control (Admin 2010; Bhattacharyya 2010; DSU 2009; Harris 2010; Ray 2010; Shell 2009; Wadia 2009).

Local youth supporting the Naxalites have been given basic training lasting several weeks by the professional health workers associated with the Naxalites or sympathetic to their cause. The training primarily focuses on identifying the most commonly occurring diseases in the area such as viral fever, malaria and diarrhoea, the applicable medicines, dose of medicine and duration of treatment to be used for these diseases. They are also educated in basic hygiene and the importance of boiling drinking water. The training is conducted in a covert manner. Free treatment and medicines are provided by these trained youths. The medicines for the various

diseases are distributed to the trained youths. One youth receives medicine for one or two diseases only, i.e. there is an element of specialisation, as villagers go to designated health workers for specific illnesses. These services seemed to have gained popular support as they are used by a large number of patients every day who receive free treatment and medicine. This has been made possible on the basis of monetary contributions from the villagers and voluntary labour service (*shramdan*). It has been reported that the Naxalites have many sympathisers in public hospitals or health centres. They provide their services and supply available medicines or kits to health centres set up by the Naxalites. Satnam narrates this fact after his meeting with a doctor, Dr Pavan, among the guerrillas in the jungle of Bastar:

> He came to the jungle twice a year and returned home after spending a month or two …. He is never without his bag of medicines …. Pavan keeps a large stock of iron tablets because they are needed by every guerrilla girl.
>
> Pavan imparts basic training in health care to the tribals here along the lines of the 'barefoot doctors' … shoes are worn by the guerrillas and the tribal doctors, not by the tribals who work with the Medical Unit. Pavan has had a long association with the guerrillas. In the camp, he conducts a class in the morning where he teaches them about various diseases, their causes and their treatment, and tells them the names of medicines. At night, they learn to read and write and, finally, they appear for an exam.
>
> He said that he could not bear to see people dying of a common and an easily curable disease like malaria (Satnam 2010: 58–59).

It has been reported that People's Committee against Police Atrocities (PCPA), an organisation supporting the Naxalites, has built 35 health centres or 'People's Hospitals' in Lalgarh area, a Naxalite affected area in West Bengal. The same organisation also persuaded many local doctors to treat patients at the centres. The PCPA also has ambulance vans and a team of doctors from Kolkata. These centres are providing health services and medicine for free to the villagers who earlier had to go far away towns or cities for any such needs. The PCPA has also built up a permanent hospital at Chakdoba in Belpahari, built by people from 25 nearby villages who provided voluntary labour (Frank 2010).

Moreover, the Naxalites formed mobile medical teams. When required, the mobile medical teams visit people in different villages and attend their health-related problems on daily basis. The teams also offer health education and lesson in basic hygiene. The Naxalite claim that in a district in Chhattisgarh, there are 50 such mobile health teams and 100 health centres (Kishenji 2009).

The Naxalites organise health camps where they invite health workers (including doctors), especially those who are working in the area, to participate. Health workers normally provide their services in the camps either out of fear or sympathy. Such health camps attract considerable media attention, and sometimes health camps are disrupted by the police under the pretext of law and order. According to a media report, a police team, following a tip-off that the Maoists were organising a health camp somewhere in Bihar rushed to the spot. Documents recovered locally revealed that the Maoists had planned a four-day medical camp in different villages of Kaimur hills (Anonymous 2008).

Several non-government organisations (NGOs) or civil society organisations collaborate with the Naxalites either for reasons of compulsion or sympathy. The NGOs are aware that they

cannot work in the Naxalite controlled areas without their agreement. Therefore, NGOs pay attention to Naxalites' concerns and support their health programmes. Some NGOs which focus on health improvement among the poor such as Médecins Sans Frontières (MSF), Society for Education and Research in Community Health, Amhi Amchya Arogya Sathi, Janswasthya Sahyog, Vanvashi Chetna Ashram and Rupantar have a natural sympathy for the health work of the Naxalites, although not necessarily for their ideology.

VI

Rebel health care in Nepal

Since 1996, the UCPN-M organised its own separate medical services partly in preparation for possible war casualties. The existence of such medical services is often not well known or, perhaps, underplayed. For example, in Sapkota's (2010) 270-page book on the People's War rebel health services are barely mentioned. The Maoists in Nepal started to recruit/ motivate urban doctors and paramedical staff in villages through their political programmes. They recruited a small group of paramedics who received both ideological and health-care training. They also included paramedics in combat groups or self-defence groups in the villages, whose main aim was to provide first aid during and after the combat (Vibhishikha, 2009). If injuries were more serious, rebels were known to go to India for treatment, for example PLA commander Khapagni who went to Bihar in 2005 with a bullet wound (Sapkota 2010: 212). Vibhishikha (2009) suggested that some 1,500 Maoist health workers were trained during the decade-long rebellion. The majority of these rebel health workers had been trained to provide a basic or rudimentary level of care.

Many rebel health workers wanted to help their communities and especially the poor, as illustrated by the following quote from a rebel health worker who: 'thought if I do not serve these poor people, no one would help them out. To realise this, I had to work with a force that wanted to change the status quo ideologically' (Devkota and van Teijlingen 2012: 21). Another health worker in the same study explained: 'I could serve the people best being a Maoist health worker. It offered me an opportunity to serve people on their doorstep' (Devkota and van Teijlingen 2012: 20). At the same time rebel health workers in Nepal stated,

> 'I provided treatment to many wounded comrades during the Kilo Siera and Romeo operations …we captured hundreds of police men ... We were involved in providing treatment to the injured police men captured in the war. This was the first time I treated people whom I used to hate' (Devkota and van Teijlingen 2012: 23).

Maoist health workers interviewed for the Nepalese part of this paper had been working in remote areas and provisional camps (after peace negotiations), with some being involved in primary health centres in areas controlled by the Maoists. They worked predominantly 'underground' during the time of the rebellion, but after the peace process in 2006 their work became more public. The Maoist health workers in Nepal appeared to have been largely motivated by political ideology. Typically respondents had learnt something about Maoism, liked what they heard and had joined up, as the following quote illustrates:

> There was a public awareness campaign in the village. At that time, everybody was a Maoist in the village and I thought why not I? I also started to attend their programmes and became a Maoist. (Devkota and van Teijlingen 2010a: 119).

The Maoist in Nepal developed a three-tier curriculum for their health workers, suggesting a very structured and organised approach to building their own health services (Devkota and van Teijlingen 2009). Each of these tiers comprised 30 to 45 days training, including a field practical. In the interviews most rebel health workers reported that they felt confident in providing basic health care services based on skills developed in the battlefield (Devkota and van Teijlingen 2009: 381). For the more complicated war injuries which the Nepalese rebels could not risk taking to government hospitals in Nepal, therefore they often travel to India for treatment. As Das highlighted (2008: 884) certain Indian border districts were regularly visited by Maoists rebels, 'mostly to seek medical aid and shelter.'

It has been argued that in Nepal the Maoist rebels put pressure on the health care providers in their 'base areas' or the contested areas to attend regularly at clinics in order to ensure consistent drug supplies and treatment for the local population (Devkota 2005). Moreover, Devkota and van Teijlingen (2010b) argue that the Maoist uprising in Nepal created an environment for improved coordination and communication amongst the key actors: the Ministry of Health & Population, local health workers, national and especially international donors, civil society and community representatives.

VII

Comparison of Maoism and rebel health care in India and Nepal

Both Nepal and India have experienced Marxist rebellions over the past few decades, and since Maoism largely travelled to Nepal from north India their ideologies are fairly similar. The ideological roots lie in the Chinese Maoism; both adopted the notion of a protracted guerrilla

war, encircling the cities from the rural areas. Linked to the notion of 'the fish in the water', whereby the water represents the people (the masses) and the fish the guerrilla fighters (Russell 2012).

The Maoist strategies are very similar in terms of mass mobilisation in rural areas and health camps as a tool for winning 'hearts and minds' of the local population. In both countries the Maoist uprising started in remote and rural areas, which were the poorest in each country, where wealth distribution was highly unequal and the state had failed to deliver proper public services. Berman and colleagues (2011) tested an economic theory of insurgency in Iraq and they concluded that improved government service provision reduced insurgent violence, particularly for smaller projects. We would argue that one can apply this theory to rebels in Nepal and India, who use their community-health care provision as a tool to gain hearts and minds. Local people in rebel-controlled territories make rational decisions regarding supporting the rebels (or the government) and their level of cooperation, as Popkin (1979) observed in Vietnam.

Both countries experienced parallel local governments where the Maoist set up 'janasarkar' (People's Government) in the areas they controlled which was run parallel to the official government provision. The response of the state was similar too, both saw it as a law and order problem which was dealt with increased policing and later army intervention to oppress the rebellion. In both countries the state tried to clear the Maoists from their hiding places.

Obviously there exist similarities and differences between the type and volume of health care (in the widest sense of the word) provided by the United Communist Party of Nepal-Maoist in Nepal and the various Naxalite or Maoist groups in India. First there is the distinction between health care needs of rebel fighters and that of general population prevention measures

and health promotion initiatives implemented in the areas controlled by the rebel groups. Since there was more of an active state of war in Nepal the Marxist rebels had perhaps different needs for its own party members/fighters. In both countries youth volunteers were used as a key tool in the health service delivery, some with more training than others. Both countries managed to get volunteers from existing health workers from the government and NGOs, who were sympathisers of the Maoists and delivered their services secretly.

The Nepalese and Indian rebels trained their own health cadres, similarly to the popular health workers trained by Farabundo Marti National Liberation Front of El Salvador and barefoot doctors trained by the Eritrean People's Liberation Front and Tigray People's Liberation Front in Ethiopia (Smith-Nonini, 1998), and in China in the 1960s (Bien 2008).

Both in Nepal and India health services were organised for and delivered to the poorer sections of society in the areas controlled by the Maoists. Although the Naxalites controlled a far smaller proportion of the country than their Nepalese counterparts, the sheer size of the Indian population means that they covered far more people with their health services. The difference in population coverage of health service provisions, which was more extensive in India than in Nepal is also related to the more aggressive state of war in the latter country. Nepal Marxists rebels had two features which are less obvious in India since Nepalese rebels were fighting an active war with the government, therefore: (a) they needed to be more mobile and move backwards and forwards in certain areas depending on reaction of the Nepalese army; and (b) they needed health care resources to look after their own wounded fighters. In India the use of rebel health services has perhaps had a greater effect on winning the 'hearts and minds' of the local population than in Nepal. We believe this is partly due to the fact that Naxalites are perhaps more established in the area they control, and partly because the Naxalites cover a much

greater number of people (even though it represents a small proportion of the total population in India).

In both Nepal and India we see the phenomenon that existing government health service provision to the poor improves due to the presence of Marxist rebel organisations. Rural health services are poor in both India and Nepal, even in areas without conflict. Hence any contribution made by rebel health services can easily make a great difference. In addition, rebel organisations put pressure on local health workers to ensure that the limited services they were contracted to deliver and drugs designated for the poorest were actually provided (Devkota & van Teijlingen 2015: 128), rather than drugs being pilfered and health workers not turning up for work.

The experience of Marxist rebel health services from India and Nepal could also be analysed in terms organising and delivering rural health services. How to motivate and retain health workers to work in less desirable rural areas remains a key public health question in many low-income countries. This problem is even more alarming in countries disrupted by armed conflicts which experience high shortage of health workers (Pavignani 2011), this includes both India and Nepal.

Besides similarities, there are some differences between Indian and Nepalese Maoist health services. The stage of development of the Indian insurgency and the Nepalese one is different as Maoists in India have made fewer inroads into the state than their Nepalese counterparts. In India the rebellion is ongoing. This apart, the different political history in Nepal with the former rebels included in the national government means that there has an opportunity to integrate former rebel health workers into the regular state health care system. Maoists in Nepal have enjoyed state power and the privileges and responsibilities that come with it. This

process is not without its problems for several reasons: first there is the issue of trust between former enemies; secondly, the recognition of the qualifications and/or their professional accreditation before integrating them could be controversial (Bunde-Birouste et al. 2004); and, lastly the formal health sector may not have enough space and motivation to absorb them in the public health arm (Pavignaniand Colombo, 2001). The Maoists in Nepal seemed to have gone further in the design of health workers than their Indian counterparts; the training programme of the former had a very detailed structured curriculum existing at different levels of training.

VIII

Concluding Remarks

Though the Maoist insurgencies in India and Nepal have roots in Marxism and Maoism and are characterised by many commonalities, there are different features to study and lessons to be learnt. There is a growing social and political sciences literature on Maoists rebels in South Asia, but few authors have focused on the health care aspects of the Maoists' organisation. As the Maoists in India continue their revolutionary fight with the government, they have time to learn lessons from their Nepali comrades, and there are, of course, lessons for the Indian establishment to learn from Nepal's insurgency. However, despite having a leading position in the state machinery Nepal's Maoists have missed an opportunity to duly recognise their war time health services and integrate them into the public health arm of the government. It was therefore high time for them to actually translate their promises made to the people for a better health care into a reality. For researchers, there exists an important opportunity to have a closer and in-depth look on the Maoist health care services vis-à-vis their political movements in two neighbouring

countries India and Nepal.

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